

**TAX-RELATED PROVISIONS IN
THE PRESIDENT'S HEALTH CARE LAW**

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT
OF THE
COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED THIRTEENTH CONGRESS

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**TAX-RELATED PROVISIONS IN THE
PRESIDENT'S HEALTH CARE LAW**

TUESDAY, MARCH 5, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
SUBCOMMITTEE ON OVERSIGHT,
Washington, DC.

The Subcommittee met, pursuant to notice, at 11:12 a.m., in room 1100, Longworth House Office Building, the Honorable Charles Boustany [Chairman of the Subcommittee] presiding.
[The advisory of the hearing follows:]

HEARING ADVISORY

Boustany Announces Hearing on the Tax-Related Provisions in the President's Health Care Law

1100 Longworth House Office Building at 11:00 AM
Washington, February 26, 2013

Congressman Charles W. Boustany, Jr. M.D. (R-LA), Chairman of the Subcommittee on Oversight of the Committee on Ways and Means, today announced the Subcommittee will hold a hearing on the tax provisions contained in the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 ("President's Health Care Law"). **The hearing will take place immediately following the Subcommittee organizational meeting that begins at 11:00 a.m. on Tuesday, March 5, 2013, in Room 1100 of the Longworth House Office Building.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Subcommittee and for inclusion in the printed record of the hearing. A list of invited witnesses will follow.

BACKGROUND:

According to the *Government Accountability Office (GAO)*, the President's health care law contains 47 tax or tax-related provisions. Estimates by the *Congressional Budget Office (CBO)* and the *Joint Committee on Taxation (JCT)* confirm that tax increases associated with the law total more than \$1 trillion over the next ten years. Many of these provisions are already in effect, and others will become effective in 2014. Key provisions include: a tax on medical device and drug manufacturers, and health insurers; a tax on individuals and families who do not purchase government-mandated health insurance, a tax on employers that do not offer government-mandated health insurance, additional Medicare taxes and taxes on investment income.

In its review of the tax provisions of the President's health care law, the Subcommittee will consider the: (1) status of implementation of key tax provisions; (2) compliance issues associated with the tax provisions and accompanying regulations; and (3) economic effects of the provisions.

In announcing the hearing, Chairman Boustany said, **"The President's health care law imposes a number of new taxes and reporting requirements on individuals and various industries—and many of those tax hikes hit the middle class. We are starting to see that these provisions make it harder for businesses to create good paying jobs and may adversely affect the quality and accessibility of health care. As the Committee moves forward with comprehensive tax reform, it is imperative that we examine the law's tax provisions and consider their impact on the administration of the Tax Code as well as on individuals, families, and employers."**

FOCUS OF THE HEARING:

The hearing will focus on implementation of the tax and tax-related provisions contained in the President's health care law.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, <http://waysandmeans.house.gov>, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submis-

sion for the record.” Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, March 19, 2013.** Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225-1721 or (202) 225-3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202-225-1721 or 202-226-3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at <http://www.waysandmeans.house.gov/>.

Chairman BOUSTANY. We will now begin our hearing on the tax-related provisions in the President’s health care law.

Three months ago President Obama signed into law the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act. For individuals, families, and small businesses struggling to pay for health care, this milestone is no cause for celebration. Today we will examine the impact of key tax provisions of that law.

The health care law contains over a trillion dollars in new taxes on employers, medical device makers, families buying health insurance, and others. These unprecedented new taxes could hardly come at a worse time as our economy continues to struggle through the slowest recovery on record.

With the Congressional Budget Office predicting that unemployment will remain above 7 percent, the law’s new taxes make it more costly for employers to hire, more expensive for families to purchase health insurance, and more difficult for the health care industry to innovate.

And it is getting worse every month. Federal agencies are busy issuing new regulations to implement the law, adding over 150 million new compliance burden hours a year and billions of dollars in cost that will be borne largely by employers. These are time and red tape costs on top of the taxes. This is not a recipe for economic growth and job creation.

Today's hearing will explore these new taxes and their economic effects. The new medical device tax is particularly destructive, as it targets one of the few remaining industries in which America continues to lead the world in innovation. This is an industry in which companies often go years without making a profit, hoping to survive long enough to reach profitability and introduce innovative, life-saving medical products.

But the new tax hits employers regardless of profitability, and has already resulted in layoffs and additional delays in new products reaching the market.

The new insurance tax and employer mandate threaten to stifle small business growth across all industries. Beginning next year, job creators will be saddled with burdensome new rules and taxes that disincentivize hiring new employees and provide economic incentives to reduce employees' hours and drop health insurance coverage altogether.

Before knowing whether the IRS will deem job creators a large employer and thus subject to the tax, employers will have to work out a complicated algorithm, aggregating the hours of all part-time workers and adding in the number of full-time workers. With the new law, Washington is effectively telling many Main Street businesses to cut their workforce and stop growing, hardly the incentives we need to be giving employers in our current economic climate.

Today's hearing is especially important because we will be hearing not only from economic and tax experts, but also job creators from across the country. These are individuals who spend their days trying to grow their businesses and expand economic opportunity, but are forced to do so against prevailing headwinds of new taxes and regulations from Washington. They know the effects of the new law firsthand because they live with these effects.

I was also hoping to welcome a witness who runs a small business in my district, but unfortunately, he had to cancel after his business partner had a medical emergency. I certainly wish his partner a speedy recovery, but this goes to show how unpredictable and how vulnerable a lot of our small business operations truly are. Washington should be making their jobs easier, not more difficult.

Last year the Subcommittee held hearings on a provision in the health care law that requires holders of FSAs and HSAs to get a prescription in order to use accounts to buy over-the-counter medicine. The House subsequently passed legislation, authored by Congresswoman Jenkins, repealing this provision, as well as a medical device tax repeal, which was authored by Congressman Paulsen.

I have introduced legislation repealing both the employer mandate tax and health insurance tax. These issues all reinforce the fact that the health care law was not simply a health care law. It was an enormous tax change, and as such, it is proper for the Sub-

committee to examine these laws, which are within the scope of tax reform.

Now I'm happy to yield to the distinguished Ranking Member, my friend Mr. Lewis from Georgia.

Mr. LEWIS. Thank you, Mr. Chairman. I thank the Chairman for holding this hearing on the Affordable Care Act. We are always pleased to discuss our landmark health care reform law, which will expand health coverage to 27 million Americans.

The last time the Oversight Subcommittee reviewed the tax provisions of this law was in September 2012. Since enacted, the Affordable Care Act has helped millions of Americans. For example, the Affordable Care Act has protected over 17 million children with preexisting conditions who can no longer be denied health coverage, and more than 6 million young adults who have health insurance through their parents' health plan until age 26.

As another example, the health care law requires insurance companies to spend a certain amount of the premiums they collect on medical care. As a result, about 13 million Americans received more than \$1 billion in rebate payments last year from insurance plans that failed to spend enough on benefits.

Because of positive reforms like these, we are moving forward. We must ensure that we act with all deliberate speed to implement the Affordable Care Act. I know that this hearing focuses on provisions that impose taxes on industries that benefit from the law and wealthy Americans. This one-sided view does not examine other provisions in the law that deliver hundreds of billions of dollars of Federal tax credits to millions of American families and small businesses.

These tax credit and cost-sharing subsidies will make health insurance affordable for middle-class Americans and families. Countless others now have peace of mind, knowing they are not just one step away from losing their health insurance, when it is needed the most.

Mr. Chairman, I am confident that the tax provisions of the Affordable Care Act will be carried out on schedule. Today I look forward to hearing where we are in the process, and the issues that remain. I want to thank all of the witnesses for their testimony and recommendations.

Thank you very much, Mr. Chairman.

Chairman BOUSTANY. Thank you, Mr. Lewis.

Now it's my pleasure to welcome the panel of seven witnesses we have before us today. Our witnesses today run the gamut from academics to budget experts to business owners. I'm delighted to have all of you here with us today. I think this will be a very enlightening hearing.

First we will hear from Douglas Holtz-Eakin, President of the America Action Forum here in Washington, D.C. Dr. Holtz-Eakin has been Chief Economist with the President's Council of Economic Advisors, Director of the Congressional Budget Office, and fellow at various think tanks. We're pleased to have his expertise today.

Next we have Dan Moore, President and CEO of Cyberonics, a global medical device manufacturer. Mr. Moore also serves as Chairman of the Medical Device Manufacturers Association, a

trade association composed of smaller medical device companies. Thank you, Mr. Moore, for joining us today.

Third, we will hear from Walter Humann, President and CEO of OsteoMed, a surgical device manufacturing company based in Dallas. Mr. Humann joined OsteoMed in 2001, growing the company into a variety of surgical device markets. Mr. Humann, thank you for joining us.

Fourth we will have David Kautter, Managing Director of the Kogod Tax Center and Executive-in-Residence in the Department of Accounting and Taxation at American University. Mr. Kautter had a distinguished career at Ernst & Young, where he recently served as Director of National Tax. Mr. Kautter also served on Capitol Hill as a legislative counsel to Senator John Danforth. Thank you for bringing your expertise to us today, Mr. Kautter.

Next we will hear from Shelly Sun, CEO and Co-Founder of BrightStar Care, a premium health care staffing company. BrightStar has 250 locations nationwide, providing the full continuum of care, from home care to supplemental staffing for corporate clients like nursing homes and physicians. Ms. Sun just finished writing her first book, and was named International Franchise Association Entrepreneur of the Year in 2009. Ms. Sun, thank you for joining us today.

Sixth we will hear from Hugh Joyce, President of the James River Air Conditioning Company in Richmond, Virginia. Mr. Joyce has been president of James River Air Conditioning for 19 years. He is here to speak from his experience as a small business owner, as well as on behalf of the National Federation of Independent Businesses. Mr. Joyce, thank you for joining us today.

And finally, we'll hear from Mr. Paul Van De Water, Senior Fellow with the Center on Budget and Policy Priorities. Dr. Van de Water, we appreciate you being here, as well.

We welcome all the witnesses. We received your written statements, and they will be made part of the formal hearing record. You will each have five minutes for your oral remarks, and I will start with you, Dr. Holtz-Eakin.

**STATEMENT OF DOUGLAS HOLTZ-EAKIN, PH.D., PRESIDENT,
AMERICAN ACTION FORUM**

Mr. HOLTZ-EAKIN. Chairman Boustany, Ranking Member Lewis, and Members of the Committee, I thank you for the privilege of appearing today. My written testimony contains a more detailed analysis of some of the major taxes imposed in the Affordable Care Act. Let me make four brief points as an overview.

Point number one is simply the scale of taxation is very large—easily over 800 billion, reaching nearly a trillion, and larger than the, I think, much more ballyhooed fiscal cliff deal that was reached earlier this year. Any law that imposes that scale of taxation ought to be looked at very carefully by the conventional metrics of tax policy.

And those would be how distortionary are the taxes which are imposed? What is the incidence of those taxes—that is, who will actually bear the burden, and are they fairly distributed? And then third, what will be the macroeconomic effects of those taxes?

Let me touch briefly on each. The ACA taxes are highly distortionary. If you take the benchmark that non-distortionary taxes will have a broad base and equal treatment of equals, the ACA taxes look very different than that.

The device tax and the health insurers tax are sector-specific taxes that will impact the ability to attract labor and capital to those sectors. As I detail in the written statement, each also has flaws in its design within that sector, the device tax discriminating against relatively small medical device manufacturers, and health insurers tax having a whole set of what I view as very problematic provisions, treating differently for-profit and not-for-profit insurers, treating even more differently those who have extensive lines of business in elderly and low income products.

It's a very distortionary tax, and is the only one that I've ever seen that actually demands that you raise a fixed amount of revenue, regardless of what it does to the industry, beginning with 8 billion next year. And so it's a very distortionary tax.

As you know, the so-called Medicare taxes, surtaxes on payroll income and on net investment income, draw sharp lines in the Tax Code. And even more troubling to me, those lines are not indexed for inflation; indexing the Tax Code for inflation has been a principle adopted by the United States since the early 1980s, and doesn't represent good tax policy.

So as a whole, I think of these as not-particularly-well-designed taxes, given the level of revenue they will raise.

They are also not especially progressive taxes. The taxes that are levied on device manufacturers are going to end up in health insurance costs, which will be then in turn shifted into premiums. Health insurance is a broadly consumed product, with the largest burden on the middle class in America.

Certainly the health insurance tax is going to show up very directly in premiums, and given some of its peculiarities in design—the inability to deduct this tax for the purposes of corporation income tax—there will be even greater upward pressures on premiums as a result.

And the so-called Cadillac tax on high-cost plans, despite its name, is a tax that's going to hit the middle class. And taken as a whole, these impacts are going to fall on the middle class and exacerbate other premium pressures that are already present in the ACA from benefit mandates and other regulations that have been imposed.

And the final point is that the ACA taxes suffer from very poor macroeconomic timing. As this Committee well knows, we are struggling to recover from a financial crisis and very deep recession. It is hardly a benchmark of great policy to levy hundreds of billions of dollars in new taxes, which are poorly designed, and to accompany them with a very heavy regulatory load, and an expansion of entitlement programs at a time when the U.S. debt exceeds the size of its economy and is being driven by the existing entitlement programs.

So I think that probably the greatest lesson that can be taken away from look at these taxes carefully is that even if you wanted to raise this revenue, you could do it better, and that thinking hard

about this in the context of tax reform, which I know the Ways and Means Committee is deeply interested in, is probably a good idea.
[The prepared statement of Mr. Holtz-Eakin follows:]

Taxes and the Affordable Care Act:
An Assessment

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

Douglas Holtz-Eakin, President*
American Action Forum

March 5, 2013

*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.¹ 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

¹ 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

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

Year	Fee
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

Annual Net Premiums	Fraction
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

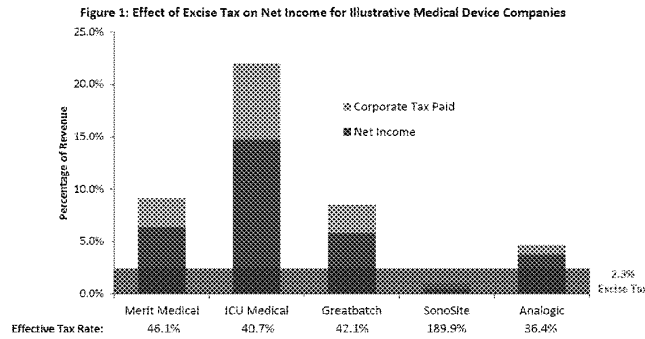
Year	2014	2015	2016	2017	2018	2019
Fees: Fully Insured Plans Only (SB)						
Premium Tax	\$8.0	\$11.3	\$11.3	\$13.9	\$14.3	\$14.3
Reinsurance	\$2.0	\$2.0	\$1.0			
Fees: Fully Insured & Self-Funded (SB)						
Reinsurance	\$10.0	\$6.0	\$4.0			
Total Fees and Assessments (SB)	\$20.0	\$19.3	\$16.3	\$13.9	\$14.3	\$14.3
Impact: Fully Insured Premiums (pct.)						
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.²



² 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)

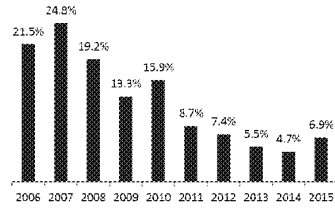
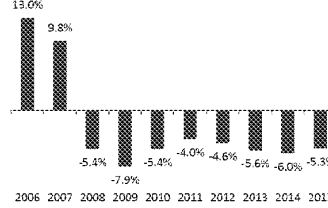


Figure 3: Change in U.S. Medical Device Companies (% Annual Change)



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
Family 1	\$30,000	\$100,000	\$130,000	+\$10,000	\$140,000	n/a	\$145
Family 2	\$30,000	\$230,000	\$260,000	+\$10,000	\$270,000	\$20,000	\$525
Family 3	\$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

Summary: Average Premium Impacts for Individual and Small Group in 2014						
<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%

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.

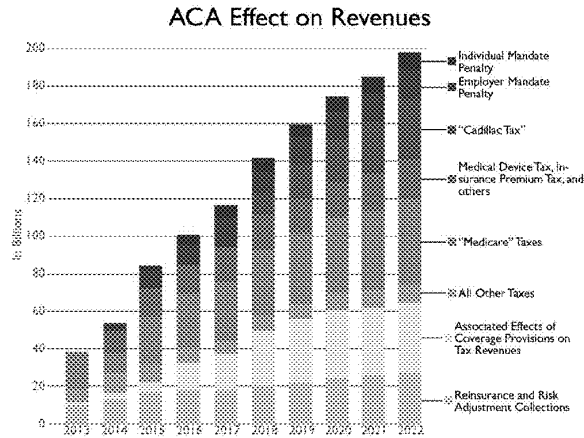
These younger, healthier individuals are likely to subsidize the cost of insurance for older patients, but not by nearly enough to avoid an overall increase. Older and less healthy individuals could enjoy a 22 percent premium decrease. It is no surprise that ACA will have an enormous impact on the structure 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.

Figure 4



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.

Chairman BOUSTANY. Thank you, Dr. Holtz-Eakin.
Mr. Moore, you are recognized for 5 minutes.

STATEMENT OF DAN MOORE, PRESIDENT AND CEO, CYBERONICS; CHAIRMAN, MEDICAL DEVICE MANUFACTURERS ASSOCIATION

Mr. MOORE. Thank you, Chairman Boustany and Ranking Member Lewis, for the opportunity to testify here today. As mentioned, my name is Dan Moore, and I am CEO of Cyberonics, a Texas-based medical device company that focuses on epilepsy and other neurological conditions. I am also the chairman of the board

for the Medical Device Manufacturers Association, and I'm pleased to be testifying today in that capacity.

The medical device technology industry is one of America's great success stories. We contribute to Americans living longer, healthier, and more productive lives. We play an important role in driving economic growth by employing high-skilled manufacturing workers, who contribute to our industry's trade surplus. We are the envy of countries around the globe.

However, I have real concerns about the future of America's global leadership in medical devices. These concerns stem in part from personal experiences as the son of a steelworker, and I'm hoping that as a country we do not lose leadership in yet another industry.

I was born in Gary, Indiana, which at one time was one of two big American steel towns. My family, friends, and neighbors were all employed in the steel industry. These hardworking Americans had opportunities for advancement when the industry was thriving.

I'm extremely proud of my father, who went from being a laborer to having responsibility for maintenance in three mills that were part of the Gary Works Corporation. He worked hard and was able to provide for my mom and our family of eight children. The United States was the global leader in steel production and manufacturing, and the byproduct of this leadership was great jobs that built communities and sustained families for decades.

Sadly, we all know what happened to this chapter of American manufacturing. I am here today to tell you today that the global leadership position of the medical device industry is at a crossroads, and not unlike what faced America's steel industry years ago.

If we lose this leadership and the great jobs and all the benefits that come with it, we will never get it back. And countless communities, again, will never look the same. The good news is that there is legislation to fix this problem, and bipartisan momentum continues to build in support of it.

Beginning on January 1st, medical device innovators began paying a 2.3 percent excise tax to the Government. I'm often asked, a 2.3 percent tax, how could it be so damaging to innovation, jobs, and patient care? After all, it's only 2.3 percent. Right? It's important to remember that this is a tax on medical device company revenues, not profits. One study estimated the tax will increase a company's effective tax rate by an average of 29 percent.

Many companies are having their entire profits wiped away because of the medical device tax. Others aren't even profitable yet, but find themselves still having to pay a tax that is destroying their ability to invest in research and development to fund future medical breakthroughs. A study showed that this onerous policy would lead to the loss of 43,000 good-paying jobs.

Regardless of company size, success, or stage of development of medical technologies, a 2.3 percent excise tax will have a significant impact, and at the end of the day a negative impact on providers and patients, the people we intend to help.

We all love the stories of innovators and entrepreneurs coming up with ideas in their garages or spare bedrooms and building American dreams into proud organizations. As I speak before you today, physicians and engineers are working on new technologies

like an artificial pancreas that will allow diabetes to control blood glucose levels automatically. Just weeks ago, the FDA approved a new product that literally allows the blind to see.

Do we really want to risk the loss of these amazing new devices by imposing an additional tax on medical device companies? Medical technology innovators are pushing the boundaries of science, all driven by American ingenuity and American manufacturing. The medical device tax is putting an end to some of these dreams and aspirations before they ever get out of the lab, or perhaps one's garage.

I respectfully urge all of you to continue working together to provide an environment where tomorrow's technologies and devices will not be sacrificed as a result of misguided policies today. None of us want to have to explain to our children one day why they don't have the opportunity to work in the same dynamic industry as their parents, focused on improving the human condition.

I pledge to all of you that I will do everything I can to help Congress and policy-makers ensure the 21st century is as bright for medical technology innovation as was the last. I urge you to support the repeal of this onerous medical device tax, a tax on innovation, jobs, and most important, a tax on patient care. Thank you for the opportunity to share my concerns today.

[The prepared statement of Mr. Moore follows:]

Written Testimony of

Dan Moore, President and CEO of Cyberonics, Inc.

March 5, 2013

U.S. House of Representatives

Subcommittee on Oversight of the Committee on Ways and Means

Hearing on the tax provisions contained in the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010 ("President's Health Care Law")

TESTIMONY

Thank you Chairman Boustany and Ranking Member Lewis for the opportunity to testify here today. My name is Dan Moore, and I am the CEO of Cyberonics, Inc., a Texas-based medical device company that focuses on device solutions for epilepsy and other neurological conditions. I am also the Chairman of the Board for the Medical Device Manufacturers Association, a group representing the innovative and entrepreneurial sector of the medical technology industry. I am here today to testify on behalf of MDMA and its hundreds of member companies to highlight this great American success story known as the medical technology industry and to share our concerns about the future of America's global leadership in medical devices. I will also share my perspectives taken from my personal experiences as the son of a steelworker, hoping that as a country, we do not lose leadership in yet another industry.

I was born in Gary, Indiana, which at one time was one of two big American steel towns, and raised in Northwest Indiana. My grandfather, father, and oldest brothers, along with many of my relatives, family friends and neighbors were all employed in the steel industry. I have fond memories of my father and others talking proudly about the work they did in the steel mills. These men had opportunities for advancement when the industry was thriving. I'm extremely proud of my father, who, through a series of promotions over the years, went from

being a laborer to having responsibility for maintenance in three of the steel mills within Gary Works. He worked hard and was able to provide for my mom and our family of eight children. My parents emphasized the importance of a college education, and it's ironic that my student loans were provided by the steel mill's credit union. The United States was the global leader in steel production and manufacturing, and the byproduct of this leadership position was great jobs that built communities and sustained families for many decades. Sadly, we all know what has happened to this chapter of American manufacturing. Workers and elected officials simply NEVER thought that we could lose our leadership position, and the great jobs, economic benefits, and positive family impact associated with a strong industry.

I consider myself extremely fortunate to be a part of a vibrant industry that plays a critical role in working with physicians and providers in the lives of patients. The medical device industry is comprised of over 400,000 highly skilled and science-driven professionals, with more than 1.4 million jobs that support this supply chain. In total, there are nearly 2 million hard working Americans who drive this proud success story, one where the United States is still the global leader. In fact, towns and communities in many states where steel and textile mills once thrived -- such as Indiana, Pennsylvania, Ohio, North Carolina and others -- have developed economically important medical technology clusters.

I am here to tell you that the global leadership position of the medical device industry is at a crossroads, and not unlike what faced America's steel industry. If we lose this leadership – and the great jobs and all the other benefits that come with it -- we will never get it back, and countless communities will again never look the same. The bad news is that the largest and one of the most daunting headwinds we face is a result of unintended consequences due to policies enacted by our government. The good news is that there is legislation to fix this problem, and bipartisan momentum continues to build in support of it.

Under a provision in the Affordable Care Act that went into effect on January 1, 2013, medical device innovators must pay a 2.3% excise tax to the government. While this policy has only been enacted for two months, it has already resulted in approximately \$200 million being sent to the I.R.S rather than being invested in patient care and job creation.

I am often asked how a 2.3% tax could be so damaging to innovation, jobs and patient care; after all, it's only 2.3%, right? It is important to remember that this is an excise tax based on medical device company revenue, not profits. One study has estimated the 2.3% excise tax on revenues will increase a company's effective tax rate by an average of 29%. This is a critical point: in addition to all of the local, state and federal income taxes that medical device companies already pay,

this policy is, on average, increasing the tax bill for one of America's most dynamic industries by almost a third.

Many companies are having their entire profits wiped away because of the medical device tax. Others aren't even profitable yet, but find themselves still having to pay a tax that is destroying their ability to grow.

Regardless of a company's size, success or stage of development of medical technologies, a 2.3% excise tax will have a significant impact, and at the end of the day, a negative impact on providers and patients, the people we intend to help.

One of the unique aspects of this innovative industry is that it is comprised overwhelmingly of small companies, 80 percent which have fewer than 50 employees. In fact, 98 percent of companies have fewer than 500 employees.

These are the very small and mid-sized companies responsible for the majority of job creation, companies on whom we are relying to help improve this economy.

To put the challenge of becoming successful in this industry into perspective, in our company's first 20 years, we had only one year with a small amount of profitability. In fact, during the first 20 years, we accumulated more than 250 million dollars in losses as we developed our life-changing technology.

Investments of tens of millions of dollars, even \$100 million or more over ten years or more, are not uncommon if one hopes one day to become a successful med-tech story. It takes tremendous amounts of research and development, clinical

trials and other expensive steps before a medical technology can – if it ever does – turn a profit.

I was fortunate to spend much of my career at a great company that was started by two individuals in the late 1970s with a dream to improve patient care and the passion to see that dream fulfilled. For nearly 18 years, I worked with engineers, scientists, manufacturers and doctors who dedicated their careers to improving the human condition. At its peak, that company grew to nearly 30,000 employees. My understanding is that company, Boston Scientific, currently has a workforce of approximately 24,000 and just announced a layoff of approximately 1,000 more people. They announced this layoff in part as a result of the device tax, which some estimates show will cost them \$75 million this year alone. This is money that should be invested in the American workforce and research and development to continue the amazing advancements in health care delivery. And this is but one story of the countless others where this policy is adversely impacting job creators. One study shows that 43,000 good paying jobs will be lost as a result of this onerous policy.

The reason I share this story is to show just how dynamic this American industry is. We all love the stories of innovators and entrepreneurs coming up with ideas in their garages or spare bedrooms and building American dreams into proud organizations. As I speak before you today, physicians and engineers are working

on new technologies like an artificial pancreas that will allow diabetics to control blood glucose levels automatically. Earlier this month the FDA approved a new product that literally allows the blind to see. Do we really want to risk the loss of these amazing new devices by imposing an additional tax on medical device companies? Medical technology innovators are pushing the boundaries of science, all driven by American ingenuity and manufacturing. The medical device tax is putting an end to some of these dreams and aspirations before they ever get out of the lab – or perhaps one’s garage.

And what does this mean to patients and providers? Sadly, policies such as the medical device tax are placing burdensome hurdles to delivering on the promises of improved patient care and a better quality of life. While many companies are addressing the device tax by cutting jobs, others are making severe cuts to R&D. The consequence of these actions is delaying or eliminating new technologies and devices that could revolutionize the health care of the future. I cannot emphasize enough just how delicate the innovation ecosystem is for medical device makers. Any cuts to R&D today will manifest themselves down the road in ways that negatively impact patients and providers.

I’ve often wondered where patient care and our industry would be had this policy been in place when I was getting started 24 years ago in medical devices. How many companies would long since have folded due to an inability to generate profit

in a reasonable time? How many jobs would have been lost, adding to the roles of the unemployed and uninsured? How many cuts to R&D would have been made, leading to unknown losses in innovation and patient care? Would all the cutting-edge devices and technologies developed over the past decade really be available today? Perhaps I would never have had the opportunity to be a part of this great American success story.

I respectfully urge all of you to continue working together to provide an environment where tomorrow's technologies and devices will not be sacrificed as a result of misguided policies today. We cannot allow this great American success story to end simply because we failed to enact policies that support innovation and patient care. None of us want to have to explain to our children one day why they don't have the opportunity to work in the same dynamic industry as did their parents, focused on improving the human condition. Repealing the medical device tax will help a proud American industry continue to be the global leader, as well as protect the innovation, jobs and communities that it supports.

America's patients, providers and workers are relying on you, and I pledge to do all that I can to help Congress and policy makers ensure that the 21st century is as bright for medical technology innovation as was the last. I urge you to support the repeal of this onerous medical device tax on innovation, jobs, and most important, patient care. Thank you for the opportunity to share my concerns with you today.

Chairman BOUSTANY. Thank you, Mr. Moore.
Mr. Humann, you are recognized for 5 minutes.

**STATEMENT OF WALT HUMANN, PRESIDENT AND CEO,
OSTEOMED**

Mr. HUMANN. Chairman Boustany, Ranking Member Lewis, Members of the Subcommittee, thank you all for the opportunity to testify before you today. Again, my name is Walt Humann. I'm president and CEO of OsteoMed, a medical device company located in Dallas, Texas. I am also on the board of the Medical Device Manufacturers Association.

On any Tuesday like today, I would normally be at OsteoMed's facilities, ensuring that our company continues to develop and produce innovative medical technologies that improve patient outcomes, lower health care costs, and provide well-paying jobs to hardworking Americans.

Instead, I am before you now to sound the alarm bell on the devastating excise tax that is already having a negative impact on thousands of medical device companies. Unfortunately, these negative consequences of the excise tax have already been felt at OsteoMed.

Like the majority of medical device companies, we have humble beginnings as a startup company. OsteoMed was founded in 1991 in Glendale, California. We started supplying proprietary patented instruments for the orthopedic industry, and quickly expanded to design, manufacture, and produce various small bone fixation devices, surgical implants, and surgical systems. I want to highlight for you a few of our products that have dramatic impacts on patient care.

One of our systems are used for children born with severe head and facial deformities. Our product allows surgeons to reconstruct very young babies for normal function and appearance, and in many cases avoid the feeding problems, the tracheotomies, and the other feeding and treatment problems that would hinder normal childhood development.

Another system we produce focuses on repairing and reconstructing the feet and ankles. OsteoMed recently was fortunate to support a mission trip to Mexico, where these products were used by surgeons to allow very young children to walk normally for the very first time. However, our ability to innovate and improve upon these projects is now threatened by the medical device tax.

When Congress passed the Affordable Care Act in 2002, it unfortunately also included this devastating tax on innovation. In particular, the ACA includes a 2.3 percent excise tax on the sales of most medical devices in the U.S. Again, this tax applies to the total revenue of a company, not to profit.

In many cases, companies will end up paying more in taxes than they actually generate in profits. As an example, two years ago we started a project within OsteoMed that greatly simplifies back surgery and reduces a two-hour operation to just 30 minutes. This project is now producing revenues, but is not yet profitable.

Unfortunately, the tax is clearly impacting the way that OsteoMed and countless other companies select future R&D projects. For some companies, the device tax has already led to significantly reduced spending on research and development. For others, it has led to a freeze on hiring and expansion projects. Finally, many companies have made the painful decision to let employees go. Unfortunately, at OsteoMed we have done all three.

Supporters of the medical device excise tax claim that the nearly 30 million new covered beneficiaries will use more medical devices, and tax will be offset. This is simply not the case. Many medical devices are products that are used on a variety of patients.

For example, automated external defibrillators are found in public places like airports, shopping malls, and here in the halls of

Congress. If a person goes into cardiac arrest today, he or she will receive the treatment regardless of their insurance status.

At OsteoMed, our products are used in trauma and reconstructive procedures. We are fortunate to live in a great country. People with injuries to the head, face, and extremities are able to receive our products. Sadly, our ability to continue to innovate on these products is threatened.

There are numerous published reports regarding the impact of the medical device excise tax. One report suggests that nearly 45,000 jobs will be lost as a result of the tax. I am here because I am concerned over 40 jobs in particular.

These are the 25 members of the OsteoMed family that had to be let go because of the medical device tax. In addition, there are more than a dozen future planned positions that now will not be pursued at OsteoMed. In the 22-year history of our company, we have never had to lay off an employee, much less for a government-related tax. Therefore, Congress must do everything it can to eliminate this devastating tax. Tens of thousands of patients who use our devices are relying on your leadership.

Nearly 300 employees and their families at OsteoMed are ready for this barrier to be removed in order for us to continue to improve health care. We must do everything in our power to ensure that this great American industry remains a truly global leader.

Thank you again for this opportunity to testify before you, and I'm happy to answer any questions later.

[The prepared statement of Mr. Humann follows:]

**Testimony on Behalf of Walt Humann, President and CEO of OsteoMed
United States House of Representatives
Ways and Means Committee, Subcommittee on Oversight**

Chairman Boustany, Ranking Member Lewis, and members of the subcommittee, thank you for the opportunity to testify today. My name is Walt Humann, and I am President & CEO of OsteoMed, a medical device company located in Dallas, Texas. I am also on the board of the Medical Device Manufacturers Association.

On any typical Tuesday like today, I would normally be at OsteoMed's facilities ensuring that our company continues to develop and produce innovative medical technologies that improve patient care, lower healthcare costs, and provide well-paying jobs to hard-working Americans. Instead, I am before you to sound the alarm bell on the devastating excise tax that already is having a negative impact on thousands of medical device companies. Unfortunately, the negative consequences of the excise tax have already been felt at OsteoMed.

Background on OsteoMed

Like the majority of medical device companies, we have humble beginnings as a small start-up company. OsteoMed was founded in April 1991 in Glendale, California. We started by supplying proprietary, patented instruments for orthopedic hip surgery, and quickly expanded to design and manufacture various small bone fixation devices, implants and surgical systems focused on the craniomaxillofacial, small bone orthopedic and spine markets. We moved to Dallas in 1993 in order to better distribute our products around the world.

Today, OsteoMed produces approximately 2,000 different products to fulfill our core mission of improving patient outcomes. I want to highlight three systems from different areas of our business for your benefit. In neurosurgical procedures such as treating trauma, aneurisms and brain tumors, neurosurgeons frequently must remove part of the skull to access the brain. OsteoMed makes the products used to reattach and/or replace parts of the skull in order to protect the brain and to restore normal appearance to the patient. Another one of our systems is used for

pediatric patients born with severe craniofacial deformities. Our product allows surgeons to reconstruct very young babies for normal function and appearance and in many cases avoid the feeding problems, tracheotomies and other treatments that permanently hinder normal childhood development. Another system we produce focuses on repairing and reconstructing the feet and ankles. OsteoMed recently supported a mission trip to Mexico where these products were used by surgeons to allow young patients to walk normally for the first time.

Over the past two decades, OsteoMed has grown. We have continued to reinvest our earnings and been able to provide more patients with innovative orthopedic treatments through new product development and more Americans with well-paying jobs through our continued expansion. Today, we employ and support close to 300 American families.

The Medical Device Industry

The medical device industry is a true American success story. The industry is comprised of over 400,000 highly skilled and science-driven professionals, with over a million more supporting the industry. In total, the industry is responsible for more than 2 million American manufacturing jobs. In my home state of Texas alone, the industry supports more than 66,000 jobs. The industry is a strong manufacturing presence in other states too. In Georgia, for instance, there are more than 30,000 device related jobs.¹ And these are true American, manufacturing jobs that pay above average wages. Jobs in the sector pay an average of 15 percent more than the average U.S. manufacturing job. The average salary of all employees in the medical device industry is \$60,000 and the industry paid \$24.6 billion in salaries in 2008.

What is truly incomparable about the medical device industry is that most companies are small. More than 98 percent of companies have less than 500 employees, and more than 80 percent have fewer than 50 employees.²

¹ Battelle, The Economic Impact of the U.S. Advanced Medical Technology Industry, March 2012
² Background: The American Medical Technology Industry and International Competitiveness, Department of Commerce, 2007.

Our industry also contributes to a positive balance of trade for our country. The U.S. truly is the global leader in the development and manufacture of innovative medical technologies. This is reflected by the fact that the industry is one of the few American manufacturing industries that maintains a positive net trade surplus. Recent estimates have put the medical device trade surplus at approximately \$5.4 billion.³

The Medical Device Tax

When Congress passed the Patient Protection and Affordable Care Act ("ACA") in 2010, it unfortunately also included a devastating tax on innovation. In particular, the ACA includes a 2.3% excise tax on the sales of most medical devices in the U.S. The tax applies to the total revenue of a company, not profit. In fact, companies are subject to the tax regardless if they are profitable or not. In many cases, companies will end up paying more in the excise tax than they actually generate in profit. Two years ago, I started a subsidiary within OsteoMed to compete in the spine market with an innovative product that greatly simplifies back surgery and reduces a two hour operation to only 30 minutes. This company is now producing revenues but was not projected to make a profit for a couple of years due to the product development and overhead investments required. Unfortunately, this subsidiary is now paying this excess tax and the timeframe to profitability has lengthened significantly.

We have already begun to see the impact of this poorly designed policy. Companies, both large and small, have begun to make hard choices to deal with the tax. For some companies, this has led to significantly reduced spending on research and development. For others, it has led to a freeze on hiring and expansion projects. Finally, many companies have made the painfully difficult decision to reduce headcount. At OsteoMed, we have enacted all three.

Supporters of the medical device excise tax claim that the nearly 30 million new covered beneficiaries will use more medical devices and the tax will be offset. However, this assumption is false for several reasons:

³ World Trade Atlas, 2007.

First, new beneficiaries are not typical medical device users. In fact, more than 80% of uninsured are under 45 years old.⁴

Second, past experience with near-universal health coverage does not necessarily imply greater utilization of medical technology. We need to look no further than in Massachusetts. OsteoMed has experienced no such windfall from near universal coverage in the state. In fact, most companies doing business in the state have experienced no noticeable increase in sales since 2007, when the state insurance mandate became effective.

Finally, many medical devices are products that are used regardless if a patient is insured or not. For example, automated external defibrillators are found in public places like airports and shopping malls. If an uninsured person goes into cardiac arrest, he or she will receive the treatment regardless of their insurance status. At OsteoMed, our products are used in trauma and reconstructive procedures. We are blessed to live in a great country and I am unaware of any people on the street after a car wreck with injured heads, faces or extremities that were unable to receive OsteoMed products regardless of their insurance status. In short, patients requiring our products receive them similar to other devices at other companies. However, these manufacturers, like OsteoMed, are still liable for the tax.

Impact of Device Tax on OsteoMed

There are numerous published reports regarding the impact of the medical device excise tax. One report suggests that nearly 45,000 jobs will be lost as a result of the tax.⁵

I am here because I am concerned about over 40 jobs in particular. These are the 25 jobs that OsteoMed had to eliminate because of the medical device tax with other planned positions that will not be pursued. In the 22 year history of the company, we have never had to lay off an employee, much less related to a government tax. However, as we prepared our 2013 budget last year, and realized

⁴ Health Insurance Coverage, Centers for Disease Control and Prevention, 2011.

⁵ Diana Furchtgott-Roth and Harold Furchtgott-Roth, Employment Effects of the New Excise Tax on the Medical Device Industry, Advanced Medical Technology Association, September 2011.

this tax would soon be a reality, we had to make the difficult decision to reduce our headcount as well as research and development expenditures.

OsteoMed is not alone in doing this. Other companies have made, or are in the process of making, the difficult decision to layoff personnel, reduce budgets for research and development of new medical treatments, or scrap plans for future hiring and investment. This is happening at an alarming rate.

Conclusion

Congress must do everything it can to eliminate this devastating tax. As was previously discussed at the onset, on a typical Tuesday I should be at OsteoMed's offices ensuring that our company continues to develop and produce innovative, life-saving medical technologies that improve patient care, lower healthcare costs, and provide well-paying jobs to hard-working Americans. However, this issue is too important for me to sit on the sidelines. We have already made the difficult decision to lay off employees and reduce, forego future hiring and cut our R&D spending. Other companies have done the same. We must do everything in our power to ensure that this American success story remains a success, and we can continue to develop lifesaving technologies for the American people.

Chairman BOUSTANY. Thank you, Mr. Humann.
Mr. Kautter, you are recognized for 5 minutes.

**STATEMENT OF DAVID J. KAUTTER, MANAGING DIRECTOR,
KOGOD TAX CENTER, AMERICAN UNIVERSITY, EXECUTIVE-
IN-RESIDENCE, DEPARTMENT OF ACCOUNTING AND TAX-
ATION**

Mr. KAUTTER. Chairman Boustany, Ranking Member Lewis, and Members of the Subcommittee, thank you for the opportunity to testify today.

My name is David Kautter. I am Managing Director of the Kogod Tax Center located at American University.

The Kogod Tax Center is a tax research institute focused on promoting balanced, non-partisan research on tax matters, including complexity.

Primarily, we focus on middle income taxpayers, small businesses, and entrepreneurs.

I have been a tax practitioner for over 40 years, and prior to joining the Kogod Tax Center, I was the Director of Tax at Ernst & Young.

Over the course of my career, I have watched the Internal Revenue Code grow increasingly complex in its structure, incomprehensible in its nature, and pervasive in its effect on economic decisions.

It is estimated that the Internal Revenue Code and regulations are over nine million words in length, and Americans spend more than 6.1 billion hours a year filing Federal tax forms.

The more than 45 tax related provisions in the Affordable Care Act will not make things any easier.

I will focus my testimony today on two particular provisions, the new tax on net investment income, and the new Medicare tax on wages.

The statute proposed regulations and preambles for just these two provisions are over 48,000 words in length, take up over 85 pages in the Federal Register, and are estimated to increase the time taxpayers will spend on compliance by well over two million hours.

The tax on net investment income constitutes a new third tax system within the Internal Revenue Code. It is its own self contained tax system which sits along side the regular income tax and the alternative minimum tax.

Like the regular tax and the alternative minimum tax, this new tax system comes complete with its own unique set of definitions, rules for computing the tax, and a threshold that is not indexed for inflation.

This new parallel universe also comes complete with its own set of new compliance obligations, additional tax forms, new tax calculations, and new estimated tax requirements.

Compliance with these rules will not be a task for the faint hearted.

From a tax planning point of view, taxpayers are already focused on simultaneously managing two entirely new calculations, modified adjusted gross income and net investment income.

This is just the beginning. Make no mistake about it. Planning to minimize and comply with the tax on net investment income will consume tens of thousands if not hundreds of thousands of hours every year for the foreseeable future.

That would be in addition to the two million hours of compliance time, and that will be in addition to the 6.1 billion hours already being spent complying with the Federal tax laws.

The additional tax on Medicare wages increases tax complexity in three ways, and they are all first's. It is the first time the Medicare tax is computed on an individual's personal tax return. It is the first time the Medicare tax is imposed solely on employees without a matching employer payment, and it is the first time that

the amount of the Medicare tax will vary with the taxpayer's marital status.

These are by no means trivial changes. They bring with them new rules for computing and paying Medicare tax, new withholding rules, and plenty of opportunities from mistakes and penalties.

The areas of complexity that concern me the most with respect to the new Medicare tax are the rules relating to withholding and the potential for the imposition of penalties.

The rules are just too complicated. Mistakes are going to be made, and substantial penalties are going to be imposed.

I am also deeply concerned about the complexity and burden this new law creates for small employers. Just like the tax on net investment income, it is already clear that employees and their employers are seeking to alter the behavior in response to this tax.

I will conclude my remarks by saying a few words about a common feature of both these taxes, and that is their imposition on income in excess of a threshold.

A taxpayer's income can increase substantially in one year due to an once in a lifetime event, such as the sale of a long held asset or the payment of a bonus that took several years to earn.

In situations such as these, taxpayers are taxed at higher rates on income that accrued over a lengthy period of time, and may never occur again in the taxpayer's lifetime.

Taxing such one time gains at higher rates contributes to a perception of unfairness and tends to increase cynicism on the part of taxpayers.

Not only that, in addition to the new thresholds for these two provisions, two other new thresholds come into effect this year, the so-called "PEP and Pease threshold," and the threshold for the top individual tax rate of 39.6 percent.

With three new thresholds, complexity is not arithmetically increased by a factor of three, it is increased exponentially because all three thresholds interact with each other.

The problem is made even more challenging because each of the thresholds that come into effect this year start at different levels of income and penalize married taxpayers compared to single taxpayers.

That concludes my prepared remarks, Mr. Chairman. Thank you very much.

[The information follows: Mr. Kautter]

**Testimony of
Mr. David J. Kautter
Managing Director of Kogod Tax Center
American University Kogod School of Business
Washington, District of Columbia**

**Committee on Ways and Means
Subcommittee on Oversight
United States House of Representatives**

**Hearing on
Tax Related Provisions in the President's Health Care Law
March 5, 2013**

Chairman Boustany, Ranking Member Lewis and Members of the Subcommittee, thank you for the opportunity to testify on the tax related provisions in the Health Care and Education Reconciliation Act of 2010 and Patient Protection and Affordable Care Act (jointly referred to as the "ACA").

My name is David Kautter and I am the Managing Director of the Kogod Tax Center. The Kogod Tax Center is a tax research institute located at American University's Kogod School of Business that promotes balanced, nonpartisan research on tax matters, including the challenges of complying with the Internal Revenue Code. Our efforts focus principally on tax matters affecting middle-income taxpayers, small businesses and entrepreneurs. We also develop and analyze potential solutions to tax-related problems faced by these three groups of taxpayers and promote public dialogue about critical tax issues.

I have been a tax practitioner for over 40 years. Prior to joining the Kogod Tax Center, I was the Director of National Tax for Ernst & Young. Over the course of my career as a tax practitioner, I have watched the tax law grow increasingly complex in its structure, pervasive in its reach and incomprehensible in its nature. There is little doubt that the nearly paralyzing complexity, overwhelming length and constantly changing nature of our federal tax laws are having a profound effect on economic decision making and impeding our global competitiveness.

It is estimated that the Internal Revenue Code is nearly four million words in length, and the income tax regulations are in excess of another 5 million words. Taxpayers are estimated to spend more than 6.1 billion hours meeting their annual federal tax filing obligations, and it is also estimated that 60% of all taxpayers retain paid tax return preparers to fulfill their federal tax filing obligations while another 30% use commercial

software. Complexity has been identified by the IRS Taxpayer Advocate in her most recent report to Congress “as the #1 most serious problem facing taxpayers.” I can personally attest that the effort required to comply with the tax law today is disheartening even to experienced tax professionals. The cost to comply is increasingly expensive in time and dollars. Not only that, the excessive burden of compliance is increasingly distorting individual and business decision making.

Patient Protection and Affordable Care Act

The ACA contains over 45 different tax or tax-related provisions. I would like to focus my testimony today on two of the more significant provisions in the ACA in terms of revenue and reach: (1) the new 0.9% Medicare tax on wages, and (2) the 3.8% tax on net investment income (NII). The statute, proposed regulations and preambles for these two provisions are over 48,000 words and take up over 85 pages in the Federal Register. The estimated total annual reporting and recordkeeping burden for the new Medicare tax on wages alone is estimated to be 1.9 million hours. And that is for the more straightforward of the two taxes I will discuss today.

Net Investment Income Tax

The ACA adds a third tax system to the Internal Revenue Code, the “Net Investment Income Tax.” This system sits alongside, and parallels, the regular income tax and the Alternative Minimum Tax (AMT) as a self-contained tax system within the Internal Revenue Code. Like the regular tax and the AMT, this new tax system comes complete with its own set of definitions, its own unique rules for computing amounts subject to the tax, its own unique rules for allocating deductions to various types of income, its own unique rules for determining which taxes are creditable against the new tax and its own special rules. The threshold for the tax, like the previous threshold for the AMT, is not indexed for inflation. This new tax system, which is its own parallel universe, also comes complete with its own compliance obligations, additional tax forms, tax calculations and requirement to pay estimated taxes. The Net Investment Income Tax appears in a new, separate Chapter of the Internal Revenue Code; this in and of itself is a matter of complexity. Except for some limited cross-references to other provisions in the Internal Revenue Code, this new Chapter does not provide definitions of its operative phrases or terminology. That is left to the IRS and the courts to develop which, again, brings its own level of complexity. The Net Investment Income Tax, like the additional tax on Medicare wages, imposes a new calculation not previously required of taxpayers. This calculation is simply added on top of an already exceedingly complex federal income tax law.

Although the Net Investment Income Tax is thought of as an increase in the rate of tax on capital gains and dividends, it is much more than that. The tax on Net Investment Income (NII) extends to a wide range of

income well beyond capital gains and dividends. Income from: (1) interest, annuities, royalties and rents other than such income derived in the ordinary course of a trade or business to which the tax does not apply, (2) income from a trade or business that is a passive activity, (3) net gains from the disposition of property that is not held in a trade or business, (4) income attributable to investment in working capital, and (5) any income derived from trading in financial instruments and commodities are all subject to the new tax.

The rate of tax is 3.8% of the lesser of: (1) an individual's net investment income for a taxable year; or (2) the excess of (a) the individual's modified adjusted gross income over, (b) the threshold amount of \$200,000 for single taxpayers, \$250,000 for married taxpayers and \$11,950 for estates and trusts. Modified adjusted gross income is fairly straightforward but the definition of Net Investment Income is more complicated. Listed below are some illustrations of areas where taxpayers will encounter substantial complexity in trying to live up to their legal obligations

Areas of Complexity in the Determination of Net Investment Income

Although this new Chapter of the Internal Revenue Code does not provide definitions of its operative phrases or terminology, proposed regulations issued by the IRS provide that many existing rules that apply for purposes of determining taxable income under the general provisions of the Internal Revenue Code will often apply for purposes of computing the tax on NII. This approach substantially simplifies what could otherwise be a complicated and duplicate set of rules that would not only be unnecessary but expensive and burdensome. This is not to say that computation of NII will be simple or non-controversial since the definitions being used are the very ones that make the existing law so complicated and incomprehensible to most taxpayers.

- **Allocation of expenses**

In computing NII, taxpayers are allowed to allocate certain deductions to their NII. In the case of itemized deductions, only the amount allowed after reducing the deductions for the 3% disallowance can be allocated. If the deduction is a miscellaneous itemized deduction, then the 2% reduction must be taken into account before the 3% reduction is computed. This will not be an easy calculation to make in some cases.

- **Treatment of Investment Income from Pass-through Entities**

Another challenge in determining NII is the requirement that investment income received by a partnership, S corporation, or limited liability company is included in the calculation of investment income of their owners. Specifically, §1411(c) adopts the passive activity rules of §469 to determine if income attributable to an individual from a pass-through entity is investment income. One of the most

complicated and controversial areas of the existing Internal Revenue Code is the passive loss rules. If the partnership, S corporation or limited liability company is not engaged in a trade or business then the individual's distributive share of the entity's income constitutes investment income. If, on the other hand, the entity is engaged in a trade or business, the entity's income attributable to an individual owner is investment income only if the activity is passive under §469 with respect to that owner. Aside from the computational challenges this rule creates, there is the difficulty in determining the entity's investment income attributable to an owner when a partnership, limited liability company or S corporation is actively engaged in a trade or business but the owner of the entity is not so engaged.

- **Disposition of Interests in Pass-Through Entities**

In the case of a disposition of an interest in a partnership or S corporation, gain or loss from the disposition is treated as investment income or loss to the extent the gain or loss is attributable to the transferor's interest in each asset, the sale of which by the partnership or S corporation would give rise to investment income or loss. Any adjustment of the gain or loss from the sale of a partnership interest or S corporation stock that is not investment income or loss must be reported and explained on a statement attached to the seller's return for the year of the disposition. Finally, income from a lower tier pass-through entity owned in part by an upper tier pass-through entity creates tracing problems for identifying the upper tier owner's share of the lower tier entity's investment income

The areas of greatest complexity and likely dispute between taxpayers and the IRS with respect to the tax on Net Investment Income are likely to center on the application of the rules to passive activities and the application of the rules to partnerships and S Corporations, especially multi-tiered ownership arrangements.

Changing Behavior

From a tax planning point of view, when it comes to the tax on NII, taxpayers will be focused on simultaneously managing two entirely new calculations: (1) Modified Adjusted Gross Income, i.e., "threshold planning" and (2) Net Investment Income. For example, if a taxpayer will likely be under the threshold in a particular year, planning will focus on increasing NII to utilize the full amount of the threshold. If a taxpayer will likely be over the threshold, planning will focus on minimizing NII for that year. This focus will be integrated with tax planning that taxpayers will be doing with respect to the regular income tax, AMT, and the additional tax on Medicare wages. Make no mistake about it, planning to minimize and comply with the tax on NII will consume tens of thousands, if not hundreds of thousands, of hours of time of taxpayers and their advisors over the next

year and every year thereafter. This will be in addition to the 6.1 billion hours currently being spent on complying with the rest of the Internal Revenue Code.

Here are some of the types of changes in behavior that we can expect to see.

- Investments in municipal bonds and whole life insurance policies that not only do not count in modified adjusted gross income (MAGI) but do not count as NII will become very attractive. Investments that defer inclusion in MAGI for extended periods of time such as growth stocks and annuities will likely be used more extensively.
- Capital gain planning will take on greater importance. While this clearly goes on today it will take on more importance. Timing the recognition of capital gains will allow taxpayers to control both their MAGI and the NII, and matching capital gains with capital losses will also take on greater importance.
- Use of the installment method of accounting. This will allow taxpayers to avoid large spikes in MAGI in the year of sale and also allow taxpayers to better control the amount of NII realized each year thereafter.
- Like-kind exchanges. Use of the like-kind exchange rules will become more popular since they can result in deferring increases in MAGI and deferring the receipt of NII.
- Retirement planning. Distributions from retirement vehicles such as qualified retirement plans and IRAs are excluded from the definition of NII and will become more attractive. In addition, Employers such as sole proprietors, S Corporations and partnerships may be inclined to contribute more to qualified plans in particular years to reduce MAGI in the year of contribution and receive distributions in a manner designed to minimize MAGI and reduce the amount of NII subject to tax in a later year.
- Roth IRAs and Roth 401ks. Even though contributions to Roth IRAs and Roth 401ks do not reduce MAGI in the year of contribution, distributions do not increase MAGI in the year of distribution nor are they NII.
- Gifts of appreciated property. Gifts of appreciated property will allow taxpayers to transfer MAGI and NII to donees. The “kiddie tax” rules will limit the ability to use this technique in some situations.
- Trusts. Trusts will have an incentive to distribute income to individual beneficiaries who have a higher MAGI threshold.
- Charitable Remainder Trusts. Contributions to CRTs will allow taxpayers to shelter NII while smoothing MAGI over a lengthy period of time. CRTs can also sell appreciated property without paying tax which

allows beneficiaries to, in effect, diversify assets without increasing MAGI at the time of sale and deferring NII.

- Passive activities. Passive income increases MAGI and is NII so taxpayers will benefit if they can generate passive losses to offset against the passive income.

Additional Medicare Tax on Wages (AMTW)

Under the ACA, an additional 0.9% tax is imposed on wages and self-employment income in excess of \$200,000 for single taxpayers, \$250,000 for married taxpayers and \$125,000 for married taxpayers filing separate returns.

The 0.9% AMTW introduces new complexity in the tax law in three ways: (1) it is the first time that Medicare tax is computed on an individual's personal income tax return; (2) it is the first time that the Medicare tax is imposed solely on employees without a matching employer payment; and (3) it is the first time that the amount of Medicare tax varies with a taxpayer's marital status. These are by no means trivial changes. They bring with them new rules for withholding, computing and paying Medicare tax, as well as plenty of opportunities for mistakes and penalties. They affect employees, employers and self-employed individuals. Described below are some illustrations of this increased complexity.

Potential Underpayment Penalties

All taxpayers are required to pay at least 90% of the tax they will owe for a taxable year either through estimated tax or direct withholding, or else face penalties. For employees, this requirement is usually met by having amounts withheld from their wages. For purposes of the AMTW, no Medicare tax can be withheld on an employee's wages less than \$200,000. Even if the employee knows that they will owe the AMTW (because of wages from another job or a spouse's wages) and the employee requests additional AMTW withholding, the employer is not allowed to withhold AMTW if the employee's wages are less than \$200,000. Instead, the employee must request that additional income tax be withheld by filing a Form W-4 with their employer. The employee can then claim the additional income tax withheld as a credit against their AMTW when he or she files their tax return. In my experience, one of the most misunderstood and improperly completed forms is the Form W-4. Having to request additional income tax withholding in order to satisfy a Medicare tax liability is a novel concept in the tax law and one which adds a complexity to what was previously a straightforward computation. The alternative available to an employee is to pay the AMTW liability by making estimated tax payments. For someone who has been an employee all his or her life, entry into the world of estimated tax payments is usually not a pleasant one. Figuring out how to make quarterly estimated tax payments,

computing them and paying them timely is not easy or intuitive. No matter which way an employee in this situation turns, she is faced with a new and complicated decision and the price for a mistake is penalties.

Potential overpayment of AMTW

A second area of complexity for employees involves married employees who earn wages in excess of \$200,000. If a married employee makes more than \$200,000, AMTW must be withheld even though the employee and his or her employer may know that no AMTW will be owed because the combined wages of the employee and the employee's spouse on a joint return will be less than \$250,000. It is clear that in this case the employee must wait until he or she files an income tax return to claim a refund for the excess AMTW that has been withheld.

Combined Wages

Another area of complexity involves the imposition of the AMTW on the combined wages of spouses who file a joint return. This departs from the rules that have existed since the enactment of Medicare and will be a source of confusion for many taxpayers.

Employee Burden if an Employer Fails to Withhold

If an employer fails to withhold the appropriate amount of AMTW, the employee will be responsible for paying the proper amount of tax either through estimated tax payments or as an addition to tax on her income tax return. Again, this is novel with respect to Medicare tax and will be a source of confusion for taxpayers, as well as a potential source of penalties.

The Problem with Thresholds

One of the complicating aspects of these new rules is that the AMTW is imposed only on wages (or combined wages in cases where taxpayers are married and file a joint return) in excess of a threshold amount (\$200,000 for single taxpayers and \$250,000 for married couples).

It is not uncommon for taxpayers to have fluctuations in their wages from year to year as a result of bonuses, stock option exercises, vesting in restricted stock or deferred compensation or other non-recurring events. In these situations, taxpayers may find themselves over the threshold in one year and subject to a substantial AMTW liability even though, had they received the income pro-rata over the period the payment was earned no tax would be due. Moreover, because the threshold amount for a married couple is 75% less than the combined threshold for two single taxpayers, the threshold penalizes couples who are married and filing joint returns.

Self-Employed Taxpayers

Another source of complexity is that self employed taxpayers must now take the AMTW into account in making their estimated tax payments. However, unlike the base 2.9% Medicare tax, the AMTW is not deductible for regular tax purposes. So, in computing the amount of estimated income tax to be paid, self-employed individuals will have to take part of their Medicare tax into account and ignore the rest. This is counter-intuitive and a potential trap for the unwary. In addition, if a self-employed individual also has wages, like many small business owners do, the interaction of the AMTW on wages and the AMTW on self employed income can become quite complicated.

Employer Burdens

The AMTW also creates a series of new rules and resulting complexity for employers. While large employers are better able to deal with this complexity, small businesses will find themselves with another set of rules that may be costly and confusing. Here are the primary additional burdens placed on employers by the AMTW: (1) employers must withhold the AMTW on wages in excess of \$200,000; (2) employers must file a return reporting the additional AMTW; (3) employers must follow very specific rules with respect to correcting underpayments and overpayments of the AMTW; (4) employers must follow very specific rules with respect to claiming refunds; and (5) penalties or additions to tax for failure to withhold the AMTW are imposed even if the employee pays the AMTW that is owed. While many of the rules that must be followed are the same as the existing rules for the base Medicare tax, having to account for one more employment tax will surely increase the likelihood of error and the likelihood of penalties.

S Corporations

Amounts paid as wages to S Corporation shareholders are subject to AMTW, but amounts distributed as earnings to the same shareholder are not. An area of increasing controversy and one that frequently reaches the courts is how much of the earnings of an S corporation a shareholder should consider wages (and thus subject to employment taxes) and how much should be treated as distributions of earnings (and not subject to employment tax). The additional 0.9% tax is likely to increase the number of disputes in this area, absorbing increasing amounts of time on the part of the IRS and small business owners.

Changing Behavior

It is already clear that employee-taxpayers and their employers are seeking to alter behavior in order to both minimize the new 0.9% tax on employees and the burden on their employers. Here are some of the areas being discussed by taxpayers and their advisers to minimize the effect of this new tax.

Because employer contributions to qualified pension plans are not subject to AMTW when they are made and distributions from qualified plans are not subject to AMTW when received, discussions are under way as to whether less compensation should be paid in cash and more contributed to qualified plans. There are limits as to how much can be contributed to qualified plans, both dollar limits and discrimination limits, but within those limits substantial discretion exists.

The tax and the employer burden can both be reduced by converting what are currently wages into tax-free fringe benefits, such as more generous health benefits, employee financial planning or employer paid parking. This not only reduces the AMTW but reduces wages subject to income tax as well as wages subject to basic FICA tax. So, to the extent taxpayers convert what were previously taxable wages into tax free-fringe benefits, not only is the 0.9% tax avoided, but income taxes and basic FICA taxes (employer and employee shares) that were previously paid will no longer be paid.

Because wages paid to an S corporation shareholder are subject to the 0.9% tax, but distributed earnings are not, some taxpayers are considering whether to conduct business as an S Corporation and paying the minimum amount of wages possible. Although this issue already exists, the addition of the 0.9% tax will add another reason to change the form of a small business to an S corporation and then minimize the amount paid to the shareholder-employee as wages, while maximizing the amount paid as earnings.

As an alternative to conducting business as an S corporation, taxpayers are considering limited partnerships because earnings paid to limited partners are not subject to the AMTW.

Also under discussion is whether employees should recognize wage income and pay the AMTW earlier in the hopes of minimizing what would have been a larger AMTW liability later. For example, exercising of stock options earlier than they might otherwise be exercised and making elections under IRC Section 83(b) on restricted stock would accelerate the payment of the .9% tax but result in an overall lower payment of income tax, base FICA taxes and the .9% tax.

Unfairness of Thresholds

A taxpayer's income can increase substantially in one year due to a once in a lifetime event, such as the sale of a home or other long held capital asset. In situations such as these, taxpayers are taxed at extraordinarily high

rates even though the gain accrued over a lengthy period of time and may never recur in the taxpayer's lifetime. The unfairness of taxing such one-time gains at higher rates will contribute to a perception of unfairness and possibly increase cynicism on the part of taxpayers.

Three New Thresholds in One Year

The ACA introduces a new threshold of \$200,000/\$250,000 over which the AMTW and the tax on NII is imposed. In addition, the PEP and Pease provisions come back into effect in 2013 for taxpayers who have AGI in excess of \$250,000/\$300,000. Third, there is a new threshold for the top individual rate of tax of 39.6% which is \$450,000/\$400,000. The imposition of three new thresholds in one taxable year substantially increases the complexity of complying with the federal tax law. With three new thresholds, the complexity is not arithmetically increased by a factor of three; it is increased exponentially because all three thresholds interact with each other.

Thank you for allowing me to testify today. I would be delighted to address any questions from any Member of the Committee or your staff today. I and others at the Kogod Tax Center would be pleased to address any further questions with you at any future date, as well.

Chairman BOUSTANY. Thank you, Mr. Kautter.
Ms. Sun, you are recognized for 5 minutes.

**STATEMENT OF SHELLY SUN, CEO AND CO-FOUNDER,
BRIGHTSTAR CARE**

Ms. SUN. Thank you, Mr. Chairman, Members of the Committee, for this opportunity.

My name is Shelly Sun. I am the Co-Founder and CEO of BrightStar Franchising. I am a member of the Board of Directors of the International Franchise Association.

BrightStar Care is a franchise system of more than 250 independently owned and operated agencies that provide home care for

over 10,000 families in 38 states, 160 franchisees employ more than 15,000 nurses and care givers.

My husband and I founded BrightStar over ten years ago with \$100,000 of our own money, and by guaranteeing \$100,000 line of credit with our bank with the equity in our home.

Small business owners take on this type of risk to start their businesses, create jobs, and help the American economy every day.

This is supposed to be the American dream as a small business owner. Invest money, take a risk, work hard, build a business, and pay back what you invested and earn a profit.

Part of what makes entrepreneurs so special is their passion for creating and providing opportunity for others. This law jeopardizes the ability of small business owners to create more jobs and reinvest profits back into their businesses.

Small business owners must make difficult decisions every day to protect their personal investments and their American dream, and this law will compel entrepreneurs to do what it takes, including reducing hours of their employees to keep their business and their dream alive.

One of the biggest challenges we have with the law is how it redefines "full time employees." Business owners in every sector of the American economy have for decades managed their workforce to the current standard of 40 hours per week.

When Congress set the definition as 30 hours per week, it forced employers to manage their workers to fewer hours. Thus, reducing the earnings potential of hundreds of thousands of employees.

Because the law requires everyone to have insurance, part time workers will have to buy insurance on their own or through an exchange. That expense will impact their personal family budget as well as demands on Medicaid.

Clearly, these are unintended and significant consequences of a law that was supposed to expand opportunities for health coverage to all.

Simplifying the definition of "full time" would provide small businesses with more certainty, allowing them to better control costs, and make long term business plans for future growth.

Fifty-five of my BrightStar franchisees are considered large employers under the Affordable Care Act. The rest are on pace to grow to that level in the next two to five years.

Thus, our franchisees, like many other successful small business owners across the country, find themselves in a Catch-22. They want to expand but if they do, they get hit with significant new health care and compliance costs that impede growth.

In this context, it is absolutely staggering to think that as defined by the Affordable Care Act, an employer with 50 full time employees is in the same category as an employer with 5,000 full time employees. We can absolutely do better.

If the 55 BrightStar franchisees who qualify under the current definition of "large employer" maintain their current scheduling level and all eligible employees enroll for this affordable coverage, the average franchisee will spend \$127,000 providing this coverage. This wipes out 50 to 100 percent of the franchisees' profit.

How can we ask small business to risk more, work harder, and invest further with administratively complex and expensive legislation like the Affordable Care Act?

We cannot. We must remove obstacles, and we must understand small business owners will find a way so they remain in business and protect the jobs they can offer. What choice do entrepreneurs have if they want to remain in business?

My two requests today on behalf of my business, on behalf of the 160 BrightStar franchisees and their 15,000 employees across the country, and on behalf of the franchising community and small businesses everywhere, first, change the definition of “full time employee” to more closely align with the current standard of 40 hours per week, setting the definition as 30 hours per week simply forces employers to manage their workers to fewer hours.

Second, define “large employer” as one with at least 50 full time employees instead of full time equivalents.

This simplifies the complexity of the law and a huge administrative burden.

Specifically, this change reduces the 55 BrightStar franchisees impacted by the unintended consequences of the Affordable Care Act down to eight.

Thank you again for the opportunity to be here with you today to work together to prevent the devastating, unintended consequences the Affordable Care Act will have on small businesses, employees, and the American economy.

Thank you.

[The information follows: Ms. Sun]

**TESTIMONY OF SHELLY SUN
CO-FOUNDER AND CEO
BRIGHTSTAR FRANCHISING, LLC
BEFORE THE**

**U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON OVERSIGHT**

"Tax-Related Provisions in the President's Health Care Law"

MARCH 5, 2013

Chairman Boustany, Ranking Member Lewis, and Members of the Subcommittee, thank you for the opportunity to testify before you today on the tax-related provisions of the President's health care law. My name is Shelly Sun, and I am the co-founder and CEO of BrightStar Franchising LLC and a member of the Board of Directors of the International Franchise Association. BrightStar is a franchised system of 255 medical and non-medical agencies providing homecare services and staffing. Over 160 franchise owners serve 10,000 families in 38 states and employ 15,000 nurses and caregivers. As a whole, the franchise industry supports nearly 18 million jobs across 300 business lines, and contributes \$2.1 trillion in output to the U.S. economy. I appear here today on behalf of BrightStar as well as the International Franchise Association, the world's oldest and largest organization representing franchising.

The Affordable Care Act's (ACA) employer mandate will have a devastating impact on the economy, will increase unemployment and will exacerbate underemployment. The law will also negatively impact my company, both as a rapidly-growing system of franchise small business employers and as a franchisor with 60 of my own employees due to the increased

costs from the Affordable Care Act. The Act is the greatest threat to the development of my business and that of my 160 franchise owners, in addition to the 825,000 franchise establishments nationwide.

The Employer Mandate

When the U.S. Supreme Court upheld the Affordable Care Act last June, the law was finally exposed for what it truly is: a tax increase. The employer mandate presents a massive challenge for small business owners everywhere who are struggling in a still fragile economic recovery. According to a study by the nonpartisan Hudson Institute, the employer mandate puts 3.2 million full-time jobs at risk in the franchise industry alone, and will add more than \$6.4 billion in increased costs to franchise businesses, not including the cost of regulatory compliance.

The tax increases and added costs aside, the law is a disincentive for franchise owners to expand and add new jobs. Employers with at least 50 “full-time equivalent” employees are subject to tax penalties under the employer mandate if they do not provide qualifying health care coverage to their employees. Fifty-five of the 160 BrightStar franchise owners are considered “large employers” under the ACA; the rest are on pace to grow to that level in the next two to five years, but are faced with a significant challenge to their business models once they hit the 50 “full-time equivalent” employee mark. Thus, our firms find themselves in a “Catch-22.” They want to expand, but if they do, they get hit with significant new health care and compliance costs, which can only retard growth. In this context, it is incredibly challenging

that an employer with 50 full time employees is in the same category as an employer with thousands of employees.

The current definition of full-time employee provides a disincentive for business owners to hire and provide full-time jobs. If owners maintain their current scheduling levels of all employees, the average added cost for a BrightStar unit with greater than 50 full time employees if all eligible employees enrolled for coverage would be \$127,000, equal to six percent of the average annual unit revenue. If owners instead choose to pay tax penalties, they will pay as little as \$6,000 and up to \$140,000 due to the elimination of the first 30 employees in the calculation of the penalty. With the goal of increasing access to healthcare, there needs to be more incentive for the small business owner to choose to offer healthcare coverage rather than choose to pay the tax penalties to the government. If the definition of full-time employee were raised from 30 to over 36 hours per week, the added cost of providing coverage will fall by 30 percent.

As a result of the employer mandate, health insurance premiums will rise just by virtue of who will enroll in employer-sponsored plans. Many lower-wage caregivers in the homecare industry will choose not to enroll in employer-sponsored plans because they are too expensive, even if they meet the law's so-called "affordability standard." The remaining employees who do choose to enroll in the coverage will likely see more value in the plan because they require the most health care services. Thus, the plans will be overloaded with less healthy employees, while more healthy associates will opt out, causing plan premiums to spiral out of control. This is a

classic case of adverse selection, and the increased costs will be borne by the employer in future years as insurers increase our premiums.

Despite employers' best efforts and intentions to offer coverage to workers, the result of the employer mandate is that both employers and employees lose. Take, for example, a real BrightStar employee that I will refer to as "Sarah Johnson." Currently, Sarah works an average of 36.5 hours per week. Her employer, a multi-unit BrightStar franchisee, is considered a "large employer" under the ACA, and has decided to reduce the impact of the employer mandate on his business by managing some variable-hour employees to stay under the 30-hour threshold. As a result, Sarah's hours will be reduced to 28 hours per week or less, which will reduce her annual wages by at least \$5,400. If you combine wages lost with the cost of Sarah's individual mandate to purchase health insurance which has an annual premium of over \$3,500, the total financial impact on Sarah is nearly \$9,000 annually.

Sarah will not receive insurance coverage through her employer, but she will also be less able to afford her own coverage through the state insurance exchange. As much as small business owners and job creators are negatively impacted by the employer mandate, the ones who really suffer are the workers themselves.

The Health Insurance Tax (HIT)

A second tax in the Affordable Care Act that will drive up insurance premiums for small business owners is the excise tax on health insurance companies in order to offset the costs of

subsidized coverage through state exchanges. The tax amounts to billions of dollars each year on the health insurance industry, and this cost will be passed directly to consumers in the fully-insured marketplace in the form of higher premiums. These taxes are estimated to reach \$87 billion dollars between 2014 and 2019, adding to the crushing burden of health insurance premiums that employers already bear.

The tax is higher for health insurance companies with larger market shares, meaning the plans from the nation's most trusted and reputable insurers will become less affordable for small business owners and their employees. Small business owners do not have a large enough pool to self-insure, and are therefore faced with either paying higher premiums in a fully-insured small-group plan or paying the \$2,000 per employee tax penalty under the employer mandate for failing to offer coverage. Employers that already offer coverage to employees will pay higher premiums for their existing plans as a result of these excise taxes.

In addition to the excise taxes on health insurance companies, the collective weight of other tax and regulatory provisions in the ACA contribute significantly to rising health insurance premiums. The Patient-Centered Outcomes Research Institute (PCORI) and transitional re-insurance fees are applied on a per-capita basis and will cost up to tens of billions of dollars. Reporting requirements from the U.S. Departments of the Treasury, Labor, and Health and Human Services require additional employees and added costs for retaining counsel and consultants. We have calculated that for a single BrightStar unit, the cost of compliance is at least \$8,000 for back-office administration and professional services. In a stagnant economy,

with rising prices and shrinking profit margins, this cost increase could have been used instead to create part of a job rather than a non-value added government compliance cost. We should be looking for ways to reduce costs for businesses and create incentives for businesses to create jobs. In the healthcare industry, employees want the flexibility of working a variable schedule and keeping track of “full time equivalents” creates an overwhelming burden for our franchisees.

Conclusion

Small businesses are the backbone of the American economy, and Congress and the Administration must find better solutions that allow small businesses to implement the Affordable Care Act efficiently. Specifically, we would ask for two simple changes that would relieve part of the burden of the employer mandate while providing small business owners with the certainty they need.

First, define a “large employer” as one with at least 50 full-time employees instead of “full-time equivalents.” Simplifying this definition will provide small businesses with more certainty about their status, allowing them to better control costs and make long-term business plans for future growth.

The second request is to change the definition of “full-time employee” to more closely align with the current standard of 40 hours per week. This is the number that American businesses

have managed their hourly employees to for decades, and setting the definition as 30 hours per week simply forces employers to manage their workers to fewer hours.

The unintended impact of the employer mandate is devastating: fewer workers will receive health insurance, and they will be less able to afford their own coverage. Franchise small business owners are faced with a choice between either paying higher premiums or paying tax penalties for not offering coverage, and neither option is a good option.

The Affordable Care Act is anything but affordable. It adds taxes, costs, and fees, while threatening the economic viability and job creation opportunities for many of our nation's small businesses.

For our franchise business owners, something has got to give. We urge you to address these fundamental challenges and allow America's small business owners to realize their true potential. If you take the initiative, millions of franchise owners and employees – and certainly the BrightStar organization – will stand with you.

Thank you for the opportunity to testify before you today, and I look forward to answering any questions you may have.

Chairman BOUSTANY. Thank you, Ms. Sun.
Mr. Joyce, you are now recognized for 5 minutes.

**STATEMENT OF HUGH JOYCE, JAMES RIVER HEATING AND
AIR CONDITIONING COMPANY**

Mr. JOYCE. Mr. Chairman, Ranking Member Lewis, and members of the Oversight Subcommittee, thank you for having me here today.

I am Hugh Joyce, and I own and operate a heating and cooling business with approximately 152 employees in the Richmond, Virginia area.

I come before you today to express my continued concerns regarding the new health care law, specifically the negative impact

and the overwhelming confusion regarding the 47 tax provisions in the law and their implementation.

In the spirit of full disclosure, I personally lobbied heavily against this bill. Not because I did not want to pay for insurance, because I was already doing that, but because I felt the bill lacked provisions to drive down true costs.

There are lots of lines of code that are spread around who is paying for the insurance. There is this Government kind of thing, but there is little that addresses insurance pooling, personal incentives to maintain health, standard insurance plan design, hospital costs and competition, market transparency, doctor monopolies on care, individual purchase models, and strategies.

There are 47 tax related provisions that hurt businesses, families and workers. Keeping up with the implementation of the regulations will be costly, time consuming, and difficult.

Employers like me must track and monitor employee hours, report, verify insurance coverage, all diverting valuable resources from productivity.

Key areas of concern are the mandated coverage's in indirect taxes that are driving costs up and affordability down. The significant new taxes on investment and pass through income reduce capital and limit the ability to expand and create jobs.

Reporting, tracking, and paperwork is daunting, especially for smaller businesses, and confusion.

Finally, the lack of simplicity. Look at our greatest new world companies, Apple, Google, Geico, JetBlue. They are all successful because they keep it simple.

I have great concerns that this health care plan and this health care act are so complicated.

Since 2009 and its enactment, our insurance premiums have risen from \$664,000 to \$924,000, with a flat head count. We are projecting our renewal premium for this year to be \$1.9 million, an 18 percent increase, which includes a two percent premium tax on our fully insured product.

These numbers are not sustainable over time. Our entire discretionary net profit will be absorbed by health insurance costs in 5 years, if the current premium trajectory continues.

Fear is the most crippling emotion. I am convinced that fear coupled with the uncertainty of new costs and frustration regarding the health care law is a key reason we are not seeing robust hiring and job creation today.

As I look across my competitive landscape, I see major disparities. My average competitor is less than five employees, if they provide insurance, they get a subsidy. My competitors with less than 15 employees do not have to do anything.

I am over 100. I am required to provide insurance and pay for it or I face penalties. Should not everyone be subject to the same rules?

If we want to lead in a global competitive platform and keep insurance affordable, we must revisit this health care law and the tax provisions.

This can be done. I think we can provide health care without major new tax increases and burdensome compliance measures.

Let's look at strategies for a simplified plan that reduces costs, opens up market competition and transparency, and provides every American with great benefits that they can buy on their own.

These strategies will provide certainty for the private sector and help us grow our economy.

[The information follows: Mr. Joyce.]



Testimony of

Mr. Hugh Joyce

before the

Ways and Means Committee

on the subject of

**Tax Implications of the Patient Protection and
Affordable Care Act (ACA)**

on the date of

March 5, 2013

Chairman Boustany, Ranking Member Lewis, and members of the Oversight Subcommittee, thank you for inviting me to testify today. I am Hugh Joyce. I own and operate a family heating and cooling business with approximately 152 employees in the Richmond area. I come before you, today, to express my continued concerns regarding the new health care law. Specifically, the negative impact and the overwhelming confusion regarding the 47 tax provisions in the law and their implementation.

I, personally, lobbied heavily against the legislation, not because I didn't want to pay for insurance for my employees, but because I felt **there was not one line of code in the bill that would significantly reduce health care costs over time**. There are lots of lines of code that "**spread around**" who pays for insurance. However, nothing that significantly addresses: pooling, personal incentives to maintain health, standard insurance plan design, hospital costs and competition, market transparency, doctor monopolies on care, delivery strategies, and so forth.

There are 47 tax related provisions that hurt businesses, families, and workers. Keeping up with implementation of regulations will be costly, time-consuming, and difficult. Employers, like me, must track and monitor employee hours and report and verify health insurance coverage. Currently, the regulations lack clarity. The penalty structure and compliance requirements act as a disincentive for many to provide coverage at all. **There will be significant unintended consequences as the provisions cascade out over time.**

Key areas of concern are:

-**Mandated coverage requirements** and indirect taxes are driving costs UP and affordability DOWN.

-**Significant new taxes** on investment and income which reduce capital and hurt the ability to expand businesses and to create new jobs.

-**Reporting, tracking, paperwork and compliance** which add significant costs to all businesses.

-**Misinformation**, bad information, confusing information, and uncertainty are strangling job creation and growth.

-**Lack of simplicity.**

Increasing Premiums and the Impact of Indirect Taxes

Since the 2009 enactment, our premiums have risen from 664,000 dollars to 924,000 dollars (headcount numbers flat). We are projecting our renewal premium for this year to be 1,090,000 dollars, an 18 percent increase including the 2 percent premium tax on our fully insured health insurance product. These numbers are not sustainable over time. Our entire discretionary net profit will be absorbed by health insurance costs in 5 years, if this premium trajectory continues.

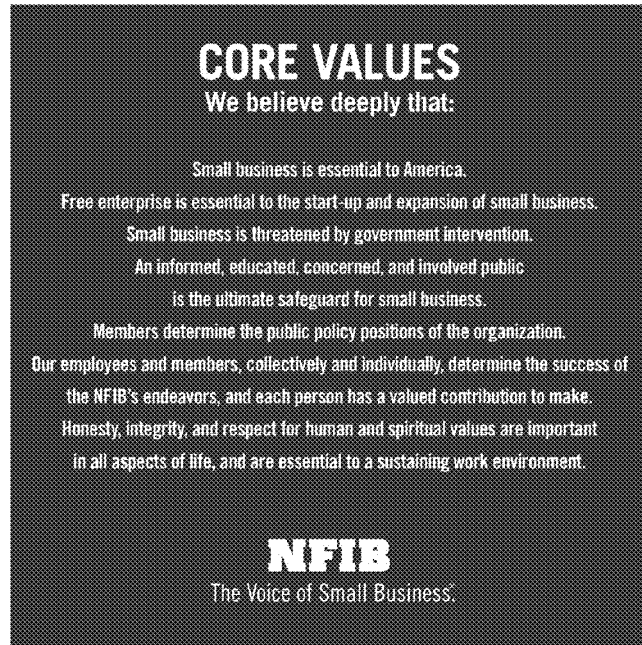
Uncertain Future and Regulatory Complexity

Fear is the most crippling emotion known to man. I am convinced that fear coupled with uncertainty, new costs, and frustration, regarding the health care law, is a key reason we are not seeing robust hiring and job creation today.

As I look across my competitive landscape, I see major disparities. My average competitor is less than 5 employees, so they don't have to provide insurance, but if they do, they may have access to tax credits. My fewer than 50 employee competitors don't have to provide coverage at all. I am greater than 50 employees. So, by law, I **MUST** offer "affordable" coverage for employees and their dependents or face taxes and penalties. Think about that???? Shouldn't ALL of us: small, medium and large be required to run our business in a fashion that we can provide this coverage and be subjected to the same rules?

If we want to lead on a competitive global platform and keep insurance affordable we must revisit this health care law and its provisions. This can be done without massive new tax increases and burdensome compliance measures. Let's look at strategies for a simplified plan that reduces costs, opens up market competition and transparency, and provides every American with a great health benefits that they buy on their own. These strategies will provide certainty for the private sector and help our economy grow again.

Thank you for your time. I look forward to any questions.



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Chairman BOUSTANY. Thank you, Mr. Joyce.
Dr. Van de Water, you are recognized for 5 minutes.

**STATEMENT OF PAUL N. VAN DE WATER, PH.D., SENIOR
FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES**

Mr. VAN DE WATER. Mr. Chairman, Ranking Member Lewis, and Members of the Subcommittee, I appreciate the opportunity to appear before you this morning.

The Affordable Care Act will extend health insurance coverage to 27 million people and help assure that Americans have access to affordable coverage, and it will do so in a fiscally responsible way.

In fact, the Congressional Budget Office has estimated that the Affordable Care Act will reduce the deficit modestly in its first ten years, but substantially in the following decade.

The tax provisions of the Affordable Care Act not only raise revenue but are also sound health and tax policy. Some provisions will encourage consumers to be more cost sensitive in purchasing health insurance and health care services.

Among these provisions are the inclusion of the cost of employer sponsored health coverage and on W-2 forms, the excise tax on high cost employer sponsored coverage, and limitations on the use of tax advantaged accounts to pay for health related expenses.

The Affordable Care Act also levies taxes or reduces Medicare payments to businesses in industries that will directly benefit from health reform. The taxes on drug manufacturers and importers, medical device manufacturers, and health insurance providers fall into this category.

Two other new taxes will affect only the wealthiest Americans who have the greatest ability to pay: the additional hospital insurance tax on high earners, and the new 3.8 percent Medicare tax on unearned income.

Finally, health reform makes health insurance coverage a shared responsibility for individuals and employers. Individuals who do not obtain coverage for themselves and their families and large employers who do not offer affordable coverage to their workers will be subject to a tax penalty.

This structure follows the Massachusetts model of health reform, which relies primarily on private health insurance plans to provide coverage.

Taken as a whole, the Affordable Care Act will significantly strengthen our nation's economy. CBO estimates that health reform will slightly reduce premiums for employer sponsored health insurance in the near term.

For employers with more than 50 workers who account for 70 percent of the insurance market, CBO estimates the law will reduce average premiums by up to three percent in 2016.

For small employers, the estimated change in premiums ranges from an increase of one percent to a reduction of two percent.

All and all, the short term economic effects of health reform will be small. Moody's Analytics terms the law's economic impact "minor," and says any disincentives from higher taxes and fees will "hardly make a difference."

The Congressional Budget Office foresees a small net reduction in labor supply, because some people who now work mainly to obtain health insurance will choose to retire earlier or work somewhat less, not because employers will eliminate jobs.

Even that effect could be partly offset by increased incentives to work for people who now face losing Medicaid coverage if they work more.

Over the long run, health reform will have many positive impacts on the economy. The lower budget deficits stemming from health reform will hold down interest rates and free up capital for private investment.

Health reform will increase labor market flexibility since workers will no longer be locked into a job by the need for health coverage.

Expanding coverage will also improve health outcomes by helping people obtain preventive and other health services and improving the continuity of care.

Most important, the Affordable Care Act includes a wide array of policies to improve health care quality and reduce costs.

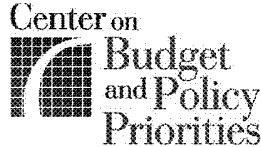
All these factors should enhance the nation's economic productivity.

In conclusion, the tax related provisions of the Affordable Care Act form part of a carefully thought out structure to expand health insurance coverage and slow the growth of health care costs without adding to the budget deficit.

Any effort to change these provisions must not be allowed to undercut any of these critical objectives.

Thank you, Mr. Chairman.

[The information follows: Dr. Van de Water]



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March 5, 2013

TESTIMONY OF PAUL N. VAN DE WATER
Senior Fellow, Center on Budget and Policy Priorities

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

Tax-Related Provisions of the Affordable Care Act

Mr. Chairman, Ranking Member Lewis, and members of the subcommittee, I appreciate the invitation to appear before you today.

The Affordable Care Act (ACA) will extend health insurance coverage to 27 million people and help assure that Americans have access to affordable coverage. And it will do so in a fiscally responsible way. In fact, the Congressional Budget Office (CBO) estimates that health reform will *reduce* the deficit — modestly in its first ten years, but substantially in the following decade.¹

The tax provisions of the ACA not only raise revenue but are also sound health and tax policy.

Some provisions will encourage consumers to be more cost-sensitive in purchasing health insurance and health care services. Among these provisions are the inclusion of the cost of employer-sponsored health coverage on W-2 forms, the excise tax on high-cost employer-sponsored coverage, and limitations on the use of tax-advantaged accounts to pay for health-related expenses.

The ACA also levies taxes on or reduces Medicare payments to businesses in industries that will directly benefit from health reform. The taxes on drug manufacturers and importers, medical device manufacturers, and health insurance providers fall into this category.

Two other new taxes will affect only the wealthiest Americans, who have the greatest ability to pay: the additional Hospital Insurance tax on high earners and the new 3.8-percent Medicare tax on unearned income.

Finally, health reform makes health coverage a shared responsibility for individuals and employers. Individuals who do not obtain coverage for themselves and their families, and large

¹ Douglas W. Elmendorf, Director, Congressional Budget Office, Letter to the Honorable Nancy Pelosi, March 20, 2010; Letter to the Honorable John Boehner, February 18, 2011; Letter to the Honorable John Boehner, July 24, 2012.

employers that do not offer affordable coverage to their workers, will be subject to a tax penalty. This structure follows the Massachusetts model of health reform, which relies primarily on private health insurance plans to provide coverage.

Taken as a whole, the ACA will significantly strengthen our nation's economy.

CBO estimates that health reform will slightly reduce premiums for employer-sponsored health insurance in the near term. For employers with more than 50 workers (which account for 70 percent of the insurance market), CBO estimates that the law will reduce average premiums by up to 3 percent in 2016. For small employers, the estimated change in premiums ranges from an increase of 1 percent to a reduction of 2 percent.²

Even if health reform were to impose some costs on employers, economic principles strongly suggest that it would have little impact on hiring decisions. Employers would ultimately pass on any such effect to workers in the form of slower growth in their after-tax compensation. CBO draws that conclusion with respect to both the excise tax on high-cost plans and the penalty on firms that do not offer affordable coverage.³

All in all, the short-term economic effects of health reform will be small. Moody's Analytics terms the law's economic impact "minor" and says that any disincentives from higher taxes and fees "will hardly make a difference."⁴ CBO foresees a small net reduction in labor supply, because some people who now work mainly to obtain health insurance will choose to retire earlier or work somewhat less, not because employers will eliminate jobs.⁵ That effect could be partly offset by increased incentives to work for people who now face losing Medicaid coverage if they work more.

Over the longer run, health reform will have many positive impacts on the economy. The lower budget deficits stemming from health reform will hold down interest rates and free up capital for private investment. Health reform will increase labor market flexibility, since workers will no longer be locked into a job by the need for health coverage. Expanding coverage will also improve health outcomes by helping people obtain preventive and other health services and improving continuity of care. Most important, the ACA includes a wide array of policies to improve health care quality and reduce costs. These factors should enhance the nation's economic productivity.

In conclusion, the tax-related provisions of the Affordable Care Act form part of a carefully thought-out structure to expand health insurance coverage and slow the growth of health care costs without adding to the budget deficit. Any effort to change these provisions must not be allowed to undercut any of these critical objectives.

² Elmendorf, Letter to the Honorable Evan Bayh, November 30, 2009.

³ Congressional Budget Office, "Box 2-1: Effects of Recent Health Care Legislation on Labor Markets," *The Budget and Economic Outlook: An Update*, August 2010, pp. 48-49.

⁴ Augustine Faucher, "Healthcare Reform Doesn't Alter the Outlook," Moody's Analytics, March 26, 2010.

⁵ CBO, Box 2-1.

Chairman BOUSTANY. Thank you, Dr. Van de Water. We will now proceed with questioning of the witnesses.

Dr. Holtz-Eakin, we have quite often heard ad nauseam that the health care law, ACA, reduces the deficit. Is that true?

Mr. HOLTZ-EAKIN. I think the original cost estimate suffered from what are now widely recognized as a lot of budget gimmicks, things like the CLASS Act, which has met its demise since the initial passage, front loaded premium receipts and back loaded spending.

There were a number of double uses of money like the Medicare reductions being used to fund the insurance expansion.

I think the answer would be no. The most important thing is that our current deficits and the projections are driven by the health entitlement programs and their rapid rate of growth, and there has yet to be an objective and non-partisan assessment of the law that says it will actually bend the cost curve.

Chairman BOUSTANY. Part of that calculation by CBO with regard to the effect on the deficit was largely because ACA raises taxes significantly, as you stated in your testimony.

Mr. HOLTZ-EAKIN. Sure.

Chairman BOUSTANY. Let's assume for a moment, for the sake of argument, that the underlying policy for health care is correct. As a physician, I happen to believe to the contrary, but let's assume for a moment it is correct.

Let's also take it one step further. Let's assume that it is reasonable or wise or good policy to extract \$1 trillion from the U.S. economy to pay for this.

Dr. Holtz-Eakin, I want you to comment, and Mr. Kautter, looking solely at the methods by which this law raises taxes, and I think you both talked a little bit about this in your testimony, it raises these new taxes on innovation, innovative companies, small businesses, many that are trying to make a profit.

It raises taxes by taxing health insurance premiums, which will be passed onto the purchasers of those premiums, raising premium costs.

Employer mandate.

Are these rational ways to extract \$1 trillion out of the U.S. economy given we have very sluggish economic growth, unemployment that is projected to remain above seven percent through 2015, and maybe beyond.

We are also looking at tax reform. It is no secret that this Committee has set a goal to fundamentally rewrite the Tax Code to simplify it and lower rates, all to promote competitiveness for American companies.

Is this a smart way to raise taxes? It seems to me ACA is a very complex tax bill. We saw added complexity with the Fiscal Cliff tax package. We are going in the wrong direction.

I would like both of you to comment on that.

Mr. HOLTZ-EAKIN. I certainly would agree, Mr. Chairman. This is going in the wrong direction. This is not good tax policy. If you look at this by the standard metrics of efficiency and equity, these are bad taxes.

I know Mr. Kautter does not love the excise taxes on payroll and net investment income, and I share his concern with the complexity and having a third Tax Code.

I think the health insurer's tax is the worse designed tax I have ever looked at. If the Committee wants to raise \$8 billion next year in some way for the insurance industry, you could do a lot better than that, and more generally, I think we should recognize the importance of broad-based taxes that are less discriminatory and less interfering with the economy.

I want to comment just on this notion of somehow these are benefit taxes. Benefit taxation is a well established principle in tax policy. Benefits accrue to individuals and taxes are paid by individuals in the end, and it is difficult to imagine the ACA being a ben-

efit tax because the idea was in fact to give low income Americans a benefit, which was insurance, very costly, and if we make them pay for that benefit, we will un-do the redistribution, which is at the heart of the law.

In the end, it is not the medical device manufacturers or the insurer's who benefit from this tax. It is workers, shareholders, and customers that ultimately should be looked at.

You cannot defend this on the basis of benefit taxation.

Chairman BOUSTANY. Thank you. Mr. Kautter.

Mr. KAUTTER. Mr. Chairman, I am very concerned about complexity, and having spent 40 years in the trenches helping all sorts of taxpayers comply with the tax law, I understand the complexity matters.

This bill has got enormous complexity in it with respect to the tax provisions. It is sort of like embarking on a great archeological dig as you work your way through the pages of the bill and now the regulations.

The tax on net investment income is a brand new third tax system. This Committee and other committees have wrestled with the alternative minimum tax and indexing the alternative minimum tax.

The net investment income tax is similar to the AMT. It has its own separate definition of income, its own method of allocating expenses to that income, its own method of calculating the tax. It determines which other taxes are creditable against that tax. It is a free standing separately contained system in the Internal Revenue Code.

I guess folks can discount it by saying well, only the top four percent or so of all taxpayers will pay the tax, a lot of those folks invest and innovate, and from a complexity point of view, it is a large step backwards.

Chairman BOUSTANY. This Subcommittee is deeply concerned about the ever rising level of complexity in the Tax Code, both from the standpoint of those who are taxed, but also from the standpoint of an IRS that keeps coming before us asking for more resources to deal with this ever growing complexity in the Code.

Mr. KAUTTER. I think the IRS has done as good a job as can be done in trying to implement the tax on net investment income. They have largely referred to existing provisions and standards.

Unfortunately, the existing provisions and standards are not very simple. You now have this new system that refers to old principles which were controversial to begin with, and these are just two of the taxes.

The Medicare tax, if someone knows they will be subject to the Medicare tax because they and their spouse will earn more than \$250,000, and they individually earn less than 200, they cannot ask to have the Medicare tax withheld from their wages. They have to ask to have additional income tax withheld.

What sense does that make to most people who are trying to fill out what is called the "W-4" for withholding. It is one of the most misunderstood forms and the potential for complexity and misunderstanding and penalties is rife.

Chairman BOUSTANY. Thank you. You pointed this out, I think, in your testimony. The net investment tax is referred to in

the law as “unearned income and Medicare contribution,” yet the revenue goes in the General Fund. It does not do anything to help Medicare, does it?

Mr. KAUTTER. It does not. It goes right into the General Fund.

Chairman BOUSTANY. The new law gives the impression that there are provisions to help finance Medicare and improve Medicare, but are there other examples of that, Dr. Holtz-Eakin, in this law?

Mr. HOLTZ-EAKIN. In the end, this law has the flaws of many laws that rely on these accounting gimmicks. Money flows into the Federal Treasury. Money flows out of the Federal Treasury.

Any labels attached to them are strictly accounting fiction because the money is gone and never saved in any meaningful way.

Medicare right now, the gap between payroll taxes and premiums coming in, spending going out, is about \$300 billion, with 10,000 new seniors every day. That is the true state of Medicare’s financial condition.

Any accounting ledger to suggest there is money in a trust fund for anything or somehow the Medicare tax will be deposited in it is in defiance of economic reality.

Chairman BOUSTANY. Thank you. That is all I have. Mr. Lewis.

Mr. LEWIS. Thank you, Mr. Chairman. Dr. Van de Water, the Affordable Care Act is a landmark law that helped millions of Americans.

For example, 86 million Americans have received one or more free check-ups or screenings to prevent and detect illness.

The Affordable Care Act delivered hundreds of billions of dollars of Federal tax credits to many American families and small businesses.

Some have suggested that the ACA is a massive tax increase on the middle class. Others have argued the opposite, that the ACA is a middle class tax cut.

The Washington Post did a fact check on the claim that the ACA was a middle class tax cut and found the claim to be true.

Mr. Chairman, I ask unanimous consent to place this article in the record.

Chairman BOUSTANY. Without objection.

[The information follows: The Hon. Mr. Lewis]

Obamacare' tax hikes vs. tax breaks: Which is greater?

By Josh Hicks, Published: July 6, 2012

Jonathan Ernst/Reuters

"The Supreme Court looked at what the structure of the law was, and they saw that 1 percent of the people would be paying this charge if they chose not to avail themselves of health insurance. But more middle-class people are going to get a tax cut in this law. There's a tax cut of \$4,000 for people who need help paying for health insurance."

--- White House Chief of Staff Jack Lew on ABC's "This Week," July 1, 2012

Republicans have seized on the Supreme Court's health-law ruling to blast the Affordable Care Act as a giant tax on the middle class. Rush Limbaugh went so far as to call it the "biggest tax increase in the history of the world," a preposterous claim we debunked in a previous column.

On Sunday, White House Chief of Staff Jack Lew refused to acknowledge that the individual mandate represents a tax, even though the majority of the Supreme Court justices defined it as such. He called the enforcement measure a "charge" that would apply only to a small fraction of the population, and that "more middle-class people are going to get a tax cut."

Let's look at the numbers to determine whether tax breaks or tax hikes — including the mandate — will be greater under "Obamacare." We'll focus on the number of people affected by both aspects of the law, since that's what Lew talked about. But we'll also review the monetary totals, just for good measure.

The Facts

Before diving into the numbers, let's remember why both campaigns need to play the semantics game: the "penalty-tax" can make either one of candidates look bad.

President Obama promised unequivocally during his 2008 campaign not to raise taxes — none whatsoever — on families making less than \$250,000 per year. Whether or not the president fulfilled that pledge hinges largely on whether the individual-mandate penalty constitutes a tax. (Our colleagues at Politifact argue he has already broken that pledge with cigarette taxes and other broad-based taxes.)

Republican challenger Mitt Romney is trying to have it both ways. He implemented a mandate in Massachusetts, but swears up and down that he never raised taxes. By the same token, he is attacking the president for increasing taxes with the health law. This week, he offered an unusual explanation for how the federal penalty qualifies as a tax while a virtually-identical measure in Massachusetts does not.

On Thursday, Obama campaign press secretary Ben LaBolt said the president views the enforcement measure as a penalty, insisting that his position should have been clear from the government's defense in front of the Supreme Court. That's a dubious claim considering how Solicitor General Donald B. Verrilli Jr. told the justices that the mandate "is justifiable under [Congress's] tax power," and that "calling it a penalty as they did would make it more effective in accomplishing its objectives; but it is in the Internal Revenue Code, [and] it is collected by the IRS on April 15."

Okay, we have demonstrated that both sides are playing fast and loose with definitional issues. Now, let's pull up the numbers to determine whether the "penalty-tax" provides more boost or burden for the middle class.

The Affordable Care Act promises tax credits and cost-sharing subsidies for individuals who earn between 100 and 400 percent of the federal poverty level. The goal is to help people satisfy the individual mandate when they can't afford insurance and don't qualify for Medicaid.

In addition, small businesses will qualify for tax credits if they have no more than 25 employees and average wages of \$50,000 per year.

On the other hand, the health law imposes a penalty of \$95 or 1 percent of adjusted gross income per adult, whichever is greater, beginning in 2014. The charge jumps to 2 percent or \$325 per adult in 2015, and it rises again to 2.5 percent or \$695 per adult in 2016.

(The Joint Committee on Taxation has provided an explanation of all revenue provisions in the Affordable Care Act in case you want to dive into the nitty-gritty details.)

A report from the nonpartisan Congressional Budget Office shows that an estimated 4 million individuals will pay penalties to the IRS in 2016 because of the mandate — no information is available for other years. This represents about 1.2 percent of the total population, according to projections from the Census Bureau. So Lew is correct with his assertion that only "1 percent of the people would be paying this charge."

How about the notion that more people will receive subsidies than those who incur penalties?

Lew is correct in this regard as well. The CBO estimates that 16 million people will receive credits or subsidies to help pay for insurance coverage through the new exchanges in 2016. That's 5 percent of the overall population.

To review, we're talking about 1.2 percent of the population paying penalties, compared to 5 percent receiving tax credits or subsidies.

We took the liberty of running our own penalty projections for 2022 — since the CBO has not provided numbers beyond 2016 — to make sure the credits and subsidies would still outweigh penalties. It ends up that the number of uninsured who pay a charge would jump to 1.7 percent of the population after 11 years, but that's hardly high enough to discredit Lew's 1 percent claim.

(A bit about our methodology: the CBO estimated that total revenue from penalties would rise by 50 percent by 2022, so we increased the number of penalty payers by that same percentage to come up with the missing figure for that year.)

It's worth noting that the health law involves more taxes than just a penalty on the uninsured --- if you consider that to be a tax. They include: an excise tax on "Cadillac plans" (plans with especially high premiums); fees on certain manufacturers and insurers; a surtax on investment income for the wealthy; higher Medicare payroll taxes for individuals making more than \$200,000 per year; a tax on medical-device manufacturers; and a tax on indoor tanning services.

It's a stretch to say that any of these taxes will affect the middle class, even those that apply to individuals, such as the taxes on "Cadillac plans" and investment income or the higher payroll taxes. But we should provide a few caveats: many conservatives argue that the hikes on businesses will affect hiring, which could affect middle-income people; and "middle class" is a term with no clear definition --- nearly everyone thinks they qualify.

Lew is on solid ground with both of his claims. But what if we look at monetary totals? Will the subsidies still outweigh the penalties?

The CBO estimated that the government will provide \$630 billion in tax credits and subsidies for insurance within the next 11 years, compared to just \$54 billion in penalties for uninsured individuals over the same period. (See Table 2 from the penalties link.)

As you can see, credits and subsidies represent nearly 12 times the amount of "tax" through the penalty.

For good measure, we compared *all* the tax hikes with the estimated tax credits and subsidies, using a combination of the CBO reports and a table from the Joint Committee on Taxation that breaks down the health law's revenue hikes. Here's what that looks like over a seven-year span:

New revenue: \$459 billion (including \$30 billion in penalties)

Credits and subsidies: \$343 billion

(Note: These totals reflect only 2012 through 2019, since those were the only common years between the CBO and JCT tables.)

In this case, the tax hikes outweigh credits and subsidies. But again, Lew mentioned "middle-class people," whom most of the tax increases won't directly affect.

Total middle-class tax hikes, as the Joint Committee on Taxation has listed them, would amount to just \$64.6 billion, compared to \$343 billion in subsidies and credits. The tax increases in this case would affect individuals making less than \$200,000. They include the penalty, plus a higher threshold for itemized deductions of medical expenses and additional taxes related to health spending accounts and flexible spending arrangements.

Pinocchio Test

It's not our business to pass judgment on the health-care law. But we have reviewed the numbers for tax hikes versus tax breaks for the middle class, and we found nothing to dispute Lew's statements.

The health law, if it works as the nonpartisan government analysts expect, will provide more tax relief than tax burden for middle-income Americans. The White House chief of staff earns a rare Geppetto Checkmark for his remarks on "This Week."

Geppetto

(About our rating scale)

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Mr. LEWIS. Dr. Van de Water, what is your opinion of whether the ACA is a middle class tax cut or tax increase, and please explain your opinion.

Mr. VAN DE WATER. Thank you for asking that question, Mr. Lewis. I think it is an excellent one. It illustrates the importance of looking at the Affordable Care Act as a whole.

We have heard a lot of discussion about individual taxes, but as I mentioned in my prepared statement, one of the important things to remember is the taxes in the Affordable Care Act were not levied for the sake of imposing taxes, but for the sake of financing the coverage expansions in the law.

Those are primarily of two sorts: first, the expansion of Medicaid for people with incomes below 138 percent of poverty, and second, financing the premium tax credits for people between 138 percent and 400 percent of poverty. Those premium tax credits, by their very nature, go to folks who are middle class, defined as having income of no more than 400 percent of poverty. And, as I recall, what that Washington Post fact check, to which you referred, did was to take a look at was all of these provisions together, not just the taxes, such as the medical device tax and so forth, but also the effects of the premium tax credits that will be provided to help people obtain health coverage. And when you look at all of those tax provisions together, I think what the Post concluded, and what I think is in fact correct, is that that the law does provide a net tax reduction for what we might consider to be middle class folk.

Mr. LEWIS. Thank you very much. Thank you. I yield back.

Chairman BOUSTANY. Ms. Black.

Mrs. BLACK. Thank you, Mr. Chairman. And I want to go back to the issue of complexity that the chairman has talked about and several of the witnesses have as well. Under the President's health care law's employer mandate tax, which I think is a very creative title that they give it, a Shared Responsibility for Employer's provision, we know that there is going to be a fairly complicated regulatory analysis to determine what tax you are going to be hit with.

And I think Ms. Sun mentioned this when she talked about deciding the definition of what full time is. So, you are going to have to consider in that what employees count as full time, what counts as part time, how many hours they worked, whether the insurance they provide to employees meets Washington's requirements and other sundry of complicated questions that will have to be answered. And, of course, we all know this starts at the end of the year.

Now, the answer to many of these questions of course is going to be by the rules that are written by the Treasury. And I hold in my hand here a temporary set of rules. We do not know whether these rules are actually going into effect or not. There are 144 pages that I hold here in my hand. These are the drafts of the latest version. I think it is also interesting that the Treasury Department admitted last week that the health care law was, and I quote this, "Not as artfully drafted as it could have been." And that the Treasury Department is working on fixing those flaws that may be in this new regulation.

So, my question, and probably the best one to start with, would be, Ms. Sun and Mr. Joyce, since you are employers who are going

to have to implement whatever comes out in these rules, and my question to you is do you feel that given the fact that we just right now have temporary rules that you do not even see, not knowing what time line is going to be when these rules are going to be final, that you will have enough time as an employer to be able to implement these provisions as you are working within your business and looking at your own budget and what you need to do for the year? Ms. Sun?

Ms. SUN. Thank you, Ms. Black. No, we absolutely do not. And we have even engaged through the International Franchise Association, bringing in Ernst & Young to try to help us and try to help educate our franchisees. But it is a five step calculation that I think you need to graduate degrees to try to figure out how to even calculate it. And our franchisees seem paralyzed to even to try to calculate it because they are afraid if they get it wrong, what is the impact going to be.

So, we see hiring freezes at our franchisees level. We have seen an unprecedented level of franchisees turning back in territories where in prior years we have had most of our franchisees opening two and three locations and employing many more people in their local communities, turning those locations back in and saying, "You know what with the Affordable Care Act, we just do not want to take on that risk." We do not want to take on the complexity. We would just potentially want to stay under 50 employees and leave the headaches until we can hope that we can get to 2014 and everyone realizes what they have done. And they see the impacts of what they have done. And this is repealed or replaced in some way, in form or in fashion, because right now we cannot figure it out.

And we have the best and brightest of Ernst & Young, which my esteemed to my colleague to my right, used to work for, and we still have difficulty trying to figure it out and trying to help our franchisees figure it out.

Mrs. BLACK. And, Mr. Joyce, before you answer let me just add one more question to Ms. Sun since she brought this up about hiring a firm to give you some advice. Have you any idea or calculation of what that might cost you in hiring this firm?

Ms. SUN. We have estimated, and we have done a pretty thorough calculation, we have estimated it will cost each of our 160 franchisees \$8,455 for every single one of our franchisees just to comply with the law at their current stage and size of business without even looking at continued growth.

Mrs. BLACK. And that is complying with the law, that is not what it is going to cost you—

Ms. SUN. So they could figure out how to comply with the law, that is what we estimate it would cost them.

Mrs. BLACK. Okay. Mr. Joyce, same question for you?

Mr. JOYCE. We agree with those—I agree with her comments. And I will just tell you, I was talking to my insurance agent last night working through my comp renewal, and I was just asking him—we were talking about the Act—and I guess the big concern is it is moving so fast there is a lack of information. Everyone is making decisions, do I hire, do I not hire? And, as I said in my comments, fear and frustration cripple business and markets. And the best thing that we can do for our country right now is excite

markets and not cripple markets. And I am telling you I believe with all my heart that the reason we are not seeing robust recovery right now is consternation over small and medium and big business with regard to these rules and regulations. It is a major concern.

Mrs. BLACK. Paralysis from not knowing what to do, the uncertainty. Thank you, and I yield back the remainder of my time.

Chairman BOUSTANY. Ms. Jenkins.

Ms. JENKINS. Thank you, Mr. Chairman. Dr. Holtz-Eakin, this Subcommittee held a hearing last year that reviewed a provision within the ACA that requires a physician's prescription in order to gain a reimbursement through tax preferred accounts like FSAs and HSAs for the purchase of over-the-counter medicines. And some of my colleagues across the aisle claim that only the wealthy use these accounts, but I know that over 19 million families alone use FSAs. What are your thoughts on this provision and the impact on families on a budget and the burden on physicians who are now seeing patients to prescribe something that can be bought over the counter?

Mr. HOLTZ-EAKIN. Well, I think that it is pretty obvious and onerous compliance cost, just making the—getting prescriptions impose a big cost on everybody. Past that, when you think about the goals of this, if you want to make people more sensitive to the kinds of things that they do, it seems odd to single out these particular accounts as the way to do it. This is a law that has a nearly infinite scope. It touches every piece of an American economic life, and to target something that has been relatively successful and popular like the FSAs and the HSAs strikes me as a really narrow way to go at it.

Ms. JENKINS. Would you consider this a tax on working families?

Mr. HOLTZ-EAKIN. This is a repeal of a clear benefit that was in the Tax Code to reach a policy objective, and it is going to make their taxes higher.

Ms. JENKINS. Do you feel that the provision provides in any way an efficiency for the health care system?

Mr. HOLTZ-EAKIN. Again, I think if you want to get genuine efficiency you have to do broad-based things, not these rifle shots. And I think that would be the way to go.

Ms. JENKINS. Okay, and on another note, several experts, as well as the Congressional Budget Office and the Joint Committee on Tax, have estimated that the health insurance tax will result in higher health insurance premiums for individuals and families. Could you please explain why the tax will lead to higher premiums and how the tax is at odds with the ACA's stated goal of making coverage affordable?

Mr. HOLTZ-EAKIN. The way the tax is designed, the fixed fee, \$8 billion for example in 2014, is allocated among insurance companies on the basis of market shares. And what that means is that every time you sell another policy, you raise your share and thus raise the tax that you have to pay. That is just like putting a sales tax on insurance. And we know what happens with sale taxes. If at all possible, you try to shift that on to the customer.

This is exacerbated in this case by the fact that for the for-profit insurers, those paying corporation income tax, they are not allowed

to deduct this tax. So if you have got a dollar of premium tax, you actually cannot just raise premiums by a dollar and come even because your tax liability is going to go up. So you have to actually raise it by \$1.54 if you do the arithmetic. That is a real upward pressure on premiums that is built into this tax.

And you might like to think maybe it will magically come out of profits, but these are insurers that operate in competitive capital markets. They do not have excess profits that you can identify. You might want health insurance workers to work for less, but I think we are trying to have workers have their incomes go up, not down and have more employment. So the net effect of this is by and large going to be higher premiums, and that is going to get shifted on to probably the middle class.

Ms. JENKINS. Okay, thank you, I yield back.

Chairman BOUSTANY. I thank the gentle woman. Before I yield to Mr. Davis, I want to mention that this Subcommittee did hear testimony last year with regard to the Small Business Health Insurance Tax Credit and the difficulties that small businesses were having in complying with it. In fact, by the IRS's own estimation it consumes about 40 million man hours per year, which averages out to about 19 hours, man hours, to comply per small business. So I thought that was important to mention. And, secondly, the projection of the number of small businesses that are availing themselves of this tax credit, it has been way below what was originally anticipated. With that, I will yield to Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman. And I want to thank the witnesses. Especially, I want to thank you for calling this hearing because it gives us an opportunity to look at several dimensions of the Affordable Care Act.

One of the things that I have noted is 105 million Americans have had a lifetime limit on their coverage eliminated, which I find to be quite commendable, 6.6 million young adults up to the age of 26 now have health insurance through their parent's insurance, and 6.1 million seniors in the donut hole have received savings on their prescription drugs. These savings total \$5.7 billion overall and averaged \$706 per senior in 2012. And, of course, these savings will continue to grow as the donut hole becomes more fully closed.

Mr. Van de Water, if I could ask you, I have noted that some commentators are concerned that the ACA will lead to a significant reduction in the labor market. And while CBO did state that the Affordable Care Act will reduce the labor supply, CBO believes that this would be due in significant part to the end of what is called "job lock." In other words, employees would choose to work less or perhaps work for themselves because the Affordable Care Act would allow them to obtain affordable health insurance from sources other than their employer. What is your opinion relative to the effect of the ACA on the labor supply?

Mr. VAN DE WATER. Thank you, Mr. Davis. Yes, you are exactly correct in describing the Congressional Budget Office's assessment of the effect of the Affordable Care Act on labor markets. CBO concluded that, as I think virtually all of our personal experience would attest, that there are people, particularly those who are approaching their retirement years, who may be sort of hanging on to a job, even one that they are finding very onerous, because that

is the only way that they can retain health insurance. In some cases, even at younger ages, people are not shifting to another job if the current job that they have has health insurance but the one that they prefer based on other factors does not. So the availability of health care coverage through the exchanges on a guaranteed issue basis will eliminate that locking of people into a particular job.

And in the case of some of the older workers, the Congressional Budget Office estimates they may decide that they will actually withdraw from the labor market a bit earlier, and obtain coverage through the exchange instead of through an employer. But even the extent to which that happens, CBO estimates will amount to a very small drop in employment.

Mr. DAVIS. I have also heard people suggest that a medical device excise tax will shift jobs overseas and investment away from the medical device industry in this country. What is your opinion of these types of arguments?

Mr. VAN DE WATER. Again, that is an excellent question. The assertion that you referred to is a common one, that the medical device excise tax will cause jobs to shift overseas. But it turns out that this tax is carefully structured so as to avoid that particular effect. And the reason is as follows, that the tax does apply to imported medical devices, as well as to devices produced domestically, but the tax does not apply to exported devices. So that means that if we are talking about devices that are going to be used in the U.S., the tax is paid whether the device is made domestically or abroad. But if we are talking about devices that are to be used overseas, the tax is not paid, whether the device is manufactured here or overseas. So in either case the playing field between American manufacturers and foreign manufacturers remains level.

Mr. DAVIS. Thank you very much, and I yield back, Mr. Chairman.

Chairman BOUSTANY. I thank the gentleman. Mr. Marchant.

Mr. MARCHANT. Thank you, Mr. Chairman. It is an honor today for me to have a couple of Texans here on this panel. And, welcome, thank you for being here today. Mr. Joyce, thank you for your statement. I think your statement embodied exactly the feelings of every business in my district. I represent a district that has Addison, Las Colinas, all the DFW Airport and all of the surrounding areas. And throughout the district every single owner, every single CEO is sitting down with their accountant, sitting down with their insurance agent, and they are trying to figure out how they are going to do business next year. And that is creating uncertainty and, in your words, it is creating fear. And in a business environment of uncertainty and fear, you do not have hiring. In fact, you have exactly the opposite. So many of these fortunate individuals that will be able to stay on their parents' insurance for another couple of years, because of the abysmal hiring atmosphere, it may be that those very individuals that have stayed on their parents' insurance for an additional couple of years actually will not have anywhere to go to work after they get out of college because the hiring has been frozen, and there is such uncertainty.

During the debate when we—when this Affordable Health Care Act was adopted, one of the major arguments the Administration

and supporters gave the companies, and the medical device companies specifically, would receive a windfall because there would be so many thousands and literally millions of people that didn't have insurance, that would have insurance that would now begin to access the health care system. And because of that, your business, Mr. Humann, your business, Mr. Moore, would have so many new customers and would be able to sell so many more instruments that your profits would go up. And because of those profits, you should help pay for this system. So, I would like to give both of you the opportunity today to address that argument?

Mr. HUMANN. Yes, thank you for the question. At OsteoMed, we just have not seen that and do not expect to see that. First of all, the products that we make patients are receiving regardless. There are products that are for trauma and for severe reconstruction issues. Secondarily, the majority of newly insured patients are younger—younger people, and they will likely not be utilizing the medical technologies that are out there. And then third, when we look at Massachusetts, which has had universal health coverage now for some time, we have seen no up-tick in our business in that state whatsoever.

Mr. MARCHANT. So, basically, in your case, the Medical device tax is just a redistribution? It is basically going to your company and saying your company or your industry is going to pay for the Affordable Health Care Act?

Mr. HUMANN. It is very simple. It is an extra cost on our business. It is one less dollar that we have to invest in innovation and new hires within OsteoMed.

Mr. MARCHANT. Thank you. Mr. Moore.

Mr. MOORE. And we ask that same question across many of our members: is there an expected windfall? And I think coming back to that Massachusetts experience, in our surveys 90 percent of companies who had been through the Massachusetts experiment of universal care did not see a windfall, did not see any growth, any greater growth in Massachusetts than they did in the rest of the country. So whether you are talking Cyberonics or the rest of the industry, we do not expect to see that windfall.

Mr. MARCHANT. And do you—do either of you expect to be able to pass—fully pass on the expense of the tax to your customer?

Mr. HUMANN. The competitive environment is incredibly tough. We have foreign manufacturers coming over. We have domestic companies that we compete against. We need to look at our costs first, and keep all of our options open and try and make the ends meet at the end of the day. This is a new cost on our business.

Mr. MOORE. Right, and, as I said in my comments, we see our taxes going up with this 2.3 percent revenue tax. Across the industry we see our taxes going up 29 percent. We are not finding a way that we think we can recover the tax. Quite the contrary, we are saying where do we cut in order to find some cost savings to offset the tax increase? And those start hitting things that we least want to hit. They hit American people in the area of jobs. They affect projects, American projects, our research and development. And fewer people working on fewer R&D projects ultimately impacts in a very negative way, ultimately patient care.

Mr. MARCHANT. Thank you, Mr. Chairman.

Chairman BOUSTANY. Mr. Paulsen.

Mr. PAULSEN. Thank you, Mr. Chairman, and also for holding this hearing and for our witnesses for all being here today. I do share the deep concern that has been expressed by many of the members here as well as some of the folks that have testified here this morning about how the Affordable Health Care Act or the taxes that are in the bill, in the new law, have actually contributed to the rising cost of health care. And are putting now a heavy burden on some of our best job creators, which we just heard about.

As co-chair of the Medical Technology Caucus and as the chief author of the bill to repeal the device tax, I have a particular interest in how this tax, this really destructive tax, has been harmful not only to American jobs but also innovation and also patient care. Now, already we have seen thousands of layoffs in this industry. I mean that is pure and simple. Thousands of layoffs in this very dynamic, very vital industry. It is in Minnesota. It is around the country. The President has repeatedly stated his objective to increase domestic manufacturing, American manufacturing. And I think the irony here is that this is a policy that is actually being very harmful to achieving this goal, as our witnesses have already pointed out. It is having the opposite effect primarily because this is a tax that applies to sales, not to profits. And it is going to raise the average tax bill by some companies by almost a third. And other countries are absolutely incentivizing these companies to make these products overseas while we are taxing and regulating unfortunately our best companies out of existence. And so this American success story I think needs to be protected. We cannot take that leadership for granted.

I want to ask this question though, Mr. Moore and Mr. Humann. I am so glad you are here to testify about the very real effects that the tax is having on your employees and on your company and on medical—on the quality of health care, but I am wondering whether there are other hidden costs that are there as part of this device tax if we dive a little deeper, beyond the tax itself? For instance, I know that due to the new tax, medical technology companies have to keep track now of which products are sold in the United States versus which are sold overseas, which products are “further manufactured,” which are subject to the retail exemption. And on top of that the tax is now paid every two weeks, every two weeks, this excise tax. And I know many companies have hired full time staff just to handle the device tax compliance.

And I have spoken to some larger companies that sell thousands of unique products. Small companies have difficulty complying with the new rules. One company said they have 129,000 products that needed to be individually analyzed, which cost the company \$10 million on the compliance side, including two full time new tax employees, four to six dedicated brand new consultants on site for a year and two new IT people as well. So that is not on the research and development side. This is on the compliance side. I do not think those are the types of jobs we should be creating.

So, Mr. Humann and Mr. Moore, in addition to the \$30 billion in the new tax that you are going to have to deal with the next few years and the job loss and the innovation struggle, how is it

now—how is it for your companies now to calculate and pay the tax?

Mr. HUMANN. Yes, without a doubt, the tax provides a complexity that has not been there before. OsteoMed's whole mission in life is to improve patient outcomes. That is what we come to work every day to be able to do. And, again, anything that we have to spend non-value added time and resources on to administrate a tax, to figure out a tax, to pay a tax is one less dollar that we have to, again, continue to innovate and come up with great new products to help people reduce health care costs and ultimately help patients.

Mr. PAULSEN. Mr. Moore, are there other costs?

Mr. MOORE. Well, I have seen estimates across the industry that reach into the hundreds of millions of dollars, which sounds like a lot of money. However, what we know is this 2.3 percent revenue tax is going to cost our industry \$29 billion. So hundreds of millions versus the \$29 billion, the bigger issue is still the device tax. And I think Republican, Democrat, there is agreement among many, bipartisan support, that this device tax is bad policy, and that it needs to be reversed.

So the implementation at this point is the least of my concerns. The bigger issue is we are losing jobs. We are losing the American manufacturing and the leadership that we have. It is like *deja vu* all over again, back to my childhood as a son of a steelworker. One of the most difficult decisions I have had to make is to begin setting up manufacturing for the first time in our 25 year history outside the United States. And, unfortunately, at this point we have broken ground. I hope to limit the number of jobs and get back to creating more jobs in America.

Mr. PAULSEN. Thank you, Mr. Chairman.

Chairman BOUSTANY. I thank the gentleman. I want to thank you for your leadership on that particular issue, but also for raising the question of the complexity in complying with that tax, especially for some of our larger companies with complex supply chains. It has gotten to be a nightmare. So, I deeply appreciate your raising that concern.

Next, Mr. Kelly, you have got 5 minutes.

Mr. KELLY. Thank you, Mr. Chairman. And thank you all for being here, especially small business owners. My whole life I have been involved in small business. My father started a business in 1953 after being a parts picker in a General Motors warehouse, coming back from the war and starting a dealership, a very small store, one car showroom, about four service bays. So I know of what you talk. And one of the most fascinating things since I have been here is to listen to the opinions of those who are not on the field. I spent a little bit of time playing football in my life, and I always thought it was much more interesting to be up in the stands. I could really pick out what people were doing wrong as opposed to being six inches from somebody that is trying to take my head off. I watch you.

And, Mr. Moore, the area I went to school and I would go by Gary, Indiana. What a great place it was at one time with all the steel mills, and the same in my town of Butler, Pennsylvania. We

had great steel mills. We had great railroad companies. We had a lot of great things that are no longer there.

But I think the disconnect here is that people do not get it that there is a cost of operation that we keep messing with all the time by increasing their tax load. And for some reason, Mr. Paulsen just talked about medical devices. You cannot increase the cost of your product and hope to compete in a global competitiveness where people do not have to play by the same rules. It is fascinating to me. One of the biggest items we sell right now are cars or navigation systems because people do not know how to get from Point A to Point B or they want to find the fastest or the quickest or the most use of freeways. And I would just tell you that most times it gets a little bit confusing, and when it does, a little voice comes on that says, "Recalculating."

This Affordable Care Act, I mean I cannot imagine something being named worse in my life, "affordable"? Heavens, no. Heavens, no. Try and work with it. I mean the people that actually have to work it. Get up out of bed in the morning, put their feet on the ground and go to work. They are the ones that have to struggle with it. And I am fascinated by folks who have never done it that can tell you how easy it is. All you need to do is get a laptop. I will put the program in for you. I will show you how it works. Tell me the struggles that you have just trying to maintain your competitive edge.

And the other thing is one of the things says the employer mandate is called the "Shared Responsibility for Employers Regarding Health Coverage Payment," which kind of suggests that me as an employer all my life, I did not really know how to take care of my employees. And that is kind of funny because I have been to baptisms. I have been to communions. I have been to weddings, and I have also been to funerals. So, I think I understand my people pretty well. Tell me some of the concerns you have? And I think this is absolutely insulting to tell people who have lived their whole life with associates that help make them successful that you did not know what you were doing, and we have got to tell you because this is an outfit that runs so well. We know how to do it.

Ms. Sun, your business has become very complicated for your franchisees, has it not?

Ms. SUN. Thank you, yes, it has become very complicated. And I think the biggest issue we have with having the health insurance cost being forced on our franchisees potentially before they are ready, we believe in providing health insurance for our employees and doing the right thing. We often go to the employee—our employees' baptisms and birthdays and funerals and new births at the hospitals and when they are sick, but many of our franchisees have only been in business for two years, three years, four years. Many of them still do not have bank loans. And to put a mandate of additional cost on their business before they are out of debt and have paid back their small business loans to the SBA, I think that is improper. And it is not government's place to be telling our small business owners how they should be interacting. That is a relationship between the employer and the employee. And that is what is scary for how the Affordable Care Act is being implemented.

Mr. KELLY. As I go back in the district, that relationship between the owner of the business and the associates that work together, as one of you talked about having to lay people off, there is nothing worst for an owner than to have to call somebody and tell them, "You know what, we are not going to be able to keep you on the payroll anymore."

I have got a friend in Erie, Pennsylvania who is in the fast food business. He is going to have to reduce his workload of people down from being fully employed to part time in order to meet this. These are the costs that people who have never done it do not get. They think they are so darn smart. What they have caused is us to lay off people that we know, that we have lived with, that we have suffered with, and that we have gotten through tough times with.

One of you talked about it, 40, they talked about the 40, right?

Mr. HUMANN. Yes.

Mr. KELLY. That is what is so critical here. We are telling those people they cannot work full time anymore, not because we do not love them, not because we do not need them, but the government has made it impossible for us to keep them on the payroll.

Mr. HUMANN. That is exactly right. They really are family members within the company, but the greater responsibility to the remaining almost 300 employees that are there. And the costs, as they continue to increase, have to be addressed. And the tax is a substantial cost.

Mr. MOORE. Mr. Kelly, if I could, I heard earlier that this is not causing jobs to move overseas. Whether you are a company of my size, and after 25 years, we have set up our first outside United States manufacturing facility, or you listen to some of the larger companies, one whom more recently announced a \$75 million new tax bill, job losses of a 1,000 in the U.S., while they are hiring more in China. I connect those two, increased taxes and moving jobs outside the U.S. As we get more tax burden, we have to find ways to make up for that tax. And one way is to move jobs offshore. And I do not like it.

Mr. KELLY. No, nobody does. I have talked to more people, it is not that they are unpatriotic, it is just that they are not stupid. They cannot keep their companies open by trying to work under a definition, under rules that make no sense. I talked to our controller today at the dealership this morning. Our costs now, we just got the bids back, \$500,000, which is nothing in Washington's terms, but for my little dealership, that adds to our cost of operation which affects the cost of labor. It affects the cost of every product we sell. It affects the way we look into the future, and I think that is the real bad part of this thing. We do not understand how badly we have hurt people's looks into the future with any type of confidence that they can survive in an area where the government should be your friend. They should be helping you get to a prosperous thing. And, you know what, we are just the opposite.

Mr. MOORE. And we do hear from those governments in other countries. I get at least an e-mail a week from another country soliciting our jobs.

Mr. KELLY. Well, thank you for staying the course, and do not give up faith. I think we can still get this thing fixed. I think we

have got some people thinking a lot more clearly about this, but thanks so much.

Mr. Chairman, thank you so much for having this hearing. I think it is so critical that the folks that are actually on the ground that face these challenges every day get a chance to come before Congress and tell them exactly how hard it is to do what they do every single day. And you are the ones that fund the whole government. I mean we are killing the goose that laid the golden egg. So striking it and keep saying, "Lay hen, lay," those days are gone. We better wake up and smell the coffee. Thank you so much. And thank you, Mr. Chairman.

Chairman BOUSTANY. Thank you, Mr. Kelly. I would ask the panel to hang around for just a moment. We have two additional questioners, Mr. Davis and Mr. Marchant. So, Mr. Davis.

Mr. DAVIS. Thank you very much, Mr. Chairman. Mr. Van de Water, let me ask you. There are those who argue that the health insurance industry fee in the ACA will be passed through to businesses and consumers in the form of significantly increased premiums. These commentators do not seem to acknowledge the downward pressure on premiums that the ACA will have. Could you please discuss these countervailing factors and include in your remarks what the CBO and the ACT believe would be the impact on premiums?

Mr. VAN DE WATER. Yes, Mr. Davis, as you indicate, that if taken by itself, the tax on health insurance providers, with other things being equal, tends to increase the cost of health insurance, there is no question that there are other features of the Affordable Care Act, which are designed to increase competition and reduce costs. And taking all of those factors into account, the Congressional Budget Office has estimated that for large employers, those with more than 50 workers, the Affordable Care Act overall will reduce average premiums by up to 3 percent in 2016.

For small employers, CBO has a range. They estimate that there possibly could be a small increase in premiums of as much as 1 percent, but there could be a decrease of as much as 2 percent. So the middle of that range actually would be for a small decrease in premiums, illustrating once again that it is important to look at the total effect of the law, not just the effect of one particular provision.

Mr. Davis, if I might, I would like to comment on something that was said a moment ago about the Medical Device Tax and the effect on jobs, following up with a question you asked previously. Clearly, there is no doubt that some medical device manufacturers, like firms in other industries, are opening up plants overseas, but it has been well documented and it is quite clear by the structure of the tax itself, since the tax does apply to imported devices that are manufactured overseas, the tax itself cannot possibly be a reason to move production overseas. There are indeed other cost reasons that apply in particular cases that lead manufacturers to make that decision, but the device tax itself does not change the balance of cost between producing domestically and producing abroad.

Mr. DAVIS. Let me ask you—could labor supply and production costs have something to do with movement?

Mr. VAN DE WATER. Presumably, it does. The gentlemen here who actually run the companies can speak to that in a way that I cannot, but I would also note that there are other device manufacturers who take a contrary point of view. And if I might, I would just like to quote a couple of them. A fellow by the name of Martin Rothenberg, who heads a device manufacturer in upstate New York, says that the claims that the device tax will cause layoffs and outsourcing, his word, not mine, he calls these claims “nonsense.” The tax, he says, will add little to the price of a new device that his firm is developing. “If our new device proves effective, and we market it effectively, the small increase in cost will have zero effect on sales. It would surely not lead us to lay off employees or shift overseas production.”

Another gentleman by the name of Michael Boyle, who founded a device firm in Massachusetts, says that the device tax is “not a job killer. It would never stop a responsible manager from hiring people when it is time to grow the business.” So, again, I just want to note that there are different views within the device industry itself about the effect of the tax.

Mr. MOORE. You know, in my case I made that decision for our company, and I can tell you I made that decision based on interactions with the government, primarily driven by another tax. After going through the process of a startup company, in our first 20 years, we only made a profit, a small profit, for one year, but cumulatively we had losses of over \$250 million. Around year 20, we were not yet profitable and losing \$50 million a year. We needed to do something. Now, five years later, we have some profitability, but we still have net operating losses in a successful business.

When I look overseas, there is another reason beyond taxation for opening a plant overseas, there is something called country of origin, which says certain countries penalize me for being solely a U.S. manufacturer in that they will not allow me to go for a product approval in their country until I have approval in my home country, where we manufacture. So, yes, there are other reasons to set up manufacturing overseas, but in our case I can speak to the decision because I am the CEO who made that decision to set up in another country, to invest millions of dollars to set up a plant in another country, to hire our first OUS manufacturing employee who starts on Monday. I made that decision based on our situation and it is tied to the device tax.

Mr. DAVIS. Thank you very much, Mr. Chairman.

Mr. HUMANN. If I could add on that, the device tax in general has on average across the industry effectively increased the tax—the effective tax rate 29 percent. And so, again, every dollar that goes to Washington is one less that we can put into our development back in Dallas or throughout the industry. At the end of the day, if it makes economic sense for a company to look overseas to be able to reduce its overhead, they have got to, and this tax certainly does not help in that process.

Chairman BOUSTANY. Thank you. Mr. Marchant.

Mr. MARCHANT. Thank you, Mr. Chairman. Just a couple of comments. Mr. Kautter, your testimony I have read, and I think, Mr. Chairman, we might if we had the time, we could have a com-

plete hearing just on the idea of this complexity of this law and the complexity of this tax changing the absolute behavior of investors. I think—I have read through it, and there is one page in here that just crystallizes it. And so if you are an investor, if you are somebody nearing retirement and you are trying to preserve your retirement, you are going to look at this, and you are going to change your behavior.

And, Mr. Eakin, you know that American business and American investors will spend a lot of money on tax avoidance. And they will spend a lot of money on tax planning. And so I commend you for your testimony here. I have read it. It is very serious testimony, and I would like to thank Mr. Eakin, for you have been on TV a lot the last two weeks and thank you for your very commonsense comments.

But, Mr. Chairman, I would commend you for bringing up this subject. This is the exact opposite of what our committee is working on. Our committee is working on simplifying the Tax Code and lowering tax rates. This does nothing to simplify the Tax Code. In fact, it makes it so complex.

The most alarming figure that I read here today was the threshold for trusts and estates is \$12,950. That will probably—that will completely alter the behavior of those trusts in the States, and I contend they will not pay that tax. Thank you.

Chairman BOUSTANY. That figure was alarming when I read your testimony as well. And I have gotten a lot—Mr. Marchant, I have got a lot of questions about that tax and how it might apply, the 3.8 percent tax, net investment—new net investment tax. So a lot of my constituents were struggling for some of the answers based on the very specific questions they were asking me. And even their accountants were confused, but your testimony helped us sort of understand generally the level of complexity that this has added. And I do agree with you, we might need to investigate this further. So I appreciate your raising that concern and question, Mr. Marchant.

With that, I want to thank all of you who have presented in front of the committee today and for being here and for your testimony. I will remind all the members that if you have additional questions, you can submit these, and they will be made part of the record. And to the witnesses, there may be additional questions that members may want to submit to you. So, we will be accepting submissions for the record, which is open for two weeks following the hearing.

With that, this hearing is now adjourned.

[Whereupon, at 12:50 p.m., the subcommittee adjourned.]

[Submissions for the Record follow:]

American Farm Bureau Federation



**Statement of the
American Farm Bureau Federation**

**TO THE
SUBCOMMITTEE ON OVERSIGHT OF THE COMMITTEE ON WAYS
AND MEANS**

**REGARDING TAX PROVISIONS CONTAINED IN THE
PATIENT PROTECTION AND AFFORDABLE CARE ACT
AND THE HEALTH CARE AND EDUCATION RECONCILIATION ACT
OF 2010**

MARCH 5, 2013

The American Farm Bureau Federation commends the Subcommittee on Oversight for holding a hearing to examine the impacts of tax provisions contained in health care reform legislation. We offer these comments on the harmful impact that new Medicare taxes, the Health Insurance Tax and tax penalties for failure to meet coverage requirements will have on our nation's farmers and ranchers.

Medicare Taxes

The Patient Protection and Affordable Care Act (PPACA) creates a new 3.8 percent tax that will be applied to "unearned" income of so-called high income taxpayers beginning in 2013. Farmers and ranchers are most likely to be impacted from profits from capital gains and rental income. In addition, a new 0.9 percent Medicare tax will be imposed on wages and self-employment income above established thresholds for high income individuals. Unlike the current Medicare tax paid by the self-employed, no income tax deduction is available for half of this new tax.

Farmers and ranchers who are landlords will be subject to a 3.8 percent Medicare Contribution Tax on rental income if they exceed AGI thresholds and realize a profit from rental property. For example, a farmland owner who rents 100 acres for \$200 per acre and spends \$1,000 for property taxes and other expenses will turn a profit of \$19,000. This amount will be included in the AGI calculation and will be subject to the 3.8 percent Medicare Contribution Tax when a taxpayer is pushed over the high-income threshold.

Farmers and ranchers exceeding the AGI thresholds will also be subject to the Medicare Contribution Tax on capital gains income when they sell land or buildings. For example, assume a farmer sells 100 acres of land for \$1 million that has been held for 30 years. After adjusting the basis for improvements made while the asset was owned, the gain from the sale is \$900,000. This amount will be included in the AGI calculation and will be subject to the Medicare Contribution Tax. This sale alone will cause the farmer or rancher to be considered "high income" and will subject the proceeds from the sale to the 3.8 percent Medicare Contribution Tax, and trigger the 0.9 percent Medicare tax on wages and self-employment income over the threshold.

These Medicare taxes impact farmers and ranchers more harshly than many other tax payers because farming and ranching is a capital intensive business and because farm and ranch profits fluctuate greatly from year-to-year due to unpredictable markets, varying yields caused by volatile weather and the erratic actions of global competitors. Profitable years must make up for lean years in order for agricultural producers to remain in business. The imposition of the 3.8 percent Medicare Contribution Tax on unearned income and the 0.9 percent Medicare tax on wages and self-employed income during a good year when AGI thresholds are exceeded reduces agricultural producers' ability to compensate for bad years and threatens business sustainability. In addition, the aggregate Medicare tax amount paid by farmers and ranchers will be more than a taxpayer earning the same income on a level basis.

The imposition of the Medicare Contribution Tax when a farm or ranch is sold amounts to a "retirement tax" on agricultural producers and is unfair to those who invest in their businesses rather than traditional retirement vehicles. Farmers and ranchers typically prepare for their senior years by reinvesting farm and ranch profits back into their businesses with the anticipation of

selling assets to fund retirement. When a farm sale occurs, a farmer or rancher is likely to have a spike in income pushing earnings above the AGI threshold for high earners, and because 84 percent of a typical farm's assets are land or buildings, there will also be a huge jump in taxable unearned income in the year of sale.

The Medicare Contribution Tax can also hurt young farmers and ranchers wanting to get into production agriculture. When capital gains taxes are assessed on land sales, sellers are not as likely to sell, or will demand a higher price to compensate for additional costs. Adding the Medicare Contribution Tax on top of capital gains taxes will make it harder for beginning farmers to acquire the land that they need to get started in business and for expanding farmers to purchase additional land. This increases the likelihood that farmland will be sold for other uses when young farmers and ranchers find it hard to buy from a retiring producer.

The *American Taxpayer Relief Act of 2012* did set the capital gains tax rate at 15 percent for taxpayers making under \$400,000 (single person)/\$450,000 (couple). Taxpayers over the threshold pay capital gains taxes at a 20 percent rate. However, the capital gains tax rate that farmers and ranchers will pay will almost always be 20 percent because income will spike and exceed the thresholds in the year that a farmer or rancher sells his land. The higher rate will be imposed even though a farmer's or rancher's average annual income would not have exceeded the thresholds. Adding the 3.8 percent Medicare Contribution Tax on top of the already inflated 20 percent capital gains tax rate is particularly onerous.

Farm Bureau supports a repeal of the 3.8 percent Medicare Contribution Tax that will be applied to "unearned" income of so called high income taxpayers and the new 0.9 percent Medicare tax that will be imposed on wages and self-employment income above established thresholds for high income individuals.

Health Insurance Tax

The Health Insurance Tax (HIT) is expected to raise \$87 billion over the first 10 years it is in place. During 2014, the year that the HIT Tax takes effect, \$8 billion dollars will be collected. This will increase health insurance costs for farmers, ranchers and other small businesses by imposing a levy on the net premiums of health insurance companies

Most farmers and ranchers and other small businesses are not self-insured because they do not have a large enough pool of employees. Instead, small employers purchase health insurance in the fully insured market. Because fully insured health plans are the plans that factor into the equation that determines how much HIT Tax an insurance company pays, the cost of the HIT Tax will be passed through to small businesses that purchase those plans.

A recent Congressional Budget Office (CBO) report confirms that the HIT Tax "would be largely passed through to consumers in the form of higher premiums for private coverage." Health insurance costs for small businesses are already rapidly trending higher, increasing 100 percent since 2000. This new tax will raise insurance costs even more, making it harder for farmers and ranchers to purchase coverage for themselves, their families and their employees.

Farm Bureau supports H.R.763, introduced by Reps. Charles Boustany (R-La.) and Jim Matheson (D-Utah) to repeal the annual fee on health insurance providers enacted as part of the Patient Protection and Affordable Care Act (PPACA).

Tax Penalties for Coverage Failure

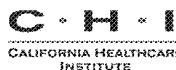
Farm Bureau believes that health care is primarily the responsibility of individuals and we remain opposed to mandates that require individuals to have health insurance and to mandates that require employers to provide health insurance for their workers.

Health insurance costs are an ongoing and significant expense for farmers and ranchers who buy coverage for themselves and their families and for the agricultural workers they employ. Most farmers and ranchers are self-employed and buy health insurance for themselves and their workers through individual and small group markets. While exchanges may help address costs, PPACA tax incentives designed to help individuals and small employers afford health insurance costs are inadequate and temporary. The health insurance coverage mandate accompanied by the threat of a tax penalty for noncompliance is only making the situation worse for people unable to afford health care coverage in the first place.

Coverage mandates the accompanying tax penalties are especially burdensome to rural American families who already pay a greater percentage of their after-tax family income on health insurance than urban American families. According to the Council of Economic Advisors, 24.2 percent of families in rural areas spend more than 10 percent of their income on health insurance coverage, compared with 18.1 percent of families in urban areas.



California Healthcare Institute



**Statement of the California Healthcare Institute (CHI)
Submitted to the
House Committee on Ways & Means
Subcommittee on Oversight**

**Hearing on
Tax-Related Provisions in the President's Health Care Law**

March 5, 2013

CHI - California Healthcare Institute, the statewide public policy organization representing California's leading biomedical innovators -- over 275 research universities and private, non-profit institutes, venture capital firms, and medical device, diagnostic, biotechnology and pharmaceutical companies -- appreciates the opportunity to present its views on the medical device excise tax contained within the Patient Protection and Affordable Care Act (PPACA) as part of this important hearing.

Since it was first proposed, CHI has voiced concern over the medical device excise tax. With an ecosystem already under significant pressure -- venture capital funding to early stage technologies is down, regulatory uncertainties are leading groundbreaking "made in America" devices to launch overseas years before here in the U.S., and coverage and payment pathways are becoming more demanding, cumbersome and expensive -- the device tax provides a case study in shortsighted policy decision-making. At a time when we should be doing everything we can to *encourage* investment, innovation and job creation, the medical device excise tax instead discourages and threatens important research and development, and is already putting jobs in California and across the country at risk.

Given the size and scope of the medical technology sector's presence in California, the 2.3 percent, \$30 billion tax has a disproportionate impact on our state. California is home to more than 1,200 medical technology companies -- more than any other state in the nation -- and the nearly 72,000 medical device jobs in California represent roughly 17 percent of the total U.S. medical technology workforce. Vibrant medical technology clusters exist in and around San Diego, San Francisco/Silicon Valley, Orange County and Sacramento, as well as the Los Angeles, Ventura/Santa Barbara, and Riverside/San Bernardino regions.

CHI appreciates the attention the Committee is bringing to this important issue and is encouraged by bipartisan, bicameral efforts to repeal the device tax, including H.R. 523 (The Protect Medical Innovation Act), which has been referred to the Committee with over 200 co-sponsors. We would be pleased to provide additional information on the damaging impact of the tax in our state. Thank you again for the opportunity to present our views.

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Cook Group

**Statement of
Stephen L. Ferguson
Chairman, Cook Group, Inc.**

**Before the U.S. House Ways and Means Committee
Subcommittee on Oversight**

March 5, 2013

Chairman Boustany, Ranking Member Lewis and Members of the Subcommittee, thank you for the opportunity to submit a statement for today's hearing on "The Tax-Related Provisions in the President's Health Care Law."

I am pleased to submit this written statement for the record today. As the Chairman of Cook, I appreciate the opportunity to tell you a bit about our company and about the impact we and thousands of companies like us have had on patients, communities and the economic health of our nation.

Today, my message is not just about a company, but employees, jobs, and patients. I have nearly five decades of experience in the medical device industry, so I've seen and heard a lot, but more often than I'd ever imagine, I'm told a story that stops me in my tracks. Two years ago, I was approached by an employee who said she wanted to stop and thank me. She said to me, "A second member of my family is alive today thanks to a Cook product. Your company has now saved two lives in my family." Months before, I was talking with her in the sundry store where she worked and she told me about her father who had been diagnosed with an aortic aneurysm. I contacted the Cleveland Clinic and asked them to expect a call. Her father could not survive traditional surgery but our new stent graft that had just been approved was a possible alternative. He was admitted and received the new device saving her father's life. The second involved technology that was approved in the U.S. in 2005. This time, it was a Bakri Balloon, a device that stops potentially fatal bleeding for mothers after they give birth. The doctors told her this device saved her step-daughter's life. When somebody tells you about medical technologies that save lives, it drives home just how important our mission is at Cook.

History of Cook

Since 1963, the company has grown from its birth in a spare bedroom in Bill and Gayle Cook's apartment to a world leader in advancing medical care for patients worldwide. There were many setbacks and countless challenges that threatened the success of Cook as our founder, Bill Cook, sought to build an innovative American company that would improve patient care. But Bill was resilient and had the same entrepreneurial spirit that makes this country so unique. These traits, combined with his focus on the

patient, are the foundation of Cook's success. The company has been the first to introduce new medical devices in more than 70 procedures.

Today, Cook is the largest, family-owned medical device manufacturer in the world. We are best known as a pioneer in the field of interventional medicine. Our products benefit patients by providing doctors with a means of diagnosis and intervention using minimally invasive techniques, as well as by providing innovative products for surgical applications. Cook sells more than 14,000 different products with 13,600 of these products serving markets of \$1 million or less worldwide. The other 400 are large market technologies. These devices are used by physicians in the more than 40 medical disciplines and range from simple wire guides, needles and catheters, to grafts, drug-eluting stents and tissue engineered products.

Cook is headquartered in Bloomington, Indiana with its U.S. manufacturing plants in Indiana, Pennsylvania, North Carolina, Illinois and California. We also have manufacturing facilities in Ireland, Denmark and Australia. We have direct sales in most of the world where the health care system is developed. Our company employs about 10,000 people around the world with approximately 7,500 of these employees based in the United States. While more than 57 percent of our sales are outside the United States, more than 80 percent of the devices are manufactured in this country.

It has been my privilege to be associated with Cook for 45 years.

The Medical Device Industry

a) Contributing to Improved Patient Health

Over the years, improvements in medical technology have led to significant advances in the health of patients. Today, patients are living healthier, more productive and independent lives. Many of these advances are due to the development of minimally invasive medical technologies that make it easier to diagnose and treat patient problems. These advances have resulted in improved patient outcomes with fewer complications. Since 1950, the life expectancy for American men and women has increased nearly 10 years. We have also seen significant results from 1980 to 2000:

- 15 percent decline in annual mortality
- 50 percent decline in the overall mortality rate from heart attack
- 25 percent decline in disability rates
- 56 percent reduction in hospital stays.

b) Contributing to Increases in Jobs, Payroll and the Economy

In addition to patient health, the medical technology industry has been a strong and vibrant contributor to the U.S. economy. The medical technology industry is responsible directly and indirectly for two million U.S. jobs. As we strive for policies that improve our economy, policymakers on both sides of the aisle have stated that a key component to turning our economy around is to invest in high technology, manufacturing, and growth industries of the future. I agree whole-heartedly and that is why we must do everything we can to ensure the U.S. maintains its leadership position in medical technology, innovation and manufacturing.

Our company is not alone when it comes to that sort of impact. According to the National American Industry Classification System (NAICS), 80 percent of the 16,424 medical device companies in the nation have fewer than 50 employees. It is an industry dominated by small companies. Cook is relatively large in the device industry, but small compared with the drug companies.

The medical device industry is one of the few U.S. industries that enjoy a net trade surplus exporting more than we import. The U.S. is the only net exporter of medical devices in the world -- the U.S. medical technology industry generates a \$5.4 billion trade surplus. It is the envy of the world, and make no mistake, we hear repeatedly from countries around the world that they want to compete with the U.S. for this market share and actively recruit companies in the U.S.

c) Contributing to Advances in Medical Innovation

While the medical technology industry has helped to fuel our fragile economy in recent years, its position as a global leader may erode over the next decade. This will no doubt affect the ability of Americans to access future break-through medical advancements, and the growth of U.S. jobs. A recent study found that in the future, China, India and Brazil will experience the strongest gains in developing next-generation lifesaving products. Without changes to U.S. policies, capital, jobs and research will move away from the U.S. and toward these markets. (PwC, "Medical Technology Innovation Scorecard; The Race for Global Leadership," January 2011.)

What effectively spurs medical innovation in this country is the association and talents of American doctors, engineers and innovators who are dedicated to discovering new treatments and therapies for patients. This requires an atmosphere that encourages innovation and a dynamic market that does not impede job creation but encourages it. Our company, like nearly all medical device companies, is facing road blocks to growing jobs in the U.S.

Policy Challenges

a) The Medical Device Excise Tax

The most significant barrier to our future U.S. job growth is the medical device excise tax. The Affordable Care Act of 2010 (ACA) contained a revenue provision that placed an excise tax of 2.3 percent on the sale of medical devices in the U.S. beginning January 1, 2013. While that does not sound like much it is a tax on gross revenue. It comes off the top and not on earnings, and it is huge. Further, whether a manufacturer makes a profit or not, the excise tax applies. **For a company like ours, which pays about 33 percent of our U.S. earnings in federal and state corporate income taxes, the excise tax will increase our effective rate on those U.S. earnings to 42 percent – this is more than a 25 percent increase.** It is true that imported goods are subject to the excise tax when sold in the U.S.; however, corporate tax rates on manufacturing income earned outside the U.S. are much lower. It is also important to note that there is not a state corporate tax on top of the federal corporate tax in countries such as Ireland (at 12.5 percent).

Since its enactment, there have been frequent announcements about device companies freezing capital expenditures, reducing research and development, expanding overseas rather than in the U.S., and/or in many instances, laying off employees due to the excise tax. It makes no sense to encourage manufacturing in the U.S. and at the same time impose an excise tax on one of the few industries that exports more products than it imports. Why would we want to impose an excise tax on one of our fastest growing and most innovative industries – medical technology – that increases the federal tax burden on medical device manufacturers by 29 percent? (Ernst & Young, *Effect of the Medical Device Excise Tax on the Federal Tax Liability of the Medical Device Industry*, November 2012).

Myths About the Device Excise Tax

1) Device manufacturers will pass along the amount of the tax – False.

Some say that a new 2.3 percent tax will only lead device manufacturers to pass on the cost of the new excise tax to purchasers (generally hospitals). That simply is not true for most companies. Hospitals are under tremendous cost pressure today with 40 percent of hospitals operating in the red. The hospitals and group purchasing organizations are saying no. This is a very competitive industry and customers have many suppliers.

Furthermore, our company, like most in our industry, has experienced significant increases in operational costs: health care costs for employees, salaries and wages, utilities, raw materials, regulatory costs, etc. We have

seen the unemployment insurance tax increase along with other state, local and property taxes. The vast majority of companies simply cannot pass all those costs on, let alone a 2.3 percent tax on gross sales.

Finally, we have existing contracts of 3 to 5 years with prices already negotiated. Even if we did not face other restraints in passing along the costs, we simply would be unable to do so because of existing contracts.

- 2) Device manufacturers will have an increased market of new patients as the uninsured now become insured and therefore seek out new treatments – False.

Many believe that the ACA will add more patients and device companies will make more money as a result. This, too, is a myth for the vast majority of device companies. According to The U.S. Department of Health and Human Services (HHS), 71 percent of the "new insured" are younger than 45 years, a great majority of whom will not need our technologies. I have seen no credible studies that indicate an increase in sales and our research and other studies demonstrate that there will not be an increase in the sales of medical devices and no windfall profits.

I must also point out that a 2012 Roth Capital survey of companies showed that their experience in Massachusetts after universal health care was enacted showed no increase in the rate of growth compared to the increase in growth of rest of the nation. Indeed, Cook's growth rate in Massachusetts trends slightly behind the national growth.

Device Company Investment in the Community

Let me tell you a bit more about the vision of our late founder and my good friend, Bill Cook. Bill believed in giving back to the community and investing in America. He believed that companies should create technologies that benefit patients, but also that the companies themselves should create jobs that benefit not just individuals and families but communities as well. Bill grew up in the small town of Canton, Illinois. A few years ago, before the excise tax, Bill decided to open up a manufacturing plant in the small community of Canton. At the time, unemployment in Canton was very high and the International Harvester plant, which employed so many, had closed. Bill made the decision for Cook to invest in Canton and today we have two new factories where 140 people now work. More than 1,000 applicants applied for the initial 30 jobs at that factory, which makes catheters. The plant will employ 300 when we are at peak capacity. This growth has had a ripple effect as the local community also invested resulting in further growth. Canton is a model of what we would like to replicate in many other mid-western towns, but unfortunately this tax has forced us to shelve plans to build a similar factory every year for the next five years.

Impact of the Device Excise Tax on Cook

In order to offset a big expense like the excise tax, a company can only look to employees, research and development or capital. Cook has never had to lay-off an employee in our 50 years of business, and we will not start now. However, we must make hard choices.

Cook has made the difficult decision that without repeal, we will move important new product lines outside of the U.S. Our previous plans to open up five new manufacturing facilities in American towns are now on hold as we use capital intended for these projects to pay the excise tax.

The impact of this tax is squarely on U.S. jobs. Cook will adjust, but those that will be most affected by the device excise tax will be the potential future employees. Make no mistake about it: we want to develop and manufacture in the U.S. but this tax is preventing our growth in this country. It is a shame that potential employees in Indiana, Illinois, Pennsylvania, California and North Carolina can compete with any place in the world based on their productivity, but are going to be denied the chance by government.

Over time, we will see an acceleration of companies manufacturing outside the U.S. to lower the costs of goods sold in an effort to offset the impact of the tax. I emphasize that this is not about labor costs. Our industry needs an educated, skilled labor force wherever we locate.

This migration of manufacturing, coupled with the fact that most clinical studies are now being conducted outside the U.S. will result in new, self-sustaining medical technology clusters that will threaten the U.S.'s global leadership position in medical technology, innovation and manufacturing. This migration will result in delays and in some cases barriers for American patients and their providers who need innovative technology to ensure quality care.

Impact of Device Tax on Other Device Companies

Cook is not alone in feeling the adverse impact of the device tax. A 25 to 30 percent increase federal taxes will dramatically change this industry. Remember that this is an industry of small companies and the industry profit margin is between 6 and 10 percent.

A good example is Orthopediatrics, a Warsaw, Indiana company whose President and CEO Mark Throdal, says his company has shelved research and mothballed developing product lines that would help disabled children walk again. He needs to devote that R&D funding to pay this medical device tax. Listen to what others say, executives who came to the Web site www.no2point3.com to urge lawmakers to repeal this tax. Dozens of founders and senior executives replied. Here are a few of their comments.

We have lower net profit margins than competitors solely due to our choice to keep prices competitive while keeping 100% of sourcing and production domestic. For one of the products we'll be releasing for 2013 my domestic cost per unit runs in the high 40s per unit. My total cost in having it manufactured offshore, including logistics, runs about 18 per piece. That cost goes even lower if production runs become larger. By doing nothing but moving my production offshore we immediately see around a 65% savings per unit - which becomes all profit margin. There needs to be a distinction between those manufacturing domestically, paying decent wages, employment taxes, providing benefits for their workers, etc., and those who bypass our system by offshoring production. From Michael Shaffer, president of Atlanta-based Vendition Partners

Or this from Dr. Stephen R. Kerr of Pullyalup, Washington:

I am a surgeon and surgical device developer in Puyallup. I have a surgical device that I am now in the process of marketing to the major surgical device manufacturers in the US. I had the fortune...or should I say, eventual misfortune, of having dinner with the VP of sales and member of the board of directors of one of our country's major medical device manufacturers. The purpose of the dinner was for him to evaluate my new medical device. The upshot of the meeting, he loved the idea, and thought it was a significant improvement not only over what their company had available, but better than any of the other competitive devices as well. Sounds promising. He then proceeded to tell me that, unfortunately, due to the looming new medical device tax, that they would not be investing in any new medical device technology anytime soon. Regarding manufacturing of their current medical device portfolio, he informed me that their company, which does the majority of their manufacturing in the US, was now building new plants overseas and would be shifting their manufacturing there permanently. In order to offset the costs associated with the medical device tax. The president has stated that the ACA will increase the number of patients available and thereby increase their sales to make up for that. Unfortunately, as a surgeon, I can tell you with utmost certainty that this reasoning is flawed. Not once in my career did I not use, or downgrade the quality of the medical technology or devices that I use due to a lack of insurance. NEVER. I implore you to further examine the 2.3% medical device tax and its negative effects on medical innovators.

Perhaps John Micek of Buford, Georgia, has the most sobering perspective: "I have lost my job due to this tax. So have 50 to 60 other people at Remington Medical, Inc. My past employer is moving to the Dominican Republic."

House Legislation to Repeal the Medical Device Excise Tax -- H.R. 523

But before this happens Congress can act to repeal this onerous excise tax. We are grateful to the 203 cosponsors of H.R. 523, a bill introduced by Representatives Erik Paulsen (R-MN) and Ron Kind (D-WI) -- as well as Members on the Ways and Means Committee who represent Cook facilities in their districts: Representatives Mike Kelly (R-PA), Aaron Schock (R-IL) and Todd Young (R-IN) -- to repeal the medical device excise tax. In fact, many of the Members serving on this committee have cosponsored this legislation or expressed support for either a delay or repeal of this tax, and we are grateful for your acknowledgment that this excise tax will have serious, unintended consequences. We hope as you deliberate further about ways to encourage medical innovation and investment in long-term economic growth you will consider advancing the repeal legislation.

b) Other Important Steps to Maintain Leadership in the Development and Manufacture of Medical Devices.

It is important to note that the medical technology industry faces other challenges from the federal government. The U.S. has been able to put a man on the moon and ought to be able to have the best system for the approval of safe and effective medical devices. Today, we have good people working hard at the FDA, but American's access to the latest technology is behind those outside the U.S. **Congress needs to support changes in the system (not lower standards) to give American patients access to the latest technology. Cook historically has introduced all of its devices in the U.S. Now, almost 100 percent are first introduced outside the U.S.**

I also would like to mention the broader issue of taxation. The U.S. medical device industry conducts most of its manufacturing and invests the majority of its research and development dollars within the U.S. but as mentioned previously this trend is changing. Both Congress and the Administration recognize the importance of creating a climate to retain and expand these jobs. **Passing legislation to enact a manufacturing tax credit and a permanent research and development tax credit are two steps toward making this happen.** The current manufacturing deduction should be replaced with a manufacturing tax credit that results in qualifying manufacturing income being taxed at 20 percent. The research and development tax credit should be made permanent because a credit that continually expires and is reinstated does not provide the necessary predictability when companies are planning to conduct research and development in 3, 5 or 10 years.

Not many years ago, 75 percent of Cook device sales were in the U.S. Now, 57 percent of Cook sales are outside the U.S. while more than 80 percent of Cook devices are manufactured in the U.S. International markets are growing much faster than domestic markets. Thus, for U.S. companies to

grow and prosper, their products must be sold internationally. This requires having operations outside the U.S. to cultivate these markets. In the medical device industry, it is necessary to have employees close to our customers to demonstrate products to health care professionals and to be able to deliver products for next day procedures. With the current U.S. tax system, companies are effectively locked out from repatriating earnings from these operations located outside the United States due to the incremental U.S. tax cost. Thus, **a repatriation incentive should be created to allow these funds to be returned to the U.S. at a minimal incremental cost with appropriate safeguards to ensure the funds create jobs.** During the prior repatriation holiday in 2004-2005, Cook invested repatriated funds in 2 start-up companies that currently employ a total of 500 people – up from a total of 73 prior to the repatriation. Another example of the use of repatriated funds at Cook was to allow for expansion at another of its subsidiaries by purchasing and renovating a larger building. This allowed the company to increase employment from 104 to 224 employees.

Closing

I write to you today as the Chairman of the Board of a multi-national medical device company. I shared with you quotes from other device companies to demonstrate the breadth of concern in the industry and am happy to assist you in reaching out to these companies if helpful to you. But today, I write to you not just as a Chairman of Cook, but as a husband, father, grandfather, patient, and, finally, as an employee myself.

I wrote earlier of our catheter plant and what we've done in Canton, Illinois, and in closing I want to tell you a story about the first person hired at the new plant which opened two years. I heard this story on a tour given to a new Congresswoman representing our district: "When I was hired I was a single mother on welfare and lived in a small, subsidized apartment in Canton. I could not afford to get married and lose my benefits. Now, I have health care, I am married, and I just purchased a home because I got the job at Cook." Like more than 1,000 others from her town, she applied for a job at Cook and she got that job, she has a 401(k), she has profit-sharing, along with health insurance and steady income. Getting off welfare enabled her to finally get married to her boyfriend. She no longer needed access to government care. She just bought a house. This job, she will willingly tell you, has changed her life - brought her and her young family self-reliance and hope for a better future.

The country needs your leadership on this issue – your statesmanship – and we need it now. I urge every Member of this Committee and beyond to put partisanship aside and do what's right: protect families and patients. Repeal this medical device excise tax. Future generations are counting on it.

Thank you.

Dental Trade Alliance

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The following statement is submitted for the record of the March 5, 2013 Subcommittee on Oversight hearing on the **Tax-Related Provisions in the President's Health Care Law**. Specifically, these comments address the 2.3 percent excise tax on medical devices.

The Dental Trade Alliance is a trade association representing distributors, manufacturers and laboratories that manufacture and supply products and services to oral health professionals. Sales in the industry total almost \$7 billion dollars. The total number of employees is over 39,000. While we are a small portion of the total expenditure for health, the importance of good oral health is increasing as more and more studies show a link between oral health and health in the rest of the body. Both cardiovascular disease and low birth weight infants are linked to oral disease.

We oppose the excise tax on medical devices and support efforts to repeal the tax. We are concerned that the excise tax on medical devices disproportionately affects dental companies. In fact, the tax equals 27 times the potential benefit from additional profits. While the Obama administration claims there will be 'windfall' profits resulting from increased health care coverage, this is not the case for dental companies. Because of this we are concerned that any increase in the cost of dental care resulting from the added tax will affect access to oral care.

The original legislation drafted for health reform included coverage for oral health. Unfortunately, because of the cost of providing this care the coverage was dropped except for very limited coverage for children.

Many tax mechanisms were used in the law to pay for extended health coverage. One of these is a tax on medical devices. The tax applied to all classes of medical devices including dental devices. During the debate, DTA, along with other groups were successful in convincing the Senate to exclude Class I devices from the tax. The Class I device category covers many, but not all dental supplies. Unfortunately, at the eleventh hour, this provision was reversed such that law now requires a tax on essentially all medical devices, whether they support procedures covered in the legislation or not,

such as dental. There were other devices specifically excluded from the law such as hearing aids and eyeglasses.

The Congress and the Department of Health and Human Services (HHS) continues to collect data on the implementation of the law. We have collected information from government and government-funded sources to provide a prediction of the impact the law will have on the dental industry. To the best of our knowledge these figures are accurate based on data available at this time.

HHS reports in "National Health Expenditures" published by the Centers for Medicare and Medicaid, Office of the Actuary in January 2009 that the law provides expanded Medicaid coverage for 18 million individuals. One third of these are children, therefore approximately 6 million additional children will become eligible for oral healthcare services under the new law. There are currently 5.1 million eligible children under Medicaid. The law also provides that any insurance provided by the 'exchanges' must include pediatric dental care, however, HHS has determined that individuals purchasing health coverage from the exchanges are not required to purchase pediatric coverage. Therefore, it is difficult to estimate how many children, if any, this will add. It is likely that many of these children are receiving care on a private pay basis. At the present time we are not aware of any estimate of the number of children that may be eligible under these plans. In a collaboration of the Pew Center on the States, the DentaQuest Foundation and the W.K. Kellogg Foundation Medicaid utilization rates for eligible children was studied. It determined that the national utilization rate among children eligible for Medicaid dental services is about 25 percent. Based on CMS Office of Actuary numbers on the average amount of care provided to an eligible child, this means that the total amount of care added could be about \$330 million.

The industry share of the \$330 million is about \$20 million, using practice management statistics on the ratio of supplies and equipment to total practice revenue from the American Dental Association survey on Dental Practice. We believe that translates to about \$2 million dollars of pretax profit. The Congressional Joint Committee on Taxation estimates that the medical device tax on dental would be \$54 million in 2013. In addition, because the tax is applied to sales instead of profits, application of the excise tax is equivalent to increasing the corporate income tax rate above 50 percent for many companies.

These figures show that the tax is totally disproportionate to the revenues and profits generated by the dental device market from the legislation. In fact, the tax will be almost 27 times the benefit to the industry.



Kenneth H. Ryesky

Kenneth H. Ryesky Tax Provisions in Health Care Law 2013 Page 1

KENNETH H. RYESKY, ESQ., STATEMENT FOR THE RECORD, UNITED STATES HOUSE OF REPRESENTATIVES COMMITTEE WAYS & MEANS, SUBCOMMITTEE ON OVERSIGHT, TAX-RELATED PROVISIONS IN THE PRESIDENT'S HEALTH CARE LAW:**I. INTRODUCTION:**

The House Ways & Means Committee, Subcommittee on Oversight, held a Hearing on 5 March 2013, regarding the tax-related provisions in the Patient Protection and Affordable Care Act and Health Care and Education Reconciliation Act of 2010. Public comments were solicited. This Commentary is accordingly submitted.

II. COMMENTATOR'S BACKGROUND & CONTACT INFORMATION:

Background: The Commentator, Kenneth H. Ryesky, Esq., is a member of the Bars of New York, New Jersey and Pennsylvania, and is an Adjunct Assistant Professor, Department of Accounting and Information Systems, Queens College of the City University of New York, where he teaches Business Law courses and Taxation courses. Prior to entering into the private practice of law, Mr. Ryesky served as an Attorney with the Internal Revenue Service ("IRS"), Manhattan District. In addition to his law degree, Mr. Ryesky holds BBA and MBA degrees in Management, and a MLS degree. He has authored several scholarly articles and commentaries on taxation, and on Adjunct faculty in academia.

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Disclaimer: Notwithstanding various discussions between the Commentator and other concerned individuals and organizations, this Commentary reflects the Commentator's personal views, is not written or submitted on behalf of any other person or entity, and does not necessarily represent the official position of any person, entity, organization or institution with which the Commentator is or has been associated, employed or retained.

III. COMMENTARY ON THE ISSUES:

A. Employer's Shared Responsibility:

The Patient Protection and Affordable Care Act provides for shared responsibility of large employers regarding Health coverage of their employees.¹ I.R.C. § 4980H, in imposing an excise tax² upon large employers who do not provide their employees with adequate health insurance coverage, establishes how employees who are not employed on a full-time ("full-time equivalents")³ and/or employees who are not employed on a steady basis throughout the year ("seasonal workers")⁴ are counted for determining whether the threshold for a "large employer" is exceeded. It is noted that I.R.C. § 4980H merely establishes the arithmetic for counting employees and seasonal workers in meeting the "large employer" threshold; it does not require that such employees actually be covered by the large employer's insurance plan.⁵

One type of employee with respect to whom the I.R.C. § 4980H "full-time equivalent" and/or "seasonal worker" provisions may be invoked and abused is the Adjunct faculty member engaged to teach at an educational institution.

This commentary will address the treatment of Adjunct faculty under the Patient Protection and Affordable Care Act.

B. Engagement of Adjunct Faculty by Academia:

Faculty members employed to teach at colleges and universities on a basis other than full-time tenured (or tenure tracked) are referred to in this Commentary as "Adjunct faculty."⁶ They

¹ Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1513, 124 Stat. 119, 253, *codified at* I.R.C. § 4980H.

² Though the characterization of this obligation as a tax has been met with much incredulity, and is arguably contrary to various Congressional assertions, it has passed muster from the United States Supreme Court as a valid exercise of Congress's Constitutional taxation power. *National Federation of Independent Business v. Sebelius*, 567 U.S. ___, 132 S. Ct. 2566, 183 L. Ed. 2d 450 (2012).

³ I.R.C. § 4980H(c)(2)(E).

⁴ I.R.C. § 4980H(c)(2)(B).

⁵ *Cf.* U.S. Constitution, Art. I, § 2, clause 3, which established the arithmetic for counting slaves and untaxed Indians for census purposes, without enfranchising such persons with the right to vote.

⁶ Other terms used include but are not limited to "Part-Time Faculty," "Contingent Faculty," "Ad Hoc Faculty," "Special Lecturers," and "Sessional Instructors."

typically are engaged on a per semester basis.⁷ The percentage of Adjunct faculty at America's postsecondary schools now exceeds 50%, having significantly climbed over the past four decades.⁸

Academia's traditional rationale for employing Adjunct faculty was as a means to utilize real world experience and expertise of accomplished individuals who otherwise would not fit into the traditional full-time faculty mold.⁹ Over the years, however, all such pretense has largely disappeared, and now the colleges and universities unabashedly utilize Adjunct faculty as a source of cheap labor.¹⁰ This has been compounded and exacerbated by academia's unveiled intention of employing Adjuncts to reduce the costs of pension, insurance, and other outlays incidental to the engagement of full-time faculty members.¹¹

This Commentary shall not entangle itself with political correctness issues which occasionally induce various individuals to become exercised and anguished on account of the use of one particular term or another, *see, e.g.* *Helm v. Ancilla Domini College*, 2012 U.S. Dist. LEXIS 1661 AT *8 - *9 (N.D. Ind. 2012).

⁷ *See, e.g.* *Collins v. Cleveland State Univ.*, 2008 U.S. Dist. LEXIS 117181 at *1 (N.D. Ohio 2008); *Naval v. Herbert H. Lehman College*, 2004 U.S. Dist. LEXIS 26007 at *18 (S.D.N.Y. 2004); *Davis v. Maryville College*, 1989 U.S. Dist. LEXIS 13982 at *4 (E.D. Mo. 1989); *Prigmore v. Miracosta Community College District*, 2004 Cal. App. Unpub. LEXIS 5429 at *4 (Cal.App. 2004).

⁸ National Center for Education Statistics, *Digest of Education Statistics, 2012*, Table 263, *advance release available at* <http://nces.ed.gov/programs/digest/d12/tables/dt12_263.asp>.

⁹ *See Knight v. Alabama*, 900 F. Supp. 272, 302 (N.Dist. Ala. 1995); *Chang v. University of Rhode Island*, 606 F. Supp. 1161, 1227 (D.R.I. 1985) ("URI is prone to hire adjunct or specialized clinical faculty in fields (e.g., nursing, dental hygiene) laden with heavy clinical components."); James Stenerson, et al., "The Role of Adjuncts in the Professoriate," *Peer Review*, p. 23, at 24 (Summer 2010); *see also* Shawn G. Kennedy, "College Changing along with the Students," *N.Y. Times*, March 29, 1981, p. L1-21 (quoting Jay J. Diamond, a dean at Nassau County Community College: "Many of our adjunct faculty members are lawyers, businessmen and engineers and we consider their expertise and experience valuable ... They allow us to stay up-to-date.").

¹⁰ *See, e.g.* *NLRB v. Cooper Union*, 783 F.2d 29, n. 3 at 32 (2d Cir. 1986), *cert. denied* 479 U.S. 815 (1986); *Barnabas v. Board of Trustees of the University of the District of Columbia*, 686 F. Supp. 2d 95, 99 (D.D.C. 2010); *Vandever v. Junior College District*, 708 S.W.2d 711 (Mo. App. 1986); Cheryl Halcrow & Myrna R. Olson, "Adjunct Faculty: Valued Resource or Cheap Labor?" *Focus on Colleges, Universities, and Schools* 2(1), p. 1 (2008); Robin Wilson, "Contracts Replace the Tenure Track for a Growing Number of Professors," *Chronicle of Higher Education*, June 12, 1998, p. A-12; Phyllis Bernstein, "Colleges Use More Adjuncts," *N.Y. Times*, November 17, 1985, p. L1-25).

¹¹ *See, e.g.* *Tubergen v. Western Piedmont Comm. College*, 2004 U.S. Dist. LEXIS 6955 at *8 (W.D. N.C. 2004); *Davis v. Maryville College*, 1989 U.S. Dist. LEXIS 13982 at *4 (E.D. Mo. 1989). *Pennsylvania Highlands Community College v. State Employees' Retirement System*, 2012 Pa. Commw. LEXIS 337 (Pa. Commw. 2012).

C. *Academia's Abuse of Adjunct Faculty:*

America's colleges and universities have degenerated beyond the aforementioned measures taken in the name of fiscal economy by failing to adequately provide their Adjunct faculty members with resources and support traditionally considered to be indispensable to teaching faculty, including access to office space,¹² and library and information databases.¹³ And while academics have long insisted that academic freedom for is a sine qua non of the educational process,¹⁴ the tentative nature of an Adjunct faculty member's employment all but precludes any semblance of academic freedom to more than half of the individuals who teach at America's colleges and universities.

And though the university is supposed to be a social system, the efficient operation of which imparts and propagates knowledge and wisdom,¹⁵ academia has failed to integrate its Adjunct faculty members into its social system, and many in academia have even denigrated and pejorated their Adjunct colleagues.¹⁶

¹² See, e.g. Matter of Sylvester L. Tuohy, N.Y.S. Tax App. Trib., DTA No. 818430 (February 13, 2003), available on the Internet at <<http://www.nysda.org/Decisions/818430.dec.htm>>; Davis v. Maryville College, 1989 U.S. Dist. LEXIS 13982 at *4 (E.D. Mo. 1989); John Soares, "Office Hours in the Pool Hall," *Chronicle of Higher Education*, 11 January 2013, p. D18; Report to the [John Jay] College Comprehensive Planning Committee on Phase II Space Requirements for the Dept. of Sciences (Spring 2000), <<http://web.archive.org/web/20040903/235307/http://web.jjay.cuny.edu/~phase2/asmntrep/cpcreport.htm>> (accessed July 30, 2006) ("Over 50 adjunct faculty share the 3 adjunct offices available to the [Sciences] Department making the offering of office hours unpredictable. Most adjunct faculty have no discernable work areas.")

¹³ See, e.g. Emory University School of Law, Library, "Borrowing Privileges for Adjunct Faculty at Law" <<http://library.law.emory.edu/for-visitors/non-law-faculty-adjuncts/#c21790>> ("Some resources, such as Lexis Nexis and WestLaw require individual passwords. Databases requiring individual passwords are not available to non- full time faculty."); Anthea Tillyer, *Educational Technology and "Roads Scholars,"* ACADEME (Amer. Assn. of Univ. Professors), July/August 2005, available on the Internet at <<http://www.aaup.org/publications/Academe/2005/05a/05jatill.htm>>; Susie Coggin, Adjunct professor resigns position, GW HATCHET, 3 May 2001, (reporting that an Adjunct at George Washington University had no computer in his office and had to drive 45 minutes to his home in order to access course administration materials); Kenneth H. Ryesky, *Information & Instructional Technology: Bringing Adjunct Faculty into the IT Fold* (monograph from Conference presentation, *Instructional/Information Technology in CUNY* (14 November 2003), ERIC Document No. ED490813, <<http://media.centerdigitaled.com/cuny-casey/Ryesky-CUNY.doc>>.

¹⁴ See, e.g. James W. Brown & James W. Thornton, Jr., *College Teaching: Perspectives and Guidelines* at 43 - 46 (McGraw-Hill, 1963).

¹⁵ See, e.g. Fred B. Millett, *Professor*, 118 - 119 (Macmillan, 1961).

¹⁶ See, e.g. Kenneth H. Ryesky, *Part Time Soldiers: Deploying Adjunct Faculty in the War against Student Plagiarism*, 2007 BYU EDUC. & L. J. 119 (2007) <<http://writingatqueens.org/files/2011/11/KHR->

D. The Adjunct Faculty Dilemma in applying I.R.C. § 4980H:

The paltry salaries of Adjunct faculty are typically reckoned based upon the credit hours taught in a given semester.¹⁷ But the time spent lecturing to the class does not constitute the totality, or even a majority, of the time during which one is engaged in teaching. Many hours are spent in preparation for the lectures, composing examinations, grading examinations and class assignments, conferring with students, and attending to other administrative matters.

It is noted that at the time this Commentary is being composed and submitted, there remains open a rulemaking proceeding by the IRS and the Treasury to implement the provisions of I.R.C. § 4980H.¹⁸ Submissions in that rulemaking proceeding have been tendered by various Adjunct faculty individuals and groups, including this Commentator;¹⁹ indeed, public comments regarding the full-time or part-time status of Adjunct faculty members were specifically solicited.²⁰ The Commentator has requested and intends to speak at the public hearing slated for 23 April 2013, and has been apprised that other Adjunct individuals and groups are also seriously considering giving oral testimony at that hearing.

Moreover, in the explanation of the Proposed Regulations, the Treasury/IRS have recognized that there are deep issues regarding Adjunct faculty, and have explicitly stated that "[i]t is not a reasonable good faith interpretation of the term seasonal employee to treat an employee of an educational organization, who works during the active portions of the academic year, as a seasonal employee."²¹

[PISoldier-Art-1.pdf](#); see also *Pollis v. New School for Social Research*, 829 F. Supp. 584, 594 (S.D.N.Y. 1993) (denying preliminary injunction), *relief calculated after verdict for plaintiff* 930 F. Supp. 899 (S.D.N.Y. 1996), *verdict vacated in part and affirmed in part* 132 F.3d 115 (2d Cir. 1997) ("[I]t is insulting and degrading to be listed as an adjunct.").

¹⁷ See, e.g. *Sobba v. Pratt Community College & Area Vocational School*, 117 F. Supp. 2d 1043, 1046 (D. Kans. 2000); *Delbridge v. Maricopa Community College District*, 893 P.2d 55, 57 (Ariz. 1994); *Sferlazza v. Commissioner of Labor*, 69 A.D.3d 1184, 891 N.Y.S.2d 757, (3d Dep't 2010); *but see* *Saulsberry v. St. Mary's University*, 318 F.3d 862, 863 - 864 (8th Cir. 2003) (reciting that the Adjunct faculty member was compensated on a per student capitation basis).

¹⁸ Docket ID: IRS-2013-0001, REG-138006-12, RIN 1545-BL33, 78 F.R. 218 (2 January 2013). Treasury Regulations are promulgated by the IRS and the Treasury using an interactive process, *Treas. Reg. § 601.601*.

¹⁹ Kenneth H. Ryesky, REG-138006-12, RIN 1545-BL33 Document ID: IRS-2013-0001-0023 (28 January 2013) <<http://www.regulations.gov/contentStreamer?objectId=09000064&11d8ea2&disposition=attachment&contenttype=pdf>>.

²⁰ 78 F.R. at 225.

²¹ REG-138006-12, RIN 1545-BL33, Explanation of Provisions, § II.C.2.b, at 78 F.R. 227.

All of this being so, many colleges and universities have already limited the number of classes their Adjuncts may teach, and indeed, have cut back on individual Adjuncts' hours from prior semesters, in order to avoid the penalties imposed by I.R.C. § 4980H for failing to provide health care coverage for full-time employees. This has been poignantly noted in some of the comments received in the aforementioned rulemaking proceeding.²²

Adjunct faculty are thus faced with a dilemma. If, for the purposes of determining their full-time status under I.R.C. § 4980H, they are credited with the true number of hours they actually work, then they will have their available work reduced if not eliminated. If, on the other hand, they allow academia to undercredit the work they actually do, then this will invite further abuses of Adjunct faculty by academia, as well as facilitate the colleges and universities' evasion of responsibility under the Patient Protection and Affordable Care Act.

E. Abuse of Adjunct Faculty and its Deleterious Effects upon America:

The taxation scheme of I.R.C. § 4980H exacerbates certain deleterious effects stemming from academia's policies and practices regarding its Adjunct faculty members. In addition to the unfavorable economics perpetuated upon the paychecks of the Adjuncts themselves, America as a whole is negatively impacted:

1. Noncoverage of Adjunct Faculty Members:

Congress has promulgated a national policy goal of near-universal if not universal health care coverage.²³ By limiting and cutting back on Adjunct faculty members' teaching assignments (and ergo, their paychecks) in order to avoid/evade the I.R.C. § 4980H tax, academia is impeding this Congressional goal.

2. The Impairment of the Postsecondary Education System:

It is axiomatic that America's prosperity and greatness are inextricably intertwined with the sound functioning of its educational system. Academia's failure to integrate its Adjunct faculty into its own fold impairs the sound and efficient functioning of the educational processes.²⁴

²² *E.g.* IRS-2013-0001-0009 Dorey Diab, Stark State College, 14 January 2013 <<http://www.regulations.gov/#?documentDetail=D=IRS-2013-0001-0009>>; IRS-2013-0001-0055, Yvonne Marie Brandon, 22 February 2013 <<http://www.regulations.gov/#?documentDetail=D=IRS-2013-0001-0055>>; IRS-2013-0001-0074, James Lynn Johnson, 7 March 2013 <<http://www.regulations.gov/#?documentDetail=D=IRS-2013-0001-0074>>.

²³ *See, e.g.* Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1501(a)(2)(D), (E) & (G), 124 Stat. 119, 243, *codified at* 42 U.S.C. § 18091(2)(D), (E) & (G).

²⁴ Steve Street, Maria Maisto, Esther Merves and Gary Rhoades, Who is Professor "Staff" and How can this Person Teach so Many Classes? (Center for the Future of Higher Education, August 2012)

As noted above, Adjunct faculty are often denied basic resources such as office space and access to libraries and databases. This obviously impedes the Adjunct's ability to confer with students, and to obtain and process important information related to the teaching function.

As the Commentator has expounded upon at length elsewhere, academia's policies toward its Adjunct faculty severely impede the Adjunct's ability and motivation to detect and penalize plagiarism and other academic dishonesty.²⁵ The implications of this should be quite troubling. When the students invariably realize that the university has consigned its Adjuncts to *Untermenschen* status, such a realization facilitates the rationalization of academic dishonesty. Students who have successfully committed academic dishonesty will only find it easier to rationalize in the future, and to rationalize other forms of dishonesty as well, thereby predisposing them, as graduates in the working world, to commit such dishonest acts as bank fraud, tax fraud, insurance fraud, identity theft, and other nefarious acts which pose such severe threats to our social and financial systems.

IV. CONCLUSION:

Complaints now emanate from diverse quarters that graduates of America's postsecondary schools lack some very basic skills which should have been attained as part of the educational experience.²⁶ Whatever else may or may not need to be done, the problem cannot be adequately addressed until academia adequately integrates and supports its Adjunct faculty.

A key objective of the Internal Revenue Code has long been to foster economic growth and a high standard of living for America.²⁷ As Ricardo observed, taxation "frequently operates

<http://futureofhighered.org/wp-content/uploads/2012/08/ProfStaffFinal1.pdf>.

²⁵ Kenneth H. Ryesky, *Part Time Soldiers: Deploying Adjunct Faculty in the War against Student Plagiarism*, 2007 BYU EDUC. & L. J. 119 (2007) <<http://writingatqueens.org/files/2011/11/KHR-PTSoldier-Art-1.pdf>>.

²⁶ E.g., Commission on the Future of Higher Education, *A Test of Leadership: Charting the Future of U.S. Higher Education*, at x (September 2006) <<http://www2.ed.gov/about/bdsecomm/isth/hiedfuture-report/final-report.pdf>>; Kevin L. Flores, et al., Deficient Critical Thinking Skills among College Graduates: Implications for Leadership, 44 Educational Philosophy & Theory 212 (March 2012); Zane K Quible, *Error Identification, Labeling, and Correction in Written Business Communication*, 46 Delta Pi Epsilon Journal 155 (Fall 2004); What do They Learn?, Washington Times, 30 November 2009, p. A-17.

²⁷ H. R. Rpt. 83-1337, at 1 - 2 (9 March 1954), (reprinted in 1954 U.S.C.C.A.N. 4017, 4025); 83rd Cong., Sen. Fin. Comm. Report on Internal Revenue Code of 1954 (1954), (reprinted in 1954 U.S.C.C.A.N. 4629, 4629). The introductory materials to the respective House and Senate documents were mostly verbatim to one another.

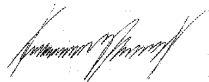
The Tax Reform Act of 1986, Pub. L. 99-514, 100 Stat. 2095 (1986), redesignated the Internal Revenue Code of 1954 as the Internal Revenue Code of 1986. The 1986 Code was "not intended to change any substantive provision of the [1954 Code] not otherwise modified by [the Tax Reform Act of 1986]." H. Conf. Rep. No. 99-841 at II-837, reprinted at 1986 U.S.C.C.A.N. 4925.

very differently from the intention of the legislature by its indirect effects." ²⁸ The indirect effects of the I.R.C. § 4980H have already begun to inflict deleterious effects upon not only the basic objective behind the statutory section's enactment, and not only upon the basic objective behind the Internal Revenue Code as a whole, but also upon America's educational system.

As matters currently stand, America's colleges and universities can be expected to apply I.R.C. § 4980H in a manner that will continue academia's abusive policies and practices towards its Adjunct faculty, including but not limited to denying Adjuncts participation in employer-sponsored healthcare plans.

The Internal Revenue Code does have provisions which are tailored to the particular atypical situations of certain classes of employees, including but not limited to soldiers in combat zones, ²⁹ military reservists, ³⁰ clergypersons ³¹ and state legislators. ³² The atypical employment situations of Adjunct faculty members at America's colleges and universities need accommodation by the Internal Revenue Code in general, and by the tax-related provisions in the Patient Protection and Affordable Care Act in particular.

11 March 2013
Respectfully submitted,



Kenneth H. Ryesky, Esq.

²⁸ David Ricardo, *The Principles of Political Economy and Taxation*, ch. 16, p. 157 (Everyman's Library, no. 590. J. M. Dent & Sons, London, 1969).

²⁹ I.R.C. § 112.

³⁰ I.R.C. § 162(p).

³¹ I.R.C. § 107

³² I.R.C. § 162(h).

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Medicaid Health Plans of America

Statement for the Record

Hearing on the “Tax-Related Provisions in the President’s
Health Care Law”

March 5, 2013

Subcommittee on Oversight

House Committee on Ways and Means

Joe Moser

Interim Executive Director

Medicaid Health Plans of America

Chairman Boustany, Ranking Member Lewis, and other distinguished members of the Subcommittee on Oversight of the House Committee on Ways and Means, I am submitting this Statement for the Record on behalf of Medicaid Health Plans of America (MHPA) for the hearing on Tax-Related Provisions in the President's Health Care Law conducted by the Subcommittee on March 5, 2013. My comments are regarding the insurer fee contained in Section 9010 of the Patient Protection and Affordable Care Act (PPACA), Public Law 111-148.

MHPA is the leading national association solely focused on representing the interests of Medicaid health plans. MHPA's 123 member plans serve more than 15 million beneficiaries in 33 states and the District of Columbia. As you may know, over half (51%) of all Medicaid beneficiaries now receive their Medicaid benefits through full-risk, capitated Medicaid health plans.

MHPA appreciates the Subcommittee's attention to the impact that tax provisions contained in the ACA, including the insurer fee, will have on individuals, families, businesses and device manufacturers. These taxes would result in higher health insurance premiums in the commercial market and could stifle innovation among manufacturers of many products used by health care consumers. As discussed during the hearing, the impact of these taxes on consumers has gone largely unrecognized by the general public and deserves a thorough discussion.

However, states' Medicaid programs and Medicaid beneficiaries will also be heavily impacted specifically by the insurer fee. The insurer fee applies to most health insurance companies in the market and this includes nearly all of MHPA's membership. Medicaid health plans that contract with states to serve as the payment and delivery system for states' Medicaid beneficiaries.

The negative impact of this fee is especially apparent when analyzing its effect on state Medicaid programs. The Medicaid program serves our nation's neediest population, including low-income pregnant women, children and individuals with disabilities. Each state's Medicaid program is funded by the federal government and states. Most states contract with managed care organizations to deliver Medicaid benefits and services to beneficiaries. The states are required by the federal government to pay Medicaid health plans actuarially sound rates to ensure that plans have enough resources to cover the care needed by enrollees as well as common costs of doing business, which include taxes and fees. This means that Medicaid health plans will be paid with state and federal dollars to cover this fee owed as a result of the PPACA. Further, this fee is nondeductible and counts as taxable income, which only exacerbates the cost.

MHPA commissioned Milliman, a leading actuarial firm, to analyze the impact of the fee on Medicaid health plans and to quantify the resulting cost to states and the federal government. The Milliman report found that over ten years, the fee would cost the government \$38.4 billion. The state portion of this estimate is \$13.6 billion and \$24.8 billion would be the federal portion.

The loss of state and federal Medicaid funding that would result from this fee being placed on Medicaid health plans will strain states and the Medicaid programs, as well as reduce funding and access to services available for Medicaid beneficiaries. As states face financial pressure to implement the PPACA

and expand the Medicaid program, the insurer fee will drain states of valuable and limited health care dollars.

In closing, MHPA supports full repeal of the insurer fee. We applaud Chairman Boustany's legislation, H.R. 763, to fully repeal the fee in order to avoid the negative impact that it will have on state Medicaid programs and beneficiaries. We urge Committee members to continue to recognize the negative impact that this fee will have on the Medicaid program as one very important component to the overall concerns regarding taxes contained in the ACA.

Thank you for the opportunity to submit a Statement for the Record on behalf of MHPA.



National Association for the Self-Employed

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Statement for the Record
Submitted to the Ways and Means Committee
United States House of Representatives
Washington, D.C.

"Tax-Related Provisions in the President's Health Care Law"

Submitted by Kristie Arslan
CEO & President, National Association for the Self-Employed
March 19, 2013

The National Association for the Self-Employed (NASE) respectfully submits this official statement for the record on the Subcommittee on Oversight's hearing held on Tuesday, March 5, 2013. For the 22 million self-employed Americans (**78% of all small business in the United States**), we continue to voice the same concerns we have had on the tax-related provisions included in the Affordable Care Act and their impact on America's smallest businesses, the self-employed.

Since the beginning of the health care reform debate, the NASE has loudly voiced its opinion that if there was a requirement to purchase a mandated level of coverage that it must be coupled with market reforms that ensured that the cost of health insurance would not grow in such a way that it would place an impossible burden on Americans to purchase health insurance. Sadly, this has become a reality. In 2009, the Congressional Budget Office (CBO) released a report estimating that health insurance premiums for the individual market will increase by 10%-13% in 2014 due to the coverage requirements, also known as the Essential Health Benefits.

Impact of Health Insurance Costs

The self-employed represent the largest segment of the small business sector, increasing out-of-pocket expense has an immediate and negative impact on their business and household income. In our June 2012 *Access to Health Coverage and Attitudes in Health Reform: A Self-Employed Perspective*, the great majority (84.9%) of the respondents indicate that rising health coverage costs have been detrimental to themselves, their families, and their business over the past three years. Most acute has been the "bottom line" impact — 53.9% say rising health coverage costs have cut their household income. Significant responses are also seen for having to scale back/drop health coverage (cited by 37.5%). Business-specific impacts are also clearly seen: 27.4% say their "business is struggling to survive," and more than one in ten say they have cancelled/put on hold plans to hire new employees and/or expand their business.

Small Business Tax Credit

For the self-employed, the health insurance mandate fundamentally changes how they purchase health insurance and with very little consideration of the significantly higher costs they will now be required to burden.

For example, the Small Business Tax Credit provides minuscule relief for those self-employed/micro-businesses owners that offer health insurance, a recent NASE survey found that only 18.6% of our members provided employer-sponsored coverage, while the remaining cited the high cost as the reason why they do not offer health insurance for their employees. For those qualifying small businesses, you must drop your existing coverage and move into the exchange market, all but guarantying a 10%-13% increase in your health insurance premiums due to the minimum coverage requirements dictated by the Essential Health Benefits and then the **tax credit is only available for two years**.

The approximate 22 million self-employed business owners are excluded from eligibility for the Small Business Tax Credit, leaving the premium assistance tax credits in the individual exchanges as their only avenue for financial assistance to afford health coverage. The fact is a substantial amount of these self-employed business owners will not qualify for the necessary premium assistance that will be needed to offset the increased cost of health insurance leaving America's smallest businesses in a far more financially precarious position than prior to health reform.

Simply put the Affordable Care Act does not include any significant tax benefit for the self-employed/micro-business community to purchase health insurance for their employees and in fact, does very little to encourage business owners to comply with the mandate due to the outrageous increase in health insurance premiums.

Further Market Reforms

While the daunting task of ensuring the Affordable Care Act and its 46 tax provisions are implemented and given adequate oversight, the NASE has proposed changes to the current tax code that would help the self-employed when it comes to purchasing health insurance:

- **Full deduction of health insurance costs for the self-employed.**
 - This would have the single greatest impact on motivating the self-employed to engage in the new health insurance exchange market. 78% of all small businesses are currently treated unfairly under the current tax code, paying nearly 15.3% in additional taxes annually due to their inability to deduct the cost of their health insurance as a business expense, **a tax benefit provided to all other businesses**. If the self-employed were treated equitably under the tax code, this would be an estimated cost savings to the small business owner of \$887 (individual) and \$2,325 (family);
- **Expansion of Health Reimbursement Arrangements (HRAs).**
 - Under the current law, the self-employed business owner (sole-proprietor) is unfairly discriminated against in participating in an HRA. This flexible benefit option currently allows small business owners to reimburse employees tax-free for out-of-pocket medical costs up to an amount designated by the business owner. Under current law, the business owner is unable to take part in this benefit. Allowing the owner to participate in an HRA will increase the take up of this tax tool allowing both business owners and their employees to receive financial assistance for their health costs. The employee receives financial assistance for health related expenses and the employer, while benefitting personally, also receives a tax-deduction for the expense - a true win-win scenario.

Conclusion

We appreciate the Committee's willingness to discuss the tax-related issues to the Affordable Care Act and its impact on the small business community. Regardless of business size or type, complying with the tax code is the great leveler for all businesses which is why any tax provisions relating to health reform are critical to the business community. It is our hope that the full Committee will work with its counter-parts on the Energy and Commerce Committee to improve the health reform law and address the above market reforms that would create a better health care system and ensure that the self-employed are treated equitably under the tax code.

The Brinks Company**Statement of****The Brink's Company****House Committee on Ways and Means****Subcommittee on Oversight****"Tax-Related Provisions in the President's Health Care Law"**

March 5, 2013

Chairman Boustany, Ranking Member Lewis and Members of the Subcommittee:

The Brink's Company ("Brink's"), formerly known as The Pittston Company, is pleased to submit this written statement for the record in connection with this important hearing. Brink's is a global leader in security-related services for banks, retailers and a variety of other commercial and governmental customers. Brink's provides retirement health care benefits for eligible former employees of its former U.S. coal operation. Retirement benefits related to its former coal operations include medical benefits provided by the Pittston Coal Group Companies Employee Benefit Plan to UMW Represented Employees.

Overview of Brink's Concern: The Patient Protection and Affordable Care Act ("PPACA") will impose an excise tax on benefits established by the Coal Industry Retiree Health Benefit Act of 1992 ("Coal Act"). Brink's is concerned that this tax, dubbed the "Cadillac Tax," could adversely affect the retiree health benefits for certain mine workers. We believe that this outcome was unintended and will have severe consequences for the coal industry and those formerly in the coal industry who are obligated to continue the health benefits, and we urge the Ways and Means Committee to remedy this unfortunate outcome in the coming months as it undertakes tax reform.

Background

Section 4980I of the PPACA imposes a "Cadillac Tax" equal to 40 percent on "excess health benefits." Excess benefits are defined as the amount that exceeds the annual limitation of \$10,200 for self-only coverage and \$27,500 for family coverage.¹ For retirees and workers in high risk professions such as miners, firefighters and longshoremen, the annual limitations are \$11,850 for self-only coverage and \$30,950 for family coverage.² As its name suggests, the tax was intended to affect only the most generous of health care benefits, and encourage employers to rein in such coverage to below the applicable limits to avoid paying the tax.

Congress, however, failed to consider the impact of this tax on benefits plans required pursuant to the Coal Act, which fixes mandatory levels of health benefits (and in some cases death benefits) provided to retirees who were age and service eligible as of February 1, 1993, and who actually

¹ See IRC Section 4980I(b)(3)(C)(i)(I) and (II) as amended by 1401 of the Reconciliation Act.

² See IRC Section 4980I(b)(3)(C)(ii)(I) and (II) as amended by section 1401 of the Reconciliation Act.



retired by September 30, 1994. These benefits, guaranteed under section 9711 of the Internal Revenue Code, also require responsible employers to provide and pay for these benefits for life. Although, under certain circumstances, employers are permitted to adopt cost containment and managed care programs, the level of benefits provided to retirees and dependents covered by the Coal Act are fixed by law, and may not be changed by any employer.³

In 2006, the Coal Act was amended to add section 9704(f) to the Internal Revenue Code to provide specific relief to companies to allow them to prepay their premium liability. The statute specifically allowed for prepayment if:

- 1) the assigned operator (or a related person) made contributions to the 1950 UMWA Benefit Plan and the 1974 UMWA Benefit Plan for employment during the period covered by a 1988 agreement and is not a 1988 agreement operator;
- 2) the assigned operator and all related persons are not actively engaged in the production of coal as of July 1, 2005; and
- 3) the assigned operator was, as of July 20, 1992, a member of a controlled group of corporations the common parent of which is publicly traded.

Under this provision, in order for the relief from liability to apply, the payment by the assigned operator must have been no less than the present value of the total premium liability of the assigned operator (or related persons or their assignees), as determined by the operator's enrolled actuary. Of course, since no Cadillac Tax existed at the time, and because benefit levels could not be changed, companies that prepaid their obligations never calculated the cost of an additional excise tax into the payments.

Cadillac Tax Result

Because the health benefits provided by the Coal Act result in excess benefits under the threshold established for application of the excise tax on Cadillac health plans, those excess benefits are subject to the excise tax. While most employers have flexibility to modify their health plans in order to avoid the tax, the Coal Act fixes the health benefits by statute. Thus, because the benefits are fixed by statute, the employers affected by the Coal Act **cannot avoid** the Cadillac Tax even if they desired to change the benefits of the plans they offered. By law, those plans cannot change. In that respect, for companies that pre-paid their Coal Act obligations, the tax on their health benefits is particularly unfair. Ultimately, the Cadillac Tax is adversely impacting the very people the law was intended to help – both coal miners and the employers who have pre-paid for their care.

Conclusion

It seems apparent that Congress did not intend for the Cadillac Tax to have this effect on the coal mining industry and its retirees. Brink's believes it would be helpful for the Ways and Means Committee to conduct a full review of the Cadillac Tax provision as it undertakes tax reform to

³ IRC 9711(a)



correct for any such unintended negative consequences. Brinks stands ready to assist the Ways and Means Committee in addressing this provision and determining how best to achieve Congress' goals without unintentionally harming this sector of the economy.



The Center for Fiscal Equity

Comments for the Record

United States House of Representatives

Committee on Ways and Means

Subcommittee on Oversight

Hearing on the Tax Ramifications of the President's Health Care Law

Tuesday, March 5, 2013, 11:00 AM

by Michael G. Bindner

The Center for Fiscal Equity

Chairman Boustany and Ranking Member Lewis, thank you for the opportunity to submit my comments on this topic. We must note that because the law is actually part of the U.S. Code, it is time to quit identifying it only with the President. It was used as an election issue in 2012 and the results speak for themselves. It is now time to tone down the rhetoric, especially given the electoral composition of the Senate and the resistance by both parties to end the filibuster.

The main issue remaining from last year's Supreme Court ruling is the expansion of Medicaid rolls and the opposition in some states to doing so. While that has seemed to be just posturing in some states, it may lead to the need to federalize the entire Medicaid program, which might occur as part of a comprehensive tax reform, such as the one suggested by the Center.

We believed at the time that opposition to the Law had nothing to do with mandates, the Commerce Clause or Medicaid funding. The real reason conservative major donors don't like the law is the funding mechanism for much of reform. These donors were not successful in court or at the ballot box, so the *American Taxpayer Relief Act of 2012* went into full force without stopping those provisions of the *Affordable Care Act* they objected to. These donors were writing checks because of provisions creating additional taxes on un-earned income that fix Medicare Part A funding and fund other health care reform, essentially turning the Hospital Insurance Tax into a Value Added Tax with an exemption on profits paid to the 98%. Fighting for repeal on this basis, however, would only be politically unpopular.

There is now no reason to repeal the ACA unless the new funding on high income earners is replaced by a broader consumption tax. As we stated in March to the Subcommittee on Health:

Note that whenever this tax applies to those whose holding operate in less than a perfectly competitive market, in other words to most commerce in 21st century America, the costs will likely be passed to the consumer and it would be more honest to simply enact a Value Added Tax or VAT-like Net Business Receipts Tax (which is proposed below).

Our prior testimony on the adequacy of mandates is as applicable now as it was in March 2012, if not more so. We believe that the stock market priced in repeal and may react negatively to the prospect of guaranteed issue and community rating. The Committee ignores these predictions at their own peril. These impacts, which are outside the scope of the testimony of government witnesses, will likely negate many of the new provisions of the *ACA*. As we stated previously:

We will now return to the question of the adequacy of mandates. The key issue for the future of health care consolidation is the impact of pre-existing condition reforms on the market for health insurance. Mandates under the *Affordable Care Act (ACA)* may be inadequate to keep people from dropping insurance - and will certainly not work if the mandate is rejected altogether for constitutional reasons.

If people start dropping insurance until they get sick - which is rational given the weakness of mandates - then private health insurance will require a bailout into an effective single payer system. The only way to stop this from happening is to enact a subsidized public option for those with pre-existing conditions while repealing mandates and pre-existing condition reforms.

In the event that Congress does nothing and private sector health insurance is lost, the prospects for premium support to replace the current Medicare program is lost as well. Premium support, as proposed by Chairman Ryan, also will not work if the *ACA* is repealed, since without the *ACA*, pre-existing condition protections and insurance exchanges eliminate the guarantee to seniors necessary for reform to succeed. Meanwhile, under a public option without pre-existing condition reforms, because seniors would be in the group of those who could not normally get insurance in the private market, the premium support solution would ultimately do nothing to fix Medicare's funding problem.

Resorting to single-payer catastrophic insurance with health savings accounts (another Republican proposal) would not work as advertised, as health care is not a normal good. People will obtain health care upon doctor recommendations, regardless of their ability to pay. Providers will then shoulder the burden of waiting for health savings account balances to accumulate - further encouraging provider consolidation. Existing trends toward provider consolidation will exacerbate these problems, because patients will lack options once they are in a network, giving funders little option other than paying up as demanded.

Shifting to more public funding of health care in response to future events is neither good nor bad. Rather, the success of such funding depends upon its adequacy and its impact on the quality of care - with inadequate funding and quality being related. For example, Medicare provider cuts under current law have been suspended for over a decade, the consequence of which is adequate care. By way of comparison, Medicaid provider cuts have been strictly enforced, which has caused most providers to no longer see Medicaid patients, driving them to hospital emergency rooms and free clinics with long waiting periods to get care.

Ultimately, fixing health care reform will require more funding, probably some kind of employer payroll or net business receipts tax – which would also fund the shortfall in Medicare and Medicaid (and take over most of their public revenue funding). We will now move to an analysis of funding options and their impact on patient care and cost control.

The committee well understands the ins and outs of increasing the payroll tax, so (we) will confine (our) remarks to a fuller explanation of Net Business Receipts Taxes (NBRT). Its base is similar to a Value Added Tax (VAT), but not identical.

Unlike a VAT, an NBRT would not be visible on receipts and should not be zero rated at the border – nor should it be applied to imports. While both collect from consumers, the unit of analysis for the NBRT should be the business rather than the transaction. As such, its application should be universal – covering both public companies who currently file business income taxes and private companies who currently file their business expenses on individual returns.

The key difference between the two taxes is that the NBRT should be the vehicle for distributing tax benefits for families, particularly the Child Tax Credit, the Dependent Care Credit and the Health Insurance Exclusion, as well as any recently enacted credits or subsidies under the ACA. In the event the ACA is reformed, any additional subsidies or taxes should be taken against this tax (to pay for a public option or provide for catastrophic care and Health Savings Accounts and/or Flexible Spending Accounts).

If cost savings under an NBRT, allow companies to offer services privately to both employees and retirees in exchange for a substantial tax benefit. Employers who fund catastrophic care would get an even higher benefit, with the proviso that any care so provided be superior to the care available through Medicaid. Making employers responsible for most costs and for all cost savings allows them to use some market power to get lower rates, but no so much that the free market is destroyed. The ability to exercise market power, with a requirement that services provided in lieu of public services be superior, will improve the quality of patient care.

This proposal is probably the most promising way to decrease health care costs from their current upward spiral – as employers who would be financially responsible for this care through taxes would have a real incentive to limit spending in a way that individual taxpayers simply do not have the means or incentive to exercise. While not all employers would participate, those who do would dramatically alter the market. In addition, a kind of beneficiary exchange could be established so that participating employers might trade credits for the funding of former employees who retired elsewhere, so that no one must pay unduly for the medical costs of workers who spent the majority of their careers in the service of other employers.

Employer provided health care will also reverse the trend toward market consolidation among providers. The extent to which firms hire doctors as staff and seek provider relationships with providers of hospital and specialty care is the extent to which the forces of consolidation are overcome by buyers with enough market power to insist on alternatives, with better care among the criteria for provider selection.

The NBRF would replace disability insurance, hospital insurance, the corporate income tax, business income taxation through the personal income tax and the mid range of personal income tax collection, effectively lowering personal income taxes by 25% in most brackets. Note that collection of this tax would lead to a reduction of gross wages, but not necessarily net wages – although larger families would receive a large wage bump, while wealthier families and childless families would likely receive a somewhat lower net wage due to loss of some tax subsidies and because reductions in income to make up for an increased tax benefit for families will likely be skewed to higher incomes. For this reason, a higher minimum wage is necessary so that lower wage workers are compensated with more than just their child tax benefits.

Thank you for the opportunity to address the committee. We are, of course, available for direct testimony or to answer questions by members and staff.

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Committee on Ways and Means, Subcommittee on Oversight

Hearing on the Tax Ramifications of the President's Health Care Law

Tuesday, March 5, 2013, 11:00 AM

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears:

This testimony is not submitted on behalf of any client, person or organization other than the Center itself, which is so far unfunded by any donations.



MATERIAL SUBMITTED FOR THE RECORD**Questions for the Record****COMMITTEE ON WAYS AND MEANS
SUBCOMMITTEE ON OVERSIGHT
HEARING ON TAX-RELATED PROVISIONS IN THE PRESIDENT'S HEALTH
CARE LAW**

March 5, 2013

Questions and Answers for the Record

Question for ALL Panelists**Q:**

I have heard from numerous small businesses in New York who are frustrated and confused regarding the employer mandate tax and the new definition of what exactly a full-time employee is. Already, the law has incentivized employers to shift employee's below the 30-hour weekly mark to legally avoid penalties and the high cost of health insurance. Employees themselves are being removed from employer-sponsored care on top of being bumped to part-time status. Can the witnesses comment on the degree to which the employer mandate tax discourages full-time employment, employer-covered health coverage and what this might mean for both employees and the economic recovery?

A:**Douglas Holtz-Eakin**

Among the key aspects of the ACA is its mandate to cover employees with health insurance. Focusing first on those employers with more than 50 workers, beginning in 2014, those firms must pay a penalty if any of their full-time workers receive subsidies for coverage through the exchange. The penalty is equal to the lesser of \$3,000 for each full-time worker receiving a premium credit, or \$2,000 for each full-time worker, excluding the first 30 full-time workers. The fees are paid monthly in the amount of 1/12th of the specified fee amounts. Firms with fewer than 50 employees are exempt from the so-called employer "play or pay" penalties if they do not offer coverage and their workers receive a subsidy in the exchange.

From the perspective of economic performance, the most important point is that the *best* possible impact is that the firm is already offering insurance, no individual ends up receiving subsidies and triggering penalties, and thus costs are unaffected. In every other instance, health insurance costs will compete with hiring and growth for the scarce resources of those firms.

One might think that the same situation prevails for the smallest firms – those under 50 employees – who are exempt from the coverage mandate. Unfortunately, for these firms, the greatest impact is the tremendous impediment to expansion. Suppose for example that a firm does not provide health benefits. Hiring one more worker to raise employment to 51 will trigger a penalty of \$2,000 per worker multiplied by *the entire*

workforce, after subtracting the first 30 workers. In this case the fine would be \$42,000 (21 (51-30) workers times \$2,000). How many firms will choose not to expand?

Alternatively, the labor market is already witnessing firms responding to the incentive to avoid full time employment. As a result, the ACA may result in considerable underemployment of those seeking full-time work.

Proponents of the ACA like to point toward the fact that small businesses will receive aid in the form of a small businesses tax credit, ostensibly offsetting the burdens outlined above. Unfortunately, the credit is available only for employers with fewer than 25 workers and those in which average wages are under \$50,000. Thus, the cost and growth impacts for those with 26 to 50 employees remains unchanged. Moreover, the credit is not a permanent part of the small business landscape. An employer may receive the credit only until 2013 and then for two consecutive tax years thereafter. Thus, the credit is available for a maximum of six years.

Turning to the credit itself, to be eligible the employer must pay at least 50 percent of the premium. The credit is equal to 35 percent of employer contributions for qualified coverage beginning in 2010, increasing to 50 percent of the premium in 2014 and thereafter. The amount of the credit is phased-out for firms with average annual earnings per worker between \$25,000 and \$50,000. The amount of the credit is also phased-out for employers with between 10 and 25 employees.

In the same way that the mandate provides an implicit tax on growth, the structure of the small business tax credit will raise the effective marginal tax rate on small business expansion. For this reason, the credit may discourage firms from hiring more workers or higher-paid workers. Consider two examples.

In the first, employers will have an incentive to avoid increases in the average rate of pay in their firm. Suppose that the average wage in a small (3 worker) firm is \$25,000 and the owner decides to add a more highly paid supervisor being paid \$50,000. This will raise the average wages in the firm to \$31,250 there by *reducing* the tax credit per worker from \$2,100 to \$1,596.¹ In effect, the structure of the credit raises the effective cost of adding valuable supervisory capacity.

In this example, total credits to the firm are essentially unchanged (\$6,300 to \$6,384) by raising the average wage. If the new supervisor were paid \$75,000 however, total credit payments would fall from \$6,300 to \$4,368. The lesson is clear in that the structure of the credit can impose large effective tax rates on raising the quality of the labor force for those receiving the small business credit.

Similar incentives affect the decision to hire additional workers because the overall tax credit falls by 6.7 percent for each additional employee beyond 10 workers. This is a very strong disincentive to expanding the size of the firm. Using the example above,

¹ This example assumes the employer contributes \$6,000 toward insurance for each employer.

suppose that the firm has 10 employees and total credits received were \$21,000. The firm's total subsidy will peak at \$21,840 with the hiring of the 13th worker. Thus, a firm employing 13 workers would get a total tax credit of \$21,840 while a firm employing 24 workers would receive a total credit of only \$3,360.²

The upshot is that the small business tax credit is a mixed economic blessing. Relatively few firms will qualify for the credit and be able to offset the costs of health insurance. For those that do qualify, receipt of the credit imposes a new regime of hidden effective marginal tax increase on improvements in scale and quality. Even more broadly, the credit does little to offset the overall impact of the mandate costs on the disincentives for full-time employment.

Dan Moore

I understand that small businesses that cannot afford to provide and thus do not already provide medical benefits for their employees may actually decrease the working hours for current employees below 30 hours per week to avoid penalties and the requirement to provide high-cost health insurance. As the leading association of small medical device companies, our member companies compete for professionals and skilled hourly manufacturing workers and, accordingly, must provide health care benefits to remain competitive. Certain aspects of the PPACA employer mandate directed to the scope of required coverage could limit the flexibility available to our member companies and drive up the cost of employer plans. Like the medical device tax, these additional costs discourage investment in other endeavors, like research and development, and limit the ability of a business to grow.

Walt Humann

Pursuant to interest on how the Affordable Care Act (ACA) employer mandate will impact OsteoMed and its employees, OsteoMed management provides the following response.

The ACA employer mandate has discouraged OsteoMed's business development and growth as we now have very strong disincentives to expand and hire full time employees and provide quality healthcare coverage at the levels currently provided to our employees. OsteoMed has already reduced spending on research and development, implemented a freeze on hiring, reduced permanent headcount and delayed plans for near term growth as a result of the pending impacts of healthcare reform. Our employees, both current and future, will ultimately suffer the consequences of the ACA through the loss of career growth opportunities and earnings.

At OsteoMed, we typically do not employ seasonal or part-time employees, however, the ACA has forced us to reconsider our current staffing models and we will likely employ more contract and/or outsourced labor as a way to mitigate costs and risks related to the new mandate and associated penalties in the future. OsteoMed currently employs approximately 260 employees, including positions that are often outsourced by other companies. We will evaluate options to reduce permanent headcounts through outsourcing and contract labor structures. Customer service, accounts payable, payroll,

² See, <http://www.acpa.org/pdffiles/ba709.pdf>

manufacturing and other positions we have considered critical to our business will be evaluated for outsourcing as we explore ways to mitigate the mandate and its related costs.

The employer mandate tax also discourages employer-covered health coverage because the penalties associated with moving employees to the exchanges are significantly less than the costs for businesses to maintain coverage. Based upon projections associated with the new mandate, it will be hard for OsteoMed to justify maintaining private health coverage for employees. We currently spend over \$3 million to provide health and welfare coverage for employees which is estimated to exceed the penalties by more than \$1.5 million next year. Given the additional burden we assumed at the beginning of the year with the new medical device excise tax, this is cannot be ignored and this money may be needed to fund projects that have been delayed or cut from our budget. Not offering healthcare benefits will negatively impact our employees in several ways. Employees will elect to purchase lesser coverage on the exchanges in order to minimize their out of pocket expenses or employees will be forced to come out of their own pocket an estimated additional \$5k-\$10k in order to maintain the current level of coverage provided by OsteoMed's employer plan.

David Kautter

There is no doubt that the employer mandate tax is discouraging full time employment and employer-covered health insurance. This is not good news for employees or the economic recovery.

One of the biggest problems as the law is being implemented is a lack of understanding on the part of employers of all sizes, especially smaller employers, of the requirements of the Affordable Care Act (ACA). The law is so far reaching and complicated that most small employers do not have even the most basic understanding of its requirements. Not surprisingly, they do not have the time to figure out the law themselves nor the resources to hire consultants to advise them. In the absence of an understanding of the consequences of their potential actions, a great many small employers are simply refusing to add additional employees. This refusal to hire will continue until it is clear to a small employer that adding new workers will not have adverse business, economic and tax consequences.

Those small employers who have managed to become familiar with the rules have often responded in two ways: (1) refusing to hire additional employees so that they remain below the 50 employee level and (2) moving employees to part time status, i.e. reducing working hours to less than 30 hours per week. Reducing employee hours to less than 30 hours per week is becoming an increasing trend and in some industries is likely to become the norm before long. This trend will make life more challenging for many who will now have to work two jobs instead of one to make ends meet. These are often employees who are at the lower end of the wage scale. Based on my experience so far, it is my belief that the employer mandate is slowing the economic recovery and will serve as a drag on economic growth for the foreseeable future.

Shelly Sun

First, I do not believe this is at all about incentivizing employers to reduce hours to avoid costs that they can afford as the question may imply. Many small business owners, like BrightStar franchisees, invested more than \$100,000 to start their business, and many took on debt to start and grow their businesses. It's highly unlikely that the SBA loan applications banks approved for these small business owners included costs of compliance or the cost of health insurance or penalties. These business owners — like many across the country — are trying to be responsible to ensure they first repay their debts, and second, where possible, avoid cutting entire jobs that can result from complying with the increased costs of these burdening regulations. Once business owners repay their debt and earn a reasonable return, many look at opportunities to attract and retain the best employees by offering those working full-time (defined as 40 hours before ACA attempted to redefine full-time) with benefits. To force businesses to take on this significant cost before debt is repaid and the business has solid cash flow is irresponsible.

Despite employers' best efforts and intentions to offer coverage to workers, the result of the employer mandate is that both employers and employees lose. Take, for example, a real BrightStar employee that I will refer to as "Sarah Johnson." Currently, Sarah works an average of 36.5 hours per week. Her employer, a multi-unit BrightStar franchisee, is considered a "large employer" under the ACA, and has decided to reduce the impact of the employer mandate on his business by managing some variable-hour employees to stay under the 30-hour threshold. As a result, Sarah's hours will be reduced to 28 hours per week or less, which will reduce her annual wages by at least \$5,400. If you combine wages lost with the cost of Sarah's individual mandate to purchase health insurance that has an annual premium of over \$3,500, the total financial impact on Sarah is nearly \$9,000 annually.

Sarah will not receive insurance coverage through her employer, but she also will be less able to afford her own coverage through the state insurance exchange. As much as small business owners and job creators are negatively impacted by the employer mandate, the ones who really suffer are the workers themselves.

The unintended impact of the employer mandate is devastating: fewer workers will receive health insurance, and they will be less able to afford their own coverage. Franchise small business owners are faced with a choice between either paying higher premiums or paying tax penalties for not offering coverage, and neither option is a good option.

The Affordable Care Act is anything but affordable. It adds taxes, costs, and fees, while threatening the economic viability and job creation opportunities for many of our nation's small businesses. To define a "large employer" as one with 50 employees is too low a ceiling and is crippling and irresponsible.

Hugh Joyce

The employer mandate absolutely will affect how and when employers switch employees from full time to part time status. We are hearing of significant numbers of businesses and even the state of Virginia reclassifying employees to 29 hours and part time staff to

avoid or prepare to avoid health care costs. There are so many unintended consequences regarding this part of the law, including:

1. Full time workers being forced to part time, causing serious pay reductions and negative family economic consequences.
2. Workers losing coverage all together and being forced to the exchange, as companies re-position.
3. Part time workers and workers losing coverage, who may now be paying for care themselves may become government subsidized. Driving costs up for our government.
4. The potential for employees to become highly disenfranchised from their employers. We see the potential for employees to battle their employers by creating threats to go to the exchange to trigger penalties for their employers.
5. The State of Virginia is actually cutting the state owned ABC store and Community College workers back to 29 hours to avoid health care costs.
6. The Senior VP of the consulting firm Mercer, Inc., the nation's largest benefit firm, stated and I quote, when asked what he thought the cost to American businesses would be: 'I have no "_____ " Idea'. This guy is an expert and he can't interpret the rules and regulations and their impact.
7. Regulations: The Healthcare law is 2400 pages. I am told there are over 20,000 pages of support rules, regulations, clarifications, and mandates. This will cause great harm to our businesses, citizens and even our government entities if it is allowed to be fully implemented.

Bottom Line: The Healthcare Law in its current form is strangling American small, medium and large businesses with new costs, new taxes and difficult and extreme rules and regulations. We must establish a better plan.

Paul N. Van de Water

Any possible effect of health reform on encouraging part-time employment is too small to appear in the aggregate economic data. To the contrary, since the trough of the recession, the number of people working part-time for economic reasons has dropped, and average weekly hours have increased.

Questions for Dr. Holtz-Eakin of the American Action Forum

Q:

Thank you for your testimony before the Ways & Means Subcommittee on Oversight. Several experts, as well as the Congressional Budget Office and the Joint Committee on Taxation, have estimated that the health insurance tax will result in higher health

insurance premiums for individuals and families. Could you please explain why the tax will lead to higher premiums and how the tax is at odds with the Affordable Care Act's stated goal of making coverage affordable?

A:

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.

Importantly, these impacts will be felt equally by the not-for-profit insurers. Non-profits have comparable resource needs for disease management, wellness efforts, or IT equipment. They also have equity capital demands, as they rely on retained earnings as reserves to augment their capital base. Bearing the burden of the tax means lower access to these reserves and diminished capital, harming their ability to continue to serve policyholders effectively.

In short, all insurers – for profit and non-profit alike – will seek to restructure in an attempt to restore net income levels, 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. The only other place to shift the tax cost is onto customers – i.e., families and small businesses. If market conditions make it impossible for insurers to absorb the economic burden of the premium tax, they will have no choice but to build the new, higher costs into the pricing structure of policies. In this way, the economic burden of the tax is shifted to the purchasers of health insurance. In particular, the more competitive are markets for equity capital and hired labor, the greater the fraction of the burden that will be borne by consumers.

The implications for purchasers of health insurance are obvious and unambiguously negative. In addition, as employers pay more for health insurance, they will have to shave back on cash wage increases, and thus taxable compensation. Thus the health insurance premium tax will have the perverse effect of lowering personal income and payroll taxes.

To top things off, the new law has an especially unpleasant feature for those facing higher premiums: the fees are not tax-deductible but higher premiums will be taxable. 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.

The upshot is clear. The health insurance tax will make insurance more, not less, expensive. This fact is at odds with reducing the cost of insurance, reducing the number of uninsured, and increasing the access to health care.

Q:

Due to the nature of the private insurance sector and the health insurance tax requirements set forth under the Affordable Care Act, the health insurance tax impacts insurers differently, depending on their federal tax status. I was hoping you could provide feedback on regulatory actions available to the Administration to reduce the premium impact of the Affordable Care Act tax on consumers. Further, if the Administration fails to act, what will the impact of the Health Insurance Tax be on consumers? What actions can Congress take to mitigate the impact of the health premium tax, short of full repeal?

A:

Broadly speaking, the health insurance tax ("premium tax") will have the least disruption if it is as broadly and evenly applied as possible. To the extent that the Administration chooses definitions of products and market shares with this in mind the effects of the tax will be minimized. Past that, Congress could choose to eliminate the tax entirely or undertake a reform of the premium tax to transform it into a tax at a fixed rate on a more conventional base (e.g., income, profits, or revenues).

Question for Mr. Van de Water of the Center for Budget and Policy Priorities

Q:

Thank you for your testimony before the Ways & Means Subcommittee on Oversight. I was hoping that you could comment on the effects of the health insurance tax as it applies to the Medicare Advantage and Medicaid Managed Care Programs. I've heard this has inadvertently set up a dynamic where the government is taxing itself. To your knowledge is this the case? Has OMB or the Treasury assessed how federal expenditures on Medicare and Medicaid will increase as a result of this tax?

A:

The health insurance tax applies broadly to most businesses that sell health insurance coverage, including those that provide coverage through Medicare Advantage, Medicare Part D, and Medicaid. Under the Medicare Advantage payment system, however, only a small portion of the tax can be passed on to the Medicare program. And since budgets

are tight, states are likely to be tough negotiators and not allow Medicaid managed care plans to pass through the entire amount of the tax. The Congressional Budget Office has presumably accounted for these effects in its overall cost estimates of the Affordable Care Act, but I am not aware of any official estimate of these individual items.

