health legislation. Thus, the government spends the money now, while pretending it is available in the future to pay for future Medicare benefits.

As Medicare's chief actuary points out, "In practice, the improved [Medicare] financing cannot be simultaneously used to finance other Federal outlays (such as the coverage expansions) and to extend the trust fund, despite the appearance of this result from the respective accounting conventions."[167]

And third, there is ample reason to be skeptical about whether the cuts will ever actually occur. Medicare's actuary warns that the proposed cuts "may be unrealistic."[168] The CBO itself cautions that "It is unclear whether such a reduction in the growth rate of spending could be achieved, and if so, whether it would be accomplished through greater efficiencies in the delivery of health care or through reductions in access to care or the quality of care."[169]

Congress's record in this regard is decidedly mixed. As the bill's proponents point out, it is untrue to say that Congress has never cut Medicare spending. At least 11 times since 1980, Congress has passed Medicare cuts that actually did take place.[170] Most were modest reductions in payments to certain types of providers, reductions in "disproportionate share" (DSH) payments to hospitals, or small increases in cost-sharing by seniors, or in Medicare premiums. At least in limited circumstances, Congress *has* been able to trim Medicare.[171]

However, Medicare is still facing a $50 trillion–$100 trillion funding gap, and Congress has proven itself unable to take the steps necessary to deal with this long-term gap. Some of the most significant cuts that have been proposed have later been reduced or repealed. For instance, in 1997, as part of the Balanced Budget Act, Congress established the "sustainable growth rate" (SGR), designed to hold annual increases in Medicare reimbursements to a manageable growth rate. But in 2002, 2003, 2005, 2007, 2008, and this year (reaching back to 2009), Congress has overturned provider payment cuts that would have been required by the SGR. A bill before Congress—the infamous "doc fix" (see below)—would permanently eliminate future SGR mandated cuts.[172]

In some ways the legislation is a victim of Medicare itself. Because the legislation does nothing to reform the program's unsustainable structure, Congress is caught between two unpalatable choices. If it makes the cuts called for under the legislation, it risks, according to the CBO "reductions in access to care or the quality of care."[173] But if it fails to make those cuts, then the legislation will add a huge new cost to an already exploding debt.

That is a recipe for legislative paralysis.

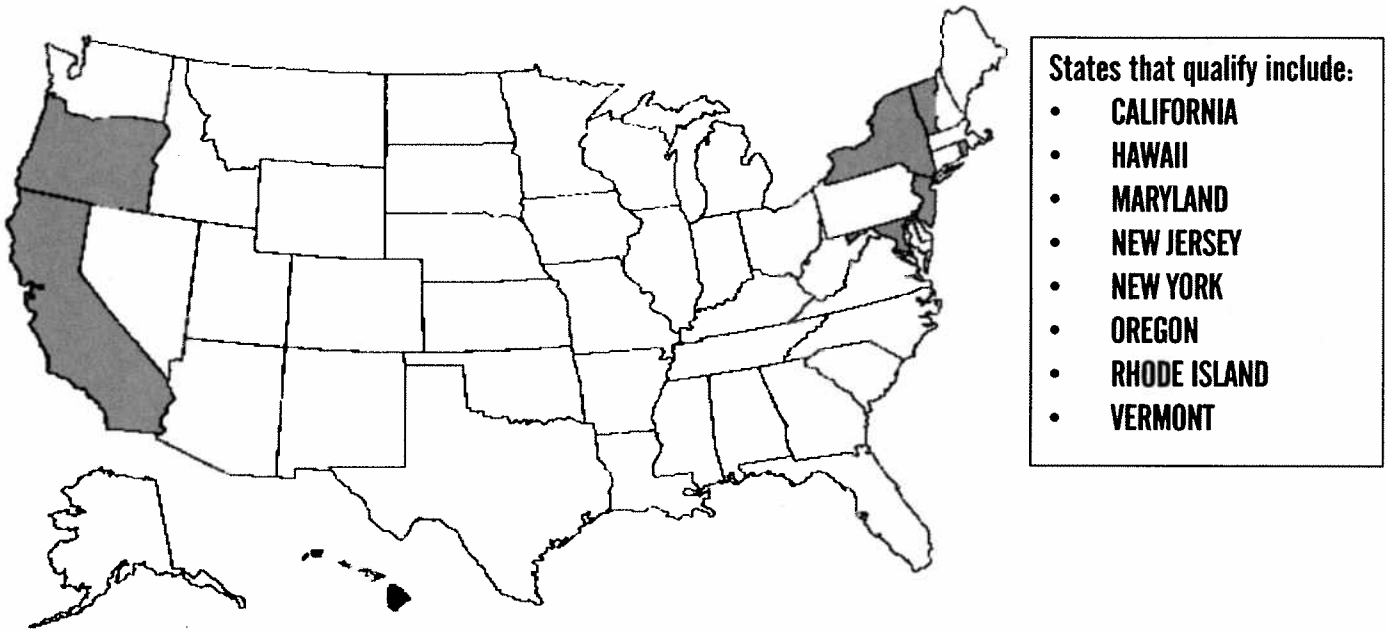
Taxes

The Patient Protection and Affordable Care Act imposes more than $669 billion in new or increased taxes over the first 10 years.[174] These include

- **Tax on "Cadillac" Insurance Plans.** One of the most heavily debated new taxes in the health care bill was the tax on high-cost insurance plans. Beginning in 2018, a 40 percent excise tax will be imposed on employer-provided insurance plans with an actuarial value in excess of $10,200 for an individual or $27,500 for families. (The threshold is increased to $11,850 for individuals and $30,950 for families whose head of household is over the age of 55 or engaged in high-risk professions such as police, firefighters, or miners.) The tax falls on the value of the plan over the threshold and is paid by the insurer, or the employer if self-insured.[175] The benefit value of employer-sponsored coverage would include the value of contributions to employees' FSAs, HRAs, and HSAs. It is estimated that 12 percent of workers will initially have policies that are subject to the tax.[176] However, the tax is indexed to inflation rather than the faster-rising medical inflation, which drives insurance

The legislation does nothing to reform the program's unsustainable structure.

Figure 5
States with Marginal Tax Rates over 50% after PPACA



Source: Tax Foundation, Private Report.

premiums. As a result, more and more workers will eventually find their insurance plans falling subject to the tax. In fact, a study for the benefits consulting firm Towers Watson concludes, "Assuming even reasonable annual plan cost increases to project 2018 costs, many of today's average plans will easily exceed the cost ceilings directed at today's 'gold-plated' plans."[177]

- **Payroll Tax Hike.** The Medicare payroll tax will be increased from 2.9 percent today to 3.8 percent for individuals with incomes over $200,000 for a single individual or $250,000 for a couple.[178] The payroll tax hike would mean that in eight states, workers would face marginal tax rates in excess of 50 percent (see Figure 5).[179]
- **Tax on Investment Income.** Starting in 2013, the 3.8 percent Medicare tax will be applied to capital gains and interest and dividend income if an individual's total gross income exceeds $200,000 or a couple's income exceeds $250,000.[180] The tax would only apply to the amount of income in excess of those limits, but would be based on total income. Thus, if a couple had $200,000 in wage income and $100,000 in capital gains, $50,000 would be taxed. Moreover, the definition of capital gains includes capital gains from the sale of real estate, meaning that an individual who sold his or her home for a profit of $200,000 or more would be subject to the tax. Given the current weakness in the housing market, this would seem to create a particularly pernicious outcome.

It is also worth noting that the Obama administration has also proposed allowing the Bush tax cuts on cap-

ital gains to expire. Combining that increase with the one contained in the health care legislation would raise the tax rate on capital gains from 15 percent today to nearly 24 percent.[181] Similarly, the top tax rate for interest on taxable bonds could rise to 43.4 percent.[182] Numerous studies have shown that high capital gains taxes discourage investment, resulting in lower economic growth, fewer jobs, and reduced wages.

- **Limit on Itemized Deductions.** Beginning in 2013, the threshold at which taxpayers can deduct medical expenses will be raised from the current 7.5 percent of adjusted gross income to a new floor of 10 percent.[183] The increased threshold would be postponed until 2016 for taxpayers age 65 or older.[184]
- **Tax on Prescription Drugs.** The legislation would levy a new tax on brand name prescription drugs designed to raise a specific amount of money annually. Rather than imposing a specific tax amount, the legislation identifies a specific amount of revenue to be raised, ranging from $2.5 billion in 2011 to $4.2 billion in 2018, before leveling off at $2.8 billion thereafter, and assigns a proportion of that amount to pharmaceutical manufacturers according to a formula based on the company's aggregate revenue from branded prescription drugs.[185] The structure of this tax almost guarantees that it will be passed along to consumers through higher prices.
- **Tax on Medical Devices.** A 2.9 percent federal sales tax is imposed on medical devices, which includes everything from CT scanners to surgical scissors.[186] The secretary of HHS has the authority to waive this tax for items that are "sold at retail for use by the general public."[187] However, almost everything used by doctors, hospitals, or clinics would be taxed. The tax would also fall on laboratory tests. The government's chief actuary has concluded that this tax, as with those on pharmaceutical manufacturers and insurers "would generally be passed through to health consumers."[188] In fact, a study by the Republican staff of the Joint Economic Committee estimates that the pass-through could cost the typical family of four with job-based coverage an additional $1,000 a year in higher premiums.[189]
- **Additional Taxes on Insurers.** Similar to the tax on pharmaceutical companies, the legislation imposes a tax on health insurers based on their market share.[190] The total assessment will begin at $8 billion and rise to $14.3 billion by 2018. Thereafter the total assessment will increase by the same percentage as premium growth for the previous year.[191] The tax will be allocated according to a formula based on both the total premiums collected by an insurer and the insurer's administrative costs.[192] However, some insurers in Michigan and Nebraska received a special exemption.[193] This tax is also expected to be passed through to consumers through higher premiums.
- **Tax on Tanning Beds.** The legislation imposes a 10 percent tax on tanning salons.[194] While tanning may be seen as a luxury or frivolous expenditure, it is actually a recommended treatment for psoriasis and certain other medical conditions. The law makes no distinction between tanning for medical or cosmetic reasons. This tax goes into effect immediately.

The combination of taxes and subsidies in this law results in a substantial redistribution of income. The new law will cost families earning more than $348,000 per year, (top 1 percent of incomes) an additional $52,000 per year on average in new taxes and reduced benefits.[195] In contrast, those earning $18,000–55,000 per year will see a net income increase of roughly $2,000 per family.[196]

The new law also contains other tax-related provisions that will add significantly to business costs. For example, the legislation requires that businesses provide a 1099 form to every

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The Patient Protection and Affordable Care Act is a tax and regulatory nightmare.

vendor with whom they do more than $600 worth of business over the course of a year.[197] Of course businesses already have to file 1099s for outlays on items like consultants. But the new rule will mean that even the smallest of businesses will have to issue a form—and file with the IRS—for virtually every purchase or payment. The burden falls on the other partner in the transaction, too. The business providing the goods and services would have to collect 1099s from all its customers and integrate them with the rest of its tax records. This would be a significant burden even for businesses with computerized record keeping. For the millions of small businesses that still do bookkeeping by hand, the cost in both time and money will be devastating. Furthermore, businesses will be required to collect all the requisite information from everyone they do business with, including their taxpayer ID, to file the required form. This, in turn, poses a whole new set of threats to privacy.

For both individual Americans and businesses large and small, the Patient Protection and Affordable Care Act is a tax and regulatory nightmare.

The CLASS Act

The health care legislation establishes a new national long-term care program, called the Community Living Assistance and Support Act (CLASS Act), designed to help seniors and the disabled pay for such services as an in-home caretaker or adult day services.[198]

The CLASS Act is theoretically designed to be self-financed. Workers would be automatically enrolled in the program, but would have the right to opt out. Those that participate will pay a monthly premium that has not yet been determined.[199] However, the CBO estimates that will be roughly $123 per month for the average worker.[200] Other estimates suggest that the premiums could be much higher, perhaps $180–240 per month.[201] Workers must contribute to the program for at least five years before they become eligible for benefits.[202] (Individuals age 55 or over at the time the program is fully implemented must not only contribute for five years, but must be employed for at least three years following the program's implementation date.)[203] There is no health underwriting of participation or premiums.

The actual benefits to be provided under the program are among the many details that remain to be determined but will not be "less than an average of $50 daily adjusted for inflation."[204] Some estimates suggest that benefits will average roughly $75 per day, or slightly more than $27,000 per year.[205] Benefits will be paid directly to the individual, not to the service provider, based on the degree of an individual's impairment, and can be used to purchase home care and other community-based long-term care assistance, as well as certain nonmedical services.[206] Benefits may be paid daily, weekly, monthly, or deferred and rolled over from month to month at the beneficiary's discretion.[207] There is no lifetime limit to benefits.

Theoretically, the program will begin to collect premiums in 2011, although so many aspects of the program remain to be determined that many experts predict implementation could be delayed until as late as 2013.[208] As mentioned, there is a five-year vesting period for benefits, so there will be no payouts until at least five years after the start of premium collections.

Eligibility for benefits will be based on the same criteria currently used to qualify for federal tax-qualified long-term care insurance benefits. That is, a person must be unable to perform at least two "activities of daily living" from a list of six such activities, or need substantial supervision due to cognitive impairment.[209] The secretary of HHS may also develop different or additional eligibility requirements.[210]

During the law's first five years it will collect premiums, but not pay benefits. As a result, over the first 10 years, the period conveniently included in the budget scoring window, the CLASS Act will run a surplus, collecting more in premiums than it pays out in benefits (see Figure 6).