Testimony on:
Taxpayer Exposure and the Patient Protection and Affordable Care Act

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Committee on Oversight and Government Reform
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Douglas Holtz-Eakin
President, American Action Forum*

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Introduction

Congressman Gowdy, Ranking Member Davis and Members of the committee, thank you for the privilege of appearing before you today. In this testimony I hope to make three major points:

- The United States faces a daunting federal budgetary outlook. As a result, there is a heightened importance attached to the fiscal implications of the Patient Protection and Affordable Care Act (PPACA);

- PPACA will contribute additional fiscal pressure that must be relieved in order to avoid a sovereign debt and related financial crisis in the United States, notwithstanding the contrary claims by proponents; and

- PPACA contains numerous provisions that will hinder economic growth, notably the costs of the employer mandate, its tax provisions, and the upward pressures on health insurance premiums.

Let me discuss each in turn.

The Threat of Future Debt

The federal government faces enormous budgetary difficulties, largely due to long-term pension, health, and other spending promises coupled with recent programmatic expansions. The core, long-term issue has been outlined in successive versions of the Congressional Budget Office's (CBO's) *Long-Term Budget Outlook*.[1] In broad terms, over the next 30 years, the inexorable dynamics of current law will raise federal outlays from an historic norm of about 20 percent of Gross Domestic Product (GDP) to anywhere from 30 to 40 percent of GDP. Any attempt to keep taxes at their post-war norm of 18 percent of GDP will generate an unmanageable federal debt spiral.

This depiction of the federal budgetary future and its diagnosis and prescription has all remained unchanged for at least a decade. Despite this, action (in the right direction) has yet to be seen.

Those were the good old days. In the past several years, the outlook has worsened significantly. Over the next ten years, according to the CBO's analysis of the President's

[1] Congressional Budget Office. 2011. *The Long-Term Budget Outlook.* Pub. No. 4277. http://www.cbo.gov/ftpdocs/122xx/doc12212/06-21-Long-Term_Budget_Outlook.pdf .

Budgetary Proposals for Fiscal Year 2012,[2] the deficit would never fall below $750 billion. Ten years from now, in 2021, the deficit would be 4.9 percent of GDP, roughly $1.2 trillion, of which over $900 billion would be devoted to servicing debt on previous borrowing. As a result of the spending binge, in 2021, public debt would have more than doubled from its 2008 level to 87.4 percent of GDP and will continue its upward trajectory.

In the other direction, some may point to the impact of the Budget Control Act of 2011 (BCA), which ostensibly pared $917 billion from projected deficits over the next 10 years. Perhaps so. But a word of caution is merited because the reductions accrue due to the assumed reductions in *future* annual discretionary spending. Perhaps this will occur. But to date *no* spending reductions have yet to occur.

Similarly, the BCA created the Joint Select Committee on Deficit Reduction, associated legislative procedures, and spending sequester enforcement. This collection of budgetary processes is intended to reduce future deficits by up to an additional $1.5 trillion over the next decade. However, even if successful, the reductions will be insufficient to stabilize the ratio of federal debt (in the hands of the public) to Gross Domestic Product (GDP).

In short, regardless of one's view of BCA, it will be imperative that the federal government undertakes substantial additional deficit reduction. Research at the American Action Forum indicates that the most effective approach is to reduce federal transfer programs, while reforming the tax code to enhance the underlying trend rate of economic growth.

Notably, PPACA is an *expansion* of transfer programs at a time when the evidence suggests going in precisely the opposite direction. In addition, it contains a number of provisions at odds with the objective of enhancing economic growth.

The Budgetary Impact of the Patient Protection and Affordable Care Act

In light of the fiscal threat from growing spending, the budgetary impacts of PPACA are central to any discussion of its merits. I begin by reviewing the CBO cost estimate that concludes ppACA will serve to lower the deficit. In the final score of ppACA, the CBO and Joint Committee on Taxation estimated PPACA would lead to a net reduction in federal deficits of $143 billion over ten years, with $124 billion in net reductions from PPACA and $19 billion derived from education provisions.

Total spending on subsidies in PPACA exceed $1 trillion dollars over ten years. This includes insurance exchange tax credits for individuals, small employers' tax credits, the creation of reinsurance and high risk pools, as well as expansions to Medicaid and the Children's Health Insurance Program.

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[2] Congressional Budget Office. 2011. *An Analysis of the President's Budgetary Proposals for Fiscal Year 2012.* Pub. No. 4258. http://www.cbo.gov/ftpdocs/121xx/doc12130/04-15-AnalysisPresidentsBudget.pdf .

To "pay for" the new entitlement, PPACA purports to impose nearly $500 billion in reductions to annual updates to Medicare fee-for-service payment rates, Medicare Advantage rates, and Medicare and Medicaid disproportionate share hospital (DSH) payments. In addition, PPACA levies more than $700 billion in new taxes from reinsurance and risk adjustment collections, penalty payments by employers and uninsured individuals, an excise tax on high-cost insurance (the "Cadillac" tax), fees on manufacturers and insurers, the so-called Medicare surtax and other revenue provisions.

To gain a rough feel of the longer-run impacts, consider extrapolating the impacts to the years 2020 to 2029 using CBO's estimated compounded annual growth rates. Under this crude approach, PPACA would be expected to yield an additional $681 billion in deficit reduction.

The prospect of these savings is tantalizing given the daunting fiscal outlook. But they raise an important question: is it really likely that the creation of two new entitlement programs (insurance subsidies and long-term care insurance via the CLASS act) will reduce the long-run deficit? The answer, unfortunately, is no. HHS has recently halted implementation of the CLASS program. The current understanding of the Bill's economic consequences, including the fact that the CLASS Act will no longer be implemented, tell a very different story.

A more realistic assessment likely emerges if one strips out gimmicks and budgetary games and reworks the calculus: PPACA will more likely raise, not lower, federal deficits, by $554 billion in the first ten years and $1.4 trillion over the succeeding ten years.

Why does the outlook change so much? The dubious budgetary provisions fall into four scenarios: unachievable savings, unscored budget effects, uncollectible revenue, and double-counting premiums.

To begin, it is unlikely that the Centers for Medicare and Medicaid Services (CMS) will ultimately be able to implement cost reductions through Medicare market basket updates, the Independent Payment Advisory Board (IPAB), and other projected savings. While the specifics of each differ, these provisions share common features. Most important, PPACA does not fundamentally reform Medicare in such a manner that will permit it to operate at lower budgetary cost. Indeed, CMS Actuary Richard Foster analyzed PPACA and concluded that the nation as a whole will spend $310 billion ***more*** than it would have without it, large part because of the "negligible financial impact over the next 10 years" for most provisions in the legislation "intended to help control future health care cost growth."

The increased demand for services will mean that health care shortages and price increases are "plausible and even probable" and that "supply constraints might interfere with providing the services desired by the additional 34 million insured persons." One would expect in this setting that providers would be expected to negotiate for higher rates, so that health care costs and premiums would increase.

These impacts lead directly to the conclusion that PPACA "jeopardizes access to care" for seniors. As a result of the Bill's payment reductions, "providers for whom Medicare constitutes a substantive portion of their business could find it difficult to remain profitable and, absent legislative intervention, might end their participation in the program (possibly jeopardizing access to care for beneficiaries)." He concludes that about "15 percent of Part A providers would become unprofitable within the 10-year projection period."

It is not hard to imagine what will transpire when the automatic payment reductions are scheduled to occur. CMS will be faced with the possibility of strongly limited benefits, the inability to serve beneficiaries, or both. Congress, recognizing the danger, will be forced to regularly override the scheduled cuts, as we've seen them do with the SGR (Sustainable Growth Rate). A similar scenario will apply to proposals from the IPAB. Under PPACA, the IPAB will be obligated to constrain the growth rate of Medicare spending. When faced with the consequences of its proposals, Congress will quickly strip it of its mandate, its independence, or both.

The second misleading aspect of the CBO score is that it ignores acknowledged costs. To operate the new health care programs over the first ten years, future Congresses will need to vote for hundreds of billions in additional spending in the next ten years. The omitted spending begins with the discretionary costs for the Internal Revenue Service (IRS) to enforce and the CMS to administer insurance coverage and explicitly authorized health care grant programs. CBO recently acknowledged that these costs raise the price tag of PPACA[3]. In addition Congress will be forced to revise the SGR formula for physician reimbursement in Medicare, which could add in excess of $300 billion to the overall tab. All of these provisions are noted in CBO's report but ***none*** of them are factored into the final score of the Bill.

In a mirror image to the dubious spending cuts, there are reasons to questions the political will of Congress to collect the excise tax on high-cost or "Cadillac" health insurance. This tax was supposed to start immediately according to the Senate's version of PPACA. After intense lobbying by organized labor, Congress relented and pushed the tax back to 2018. This raises the possibility that it will prove politically infeasible to ever implement the tax leading to a failure to collect the associated tax revenue of $78 billion over the next ten years.

Scoring for PPACA originally double counts premiums for the CLASS Act and Social Security. In principal, these receipts should be reserved to cover future payments and not be devoted to financing other spending. In the case of the CLASS Act, PPACA raises $70 billion in premiums in the first ten years -- while there is a $53 billion anticipated increase in Social Security tax revenue. In both cases, monies that should be dedicated to paying the corresponding long-term care and retirement benefits is being counted on to finance the

[3] See http://www.cbo.gov/ftpdocs/114xx/doc11493/Additional_Information_PPACA_Discretionary.pdf.

new entitlement spending for health subsidies. Now that the CLASS Act is basically dead, that revenue is off the table entirely.

CBO has also radically underestimated the number of individuals who will be purchasing insurance on the insurance exchanges with the help of tax-payer funded subsidies. The key driver of this will be a dramatic reduction in employer sponsored health insurance. According to an analysis I did with my colleague Cameron Smith, it would be cost-effective and rational behavior for a significant number (we estimate 35 percent) of companies to stop offering coverage and push employees onto the exchanges. The McKinsey study last summer backed up our findings with a survey that also predicts a large drop in employer-sponsored insurance.

What is the bottom line? Adding policy realism to the projections produces a radically different bottom line. PPACA would generate additional deficits in excess of $500 billion in the first ten years. And, as the nation would be on the hook for the cost of subsidizing insurance purchased through the exchanges for a rapidly expanding number of people, the deficit in the second ten years would approach $1.5 trillion.

The Economic Growth Impact of the Patient Protection and Affordable Care Act

The Need for Pro-Growth Policies.

The United States' economy has endured a severe recession and is currently growing slowly. The pace of expansion remains solid and unspectacular. In many ways this is not surprising. As documented in Rogoff and Reinhart (2009), economic expansions in the aftermath of severe financial crises tend to be more modest and drawn out than recovery from a conventional recession.[4] Accordingly, it is imperative that policy be focused on generating the maximum possible pace of economic growth. More rapid growth is essential to the labor market futures of the millions of Americans without work. More rapid growth will be essential to minimizing the difficulty of slowing the explosion of federal debt to a sustainable pace. More rapid growth will generate the resources needed to meet our obligation to provide a standard of living to the next generation that exceeds the one this generation inherited.

Unfortunately, key provisions of PPACA are inconsistent with strong, pro-growth policies. In what follows, I focus on three in particular: mandate costs, administrative burdens, and tax increases.

Employer Mandate Costs

Among the key aspects of PPACA 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

[4] See *This Time Is Different: Eight Centuries of Financial Folly*, by Carmen M. Reinhart and Kenneth Rogoff, 2009.

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 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?

Proponents of PPACA 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.

The combination of requirements for premium contributions, limitations on employees, limitations on earnings, and phase-outs has surprised the small business community. In particular, the reform's strict definition that a firm is only a small business if it has 25 or fewer employees proved convenient to the legislators who crafted the bill. This narrow definition has led to a number of studies that assert that more than 80 percent of small businesses will be eligible for the tax credit.

Even those studies that recognize the limitation imposed by the 25-employee limit tend to overstate the likely penetration of the credit. For example, the Small Business Majority and

Families USA recently estimated that 84 percent of the nation's 4.8 million businesses that employ 25 or fewer employees will be eligible for the tax credit.[5] Unfortunately, the net impact of the credit in offsetting the cost burden of PPACA will depend not upon *eligibility* but rather on *receipt* of the tax credits. This distinction was noted early in the debate by CBO. In November 2009 when the law was being considered before Congress, CBO found that, "A relatively small share (about 12 percent) of people with coverage in the small group market would benefit from that credit in 2016."[6]

A more useful study focuses on the estimated number of small firms who would qualify for the small business health insurance tax credit. A recent analysis conducted by the National Federation of Independent Business (NFIB) found that the total number of firms that offer health insurance and pay more than half of their employees' premium costs, as mandated under PPACA, is more likely 35 percent of all firms with less than 25 employees.[7]

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.[8] 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, 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

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[5] See http://www.smallbusinessmajority.org/_pdf/tax_credit/Helping_Small_Businesses.pdf.
[6] See, http://cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.
[7] See, http://www.nfib.com/nfib-on-the-move/nfib-on-the-move-item?cmsid=52099.
[8] This example assumes the employer contributes $6,000 toward insurance for each employer.

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.[9]

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 increases on improvements in scale and quality.

Tax Increases

PPACA raises more than $700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions. There is no theory or empirical research on job creation that suggests that large tax increases will spur employment. Taken at face value, one should be skeptical PPACA will not harm the pace of overall economic recovery.

There are two taxes of particular interest contained in PPACA. Section 9015 increases the Medicare HI (Hospital Insurance) tax by 0.9 percentage points on wages in excess of $200,000 ($250,000 for couples filing jointly, $125,000 for married individuals filing separately), and also applies to self-employed earnings.

Sec. 1402 of the Healthcare and Education Reconciliation Act (HCERA) imposes a 3.8 percent Medicare contribution tax on individuals, estates, or trusts of the lesser of net investment income or the excess of modified adjusted gross income over the threshold amount. The threshold amount is $250,000 for joint returns, $125,000 for married filing separately, or $200,000 for any other case. Both taxes are effective for taxable years beginning after 2012.

The first point to note is that these taxes have nothing to do with Medicare finance. While gross inflows may be credited to the HI trust fund, these dollars will finance the expansion of the new insurance subsidy entitlement program.

The second point to note is that these taxes apply to the labor and investment earnings of pass-thru entities taxed through the individual income tax. Thus, they are targeted at precisely the same group of individuals most likely to be business owners or entrepreneurs. The Joint Committee on Taxation projects that $1 trillion in business income will be reported on individual income tax returns in 2011. Notably, of that $1

[9] See, http://www.ncpa.org/pdfs/ba703.pdf.

trillion, roughly one-half, $470 billion, will be reported on returns that are likely to be the new surtaxes.[10]

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.

A final tax impact of PPACA is that the impact of phase-outs of refundable credits may have even more perverse growth consequences. As I have noted previously, the phase-outs in insurance subsidies contribute to high effective marginal tax rates.[11] The effect is to raise the effective marginal tax rate to as high as 41 percent on some of the lower-income U.S. workers. This has implications for the ability of families to rise from the ranks of the poor, or to ascend toward the upper end of the middle class. This growth and mobility is the heart of the American dream and is the most pressing issue at this time.

PPACA and Health Insurance Premiums

Health care reform was presumed to encompass both expansion of affordable insurance options and provision of quality medical care at lower costs. The reality of PPACA could not be more different. Objective analysts have uniformly concluded that the new law raises – not lowers – national health care spending.[12] The rising bill for national health care spending will, in turn produce sustained upward pressures on health insurance premiums.

In addition, PPACA's array of insurance market reforms will increase premiums. Barring limits on annual and lifetime out-of-pocket spending, coverage of pre-existing conditions for children, and the ability for children to stay on parents' policies, are all initiatives that enhance benefits. These benefits must necessarily be covered by higher premiums.

These features of the law are increasingly well understood, much to the dismay of insurance consumers. However, other aspects of the new law are less appreciated. In

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[10] The Joint Committee on Taxation analysis does not take into account the impact on small, non-publicly-traded "C" corporations. There are several million of these entities, which will likely be adversely affected by the marginal rate increases on ordinary and capital income.
[11] Brill, Alex and Holtz-Eakin, Douglas, "Another Obama Tax Hike." *Wall Street Journal,* February 4, 2010. *See also*, Douglas Holtz-Eakin and Cameron Smith, "Labor Markets and Health Care Reform, 2010. http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10_0.pdf.
[12] See http://www1.cms.gov/ActuarialStudies/Downloads/S_ACA_2010-01-08.pdf or http://www.cbo.gov/ftpdocs/117xx/doc11705/08-18-Update.pdf.

particular, the financing of the health care law will have significant implications for purchasers of insurance as well.

As noted above, PPACA raises more than $700 billion in tax revenue from an excise tax on high-premium plans; reinsurance and risk adjustment collections; penalty payments by employers and uninsured individuals; fees on medical device manufacturers, pharmaceutical companies, and health insurance providers; and other revenue provisions.

The impact of fees on medical devices, insurers, and pharmaceutical companies is important and not well-understood. To understand better, consider the fee on health insurers. The fee 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 next 10 years. The aggregate annual fee for all U.S. health insurance providers begins at $8 billion in 2014 and then rises thereafter. (See Table 1.)

Table 1
Aggregate Insurance Fees

Year	**Fee**
2014	$ 8 billion
2015	$11.3 billion
2016	$11.3 billion
2017	$13.9 billion
2018 & Beyond [13]	$14.3 billion
Total through 2020	$87.4 billion

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 $62.5 million ($12.5 million from the 50 percent component between $25 million and $50 million, and $50 million from the remainder). The aggregate fee is apportioned among the insurers based on their shares of the affected premiums. Importantly, the fees are not deductible for income tax purposes.

[13] The statute provides that after 2018 the insurance fee is equal to the amount of the fee in the preceding year increased by the rate of premium growth for the preceding calendar year.

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

Some assume that the insurers will be the only ones hit by these new taxes. Unfortunately, this ignores the influence of market forces. 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. Firms don't really pay taxes; they attempt to shift them 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.

A basic lesson of tax policy is that people pay taxes, firms do not. Accordingly, the economic burden of the $87 billion in premium taxes must be borne by individuals. Which individuals will bear the economic cost?

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 reduce compensation growth and squeeze labor expansion plans (or even lay off workers). However, there are sharp limits on the ability of companies to shift the effective burden of excise taxes onto either shareholders (capital) or employees (labor).

The only other place to shift the tax cost is onto customers – i.e., families and small businesses. This economic reality is reflected in the CBO and Joint Committee on Taxation revenue estimating procedures. Specifically, they apply a 25 percent "offset" to the estimated gross receipts of any excise tax. In terms of the premium tax, this convention has two important implications. First, if the aggregate fee were recognized as a premium excise tax that carried incentives to shift some of the burden via lower dividends, capital gains, and wages, then the aggregate fee will overstate the net budget receipts. To the extent this happens, receipts of income-based taxes will fall hence the need for an offset to the gross receipts of the excise tax.

The second implication is that the remainder of the tax is passed on to consumers. That is, the offset is not 100 percent meaning that the non-partisan consensus-based revenue estimators have concluded that the vast majority of the burden of excise taxes will *not* be borne by shareholders or workers.

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 markets are for equity capital and hired labor, greater is 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. Instead of an upward pressure on premiums of $87.4 billion in fees over the next 10 years, the upward pressure will be $134.6 billion.

The health insurance fee will likely quickly and nearly completely be incorporated into higher insurance premiums. The premium tax alone means that American families will pay as much as $135 billion more in insurance premiums over the next 10 years. Incorporating the impact of medical devices and pharmaceuticals raises the total impact.

The final channel by which PPACA affects insurance costs are the mandates regarding insurance benefit designs. Mandating greater benefits will unambiguously raise the costs of insurance. However, one widely-touted promise of PPACA was that if the American people "like your health plan, you can keep it."

In this regard, it is important to note that the interim final rules governing insurance copayments, deductibles, premium increases, and employer contributions are so strict that that even conservative estimates by the U.S. Department of Health and Human Services (HHS) indicate a majority of Americans will be unable to keep their existing health care coverage by 2013.[14] A more realistic estimate, accounting for the response from American businesses since the rules were released, places the likely percentage of plans without grandfathered status well above the HHS' high-end estimate of 69 percent of plans by

[14] "Group Health Plans and Health Insurance Coverage Rules Pertaining to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act," Federal Register. Volume 75. Page 34571.

2013.[15] Thus it appears that the interim final rules ensure that grandfathered status will be lost in the near-future and that a substantial majority of Americans will face higher costs.

The Response of Small Businesses to Higher Costs

The previous sections have outlined the direct and indirect cost pressures that will prevail under the health care reform law. Small businesses will react to these incentives in order to prosper to the greatest extent possible. In the process, there will be attempts to shift these financial burdens away from the businesses themselves. That is, the ultimate cost of PPACA's small business provisions may be shifted to other parties.

One obvious strategy is to raise prices to cover the newly-imposed costs, thereby shifting the costs to consumers. At present, economic weaknesses undercut pricing power, making it unlikely that this channel will prevail for some time to come. However, to the extent that the economy recovers, shoppers relying on small business goods and services will find prices stiffening to match increases in health insurance costs.

An alternative route will be to pass increases in health care costs to workers in the form of slower wage growth. Of course, it may not be possible to pass along the full cost in the form of lower wages. If a full-time worker is at or near the minimum wage, it will not be possible to offset higher costs with lower wages. Instead, employer's will be forced to shorten hours or drop workers altogether. The Lewin Group estimates that there will be a loss of employment between 157,300 and 366,200 people if PPACA were fully implemented in 2011. Specifically for small businesses (less than 500 employees), Lewin estimates that employment losses will be between 50,200 and 113,000 jobs.[16]

The final possibility is that small business owners will attempt to absorb these cost increases out of scarce business capital. In this instance, the reduced liquidity (especially at a time of credit market tightness) will raise the probability of the failure of small businesses.[17]

PPACA and Employer-Sponsored Insurance

Today about 163 million workers and their families receive health insurance coverage from their employers. Proponents of PPACA insisted that a key tenet of was to build on this system of employer-sponsored coverage.

Roughly one-half of the $900 billion of spending in PPACA is devoted to subsidies for individuals who do not receive health insurance from their employers. These subsidies are

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[15] "2010 UBA Health Plan Survey." United Befit Advisors. October 2010.
[16] See, http://www.lewin.com/content/publications/LewinGroupAnalysis-PatientProtectionandAffordableCareAct2010.pdf.
[17] The importance of capital market constraints is demonstrated in Holtz-Eakin, Douglas, David Joulfaian, and Harvey S. Rosen. 1994. "Sticking it Out: Entrepreneurial Survival and Liquidity Constraints." *Journal of Political Economy* (February):53-75.

remarkably generous, even for those with relatively high incomes. For example, a family earning about $59,000 a year in 2014 would receive a premium subsidy of about $7,200. A family making $71,000 would receive about $5,200; and even a family earning about $95,000 would receive a subsidy of almost $3,000.

By 2018, subsidy amounts and the income levels to qualify for those subsidies would grow substantially: a family earning about $64,000 would receive a subsidy of over $10,000, a family earning $77,000 would receive a subsidy of $7,800 and families earning $102,000 would receive a subsidy of almost $5,000.

An obvious question is how employers will react to the presence of an alternative, subsidized source of insurance for their workers, which can be accessed if they drop coverage for their employees. The simplest calculation focuses on the tradeoff between employer savings and the $2,000 penalty (per employee) imposed by PPACA on employers whose employees move to subsidized exchange coverage. Consider a $12,000 policy in 2014, of which the employer would bear roughly three-quarters or $9,000. A simple comparison of $9,000 in savings versus a $2,000 penalty would seemingly suggest large-scale incentives to drop insurance.

Unfortunately, the economics of the compensation decision are a bit more subtle than this simple calculation. Health insurance is only one portion of the overall compensation package that employees receive as a result of competitive pressures. Evidence suggests that if one portion of that package is reduced or eliminated – health insurance – and another aspect – wages – will ultimately be increased as a competitive necessity to retain and attract valuable labor. Thus, the key question is whether the employer can keep the employee "happy" – appropriately compensated and insured – *and* save money.

As Table 3 outlines, the answer is frequently "yes" – thanks to the generosity of federal subsidies. To see the logic, consider the first row of the table, which shows the implications for a worker at 133 percent of the Federal Poverty Level (FPL) or $31,521 in 2014. We project that this worker will be in the 15 percent federal tax bracket, which means that $100 of wages (which yields $85) is needed to offset the loss of $85 dollars of employer-provided health insurance (which is untaxed). Consider now a health insurance policy worth $15,921, of which the employer picks up 75 percent of the cost. The employer's contribution to health insurance of $11,941 is the equivalent of a wage increase of $14,048 to the worker.

Table 3

Health Care Reform and Employer-Sponsored Insurance in 2014

(Employer Health Plan = $11,941)

Percent of Federal Poverty Level	Income[1]	Tax Bracket[2]	Wage Equivalent of Employer Health Plan[3]	Federal Subsidies[4]	Required Pay Raise[5]	Employer Free Cash Flow[6]	Employer Drop Decision[7]
133%	$31,521	15%	$14,048	$14,176	($128)	$9,941	Drop
150%	$35,550	15%	$14,048	$13,385	$663	$9,941	Drop
200%	$47,400	25%	$15,921	$10,985	$4,936	$9,941	Drop
250%	$59,250	25%	$15,921	$7,530	$8,391	$9,941	Drop
300%	$71,100	25%	$15,921	$5,187	$10,734	$9,941	Keep
400%	$94,800	28%	$16,585	$2,935	$13,650	$9,941	Keep

1. Income calculated based on 2009 FPL for a family of four of $22,050 (HHS), indexed to CPI projections (CBO)
2. Tax bracket calculated based on 2010 tax brackets, indexed to CPI projections (CBO)
3. Computed as CBO estimate of Silver Plan in 2016, indexed to 2014 ($11,941), and divided by (1-Tax Rate)
4. Estimated federal insurance subsidy
5. Wage equivalent minus subsidies
6. Value of insurance plan minus $2,000 penalty
7. Drop if required pay raise is greater than free cash flow

Do the economics of PPACA ever suggest that employer's could drop? Yes. The employer would receive $14, 176 in subsidies – *more than the value of the lost health insurance*. On paper, they could take a pay cut and be better off. Clearly, the employer comes out way ahead – $11,941 less the penalty. Obviously, there is room for the employer to actually improve the worker's life by having a small pay raise and the same insurance and still save money. This is a powerful, mutual incentive to eliminated employer-sponsored insurance.

The remaining rows of Table 3 repeat this calculation for workers at ascending levels of affluence. For example, at 200 percent of the FPL (federal povery level), the "surplus" between the pay raise required to hold a worker harmless ($4,936) and the firm's cash-flow benefit from dropping coverage ($9,941) has narrowed, but the bottom line decision in the final column is the same. Indeed, the incentives are quite powerful up to 250 percent of FPL, or $59,250. Only for higher-income workers do the advantages of untaxed health insurance make it infeasible to drop insurance and re-work the compensation package.[18]

[18] Notice that what this really means is that an existing federal subsidy (via the tax code) trumps the new federal subsidy!

How big could this impact be? In round numbers, at present there are 123 million Americans under 250 percent of the FPL. Roughly 60 percent of Americans work and about 60 percent of those receive employer-sponsored insurance. This suggests that there are about 43 million workers for whom it makes sense to drop insurance.[19]

CBO estimated that only 19 million residents would receive subsidies, at a cost of about $450 billion over the first 10 years. This analysis suggests that the number could easily be triple that (19 plus an additional, say, 38 million in 2014) – meaning the price tag would be $1.4 trillion.

In contrast, the CBO predicted that only 3 million individuals who previously received coverage through their employers will get subsidized coverage through the new exchanges. One mechanism that would reduce employer drop is if high-wage workers continue to receive insurance and non-discrimination rules force employers to offer insurance to all workers – even those for whom it makes sense to drop coverage. For those firms dominated by lower-wage workers this is unlikely to succeed as it will be possible to use the accumulated savings to retain the few high-wage workers. Or, there may be incentives for firms to "out-source" their low-wage workers to specialist firms (that do not offer coverage) and contract for their skills. In any event, the massive federal subsidies are money on the table inviting a vast reworking of compensation packages, insurance coverage, and labor market relations.

Concluding Remarks

In light of the federal budgetary outlook it is troubling that PPACA contains numerous provisions that will hinder economic growth and further increase the deficit. A more realistic look at the economic incentives created by the Act's provisions show that it will in effect hurt employment, hinder growth and far from providing affordable coverage to the majority of Americans will dramatically raise premium costs, hurting both individuals and employers.

As our country is just recovering from a deep recession and still struggling to create jobs, PPACA only undermines those efforts. Far from being simply a healthcare bill, PPACA's impact will reverberate throughout the economy, affecting businesses small and large and ultimately increasing healthcare spending and with it our nation's growing and unsustainable debt.

I look forward to answering your questions.

[19] This is likely an upper bound estimate as there is a positive correlation between wage levels and the probability of having insurance.

Biography - full

Douglas Holtz-Eakin has a distinguished record as an academic, policy adviser, and strategist. Currently he is the President of the American Action Forum and most recently was a Commissioner on the Congressionally-chartered Financial Crisis Inquiry Commission. Since 2001, he has served in a variety of important policy positions. During 2001-2002, he was the Chief Economist of the President's Council of Economic Advisers (where he had also served during 1989-1990 as a Senior Staff Economist). At CEA he helped to formulate policies addressing the 2000-2001 recession and the aftermath of the terrorist attacks of September 11, 2001. From 2003-2005 he was the 6th Director of the non-partisan Congressional Budget Office, which provides budgetary and policy analysis to the U.S. Congress. During his tenure, CBO assisted Congress as they addressed numerous policies -- notably the 2003 tax cuts (JGTRRA), the Medicare prescription drug bill (MMA), and Social Security reform. During 2007 and 2008 he was Director of Domestic and Economic Policy for the John McCain presidential campaign. Following the 2008 election Dr. Holtz-Eakin was the President of DHE Consulting, an economic and policy consulting firm providing insight and research to a broad cross-section of clients.

Dr. Holtz-Eakin has held positions in several Washington-based think tanks. He was Senior Fellow at the Peter G. Peterson Institute for International Economics (2007-2008), and the Director of the Maurice R. Greenberg Center for Geoeconomic Studies and the Paul A. Volcker Chair in International Economics at the Council on Foreign Relations (2006). He has also been a visiting Fellow at the American Enterprise Institute, Heritage Foundation, and American Family Business Foundation.

Dr. Holtz-Eakin built an international reputation as a scholar doing research in areas of applied economic policy, econometric methods, and entrepreneurship. He began his career at Columbia University in 1985 and moved to Syracuse University from 1990 to 2001. At Syracuse, he became Trustee Professor of Economics at the Maxwell School, Chairman of the Department of Economics and Associate Director of the Center for Policy Research.

Dr. Holtz-Eakin serves on the Boards of the Tax Foundation, National Economists Club and Committee for a Responsible Federal Budget, and the Research Advisory Board of the Center for Economic Development.

Committee on Oversight and Government Reform
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Name: DOUGLAS HOLTZ-EAKIN

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2008. Include the source and amount of each grant or contract.

- NONE -

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

- NONE -

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2008, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

- NONE -

I certify that the above information is true and correct.
Signature: [signature]

Date: 10/25/11