Health reform created the opportunity to redirect tax incentives to promote greater equity, efficiency, and choice in insurance markets. The opportunity, however, has largely been lost. First, tax credits for insurance will be available only through new health insurance exchanges, not to workers with coverage through their employers, which discriminates against one group of low-income people over another based on where they work, not what they can afford. Second, the “Cadillac” tax on high-cost insurance is intended to improve incentives for efficiency in the health system, but it is only a half step that also creates new inequities. Third, new taxes imposed on insurers and health suppliers will ultimately be paid by consumers, contrary to some claims. Finally, a new Medicare tax fails to stabilize the program’s financing and could have the perverse effect of delaying adoption of difficult policy actions needed to place Medicare on a sustainable fiscal path.

Keywords: health reform, health insurance, Medicare, payroll tax, tax exclusion, tax credits

JEL Codes: H22, I11, I18

“Why do you want to climb Mount Everest?”
“Because it’s there.”
George Mallory, who did not survive the attempt

The United States has a long tradition of using the tax code to implement social policy. A multitude of credits, deductions, exclusions, and exemptions designed to promote specific kinds of consumption and investment decisions have been incorporated in personal and corporate income taxes. The tax code promotes home ownership, saving for retirement, charitable donations, purchases of energy-efficient products, mass transit, farming, and scores of other economic and lifestyle decisions made by families and businesses across the country.

The recently-enacted health reform legislation relies on changes in tax provisions to promote the purchase of health insurance and to raise funds necessary to support new spending programs. The tax mechanism was unavoidable. Experts have been praising...
and criticizing the role of tax incentives in health care for decades, and health reform was a chance to correct past mistakes — and make new ones. It also may have been more palatable politically and more feasible administratively to use the tax system’s existing apparatus rather than create new spending programs run out of the Department of Health and Human Services.

However, just because the opportunity is there does not mean changes in the tax code will achieve our health policy goals or that there will not be serious casualties along the way. Tax credits will be extended only to those who are eligible for insurance sold through health insurance exchanges, which excludes anyone with employer-sponsored coverage. That creates a new inequity in a system rife with such problems, and it could adversely affect the long-term economic prospects of families who stand to benefit most from the new policy. The “Cadillac” tax on high-cost insurance is intended to improve incentives for efficiency in the health system, but it is only a half step that also creates new inequities.

Other new taxes create additional problems. Levies on medical suppliers will increase the cost of care. New taxes on employers will result in some loss of retiree drug coverage and have caused large firms to reconsider whether to offer employee health benefits at all. Higher Medicare taxes on wages and a new tax on investment income will create disincentives for work and investment and will give politicians an excuse to avoid addressing the serious fiscal challenges facing Medicare.

I. MUCH CHANGE, LITTLE REFORM

The new health reform law — the Reconciliation Act of 2010, as amended, in combination with the Patient Protection and Affordable Care Act (hereafter referred to as PPACA) — places new reliance on the tax system to expand federal funding for health care and to enforce new insurance requirements on individuals and firms. According to the Joint Committee on Taxation (2010c), PPACA contains 45 revenue provisions, nearly all having their principal impact on the health sector.1

The Joint Committee lists provisions that use the tax code to implement health policy. The provisions include: (1) the refundable tax credit that subsidizes purchases of health insurance through the exchanges, (2) the tax credit for small businesses that offer health insurance to their employees, (3) a variety of new taxes (including an excise tax on individuals who do not purchase health insurance as well as taxes on insurers, certain health product suppliers, and others), and (4) changes to the tax treatment of various mechanisms used to finance health spending, such as health spending accounts and flexible spending arrangements.

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1 The five exceptions are: (1) requiring businesses to report payments to other businesses equal to $600 or more in a year, (2) expansion of a credit for adoption, (3) elimination of a credit for “black liquor,” a fuel used in the paper industry, (4) penalties for violating the requirement that tax-favored transactions must have economic substance (separate benefits other than the tax benefits), and (5) increases in the required estimated tax payments made by corporations.
Missing from the Joint Committee’s list are other provisions that require guidance from the Internal Revenue Service (IRS) before they can be implemented. For example, the IRS (2010) issued guidance on the tax treatment of health benefits provided as a result of the new requirement in section 1001 of PPACA that dependent coverage of children be extended up to age 26. We can expect to see many more instances in which IRS rulings will effectively determine how a health provision will be implemented.

The magnitude of these changes and their potential impact on the health system is unprecedented. However, there is no assurance that the new tax provisions established by PPACA represent an improvement. Moving vast sums of money around the economy is no indication that the expansion of insurance coverage and greater use of health services that could result will be worth the cost or remain sustainable over the long term.

Gauging the future success of the new legislation depends on what one thinks are the policy objectives. Obviously, one goal was to expand coverage to millions of uninsured Americans. Vice President Joe Biden said another goal was income redistribution — which he called “fairness” (Task, 2010). Other objectives often alluded to during the debate over the legislation include slowing the growth of health spending (“bending the curve”), expanding access to health services (which goes beyond simply giving everyone an insurance card), and paying for the new federal entitlement program without increasing the budget deficit.

Accomplishing such ambitious goals requires fundamentally restructuring the way our nation finances health care and manages the health system, which implies major changes in tax and health policy. Unfortunately, PPACA falls well short of such a restructuring. The opportunity to correct long-standing defects in tax incentives related to health spending has been largely bypassed. Moreover, the new system of insurance subsidies is inequitable and will exacerbate the problems of runaway health spending.

A. Tax Credits Create New Inequities

Tax preferences have had a powerful influence on how health insurance is bought and sold in this country. Most people receive coverage through an employer, at least partly because of the exclusion of employer-sponsored health benefits from personal income and payroll taxes. According to the U.S. Census Bureau (2009), 82 percent of insured people who were under age 65 in 2008 purchased their coverage through an employer. However, those who do not work or who work for employers not offering health benefits — and who often have lower incomes and higher-than-average health needs — do not receive this subsidy and must pay the full cost of their insurance. PPACA creates a new tax credit to help low- and middle-income families buy health insurance; however, the credit is not available to everyone on an equal basis.

The new legislation is an exercise in income redistribution on a scale arguably not previously seen in the health sector. CBO (2009) estimates that $938 billion will be spent to subsidize insurance for low-income individuals over the next decade, through Medicaid expansions, subsidies for insurance purchased on the exchange, and tax credits for small businesses who offer insurance to their employees.
Although tax policy under PPACA is the main focus of this study, it is worth noting an inequity in the way the Medicaid expansion is structured. The poorest families with incomes below 133 percent of the federal poverty level will be assigned to Medicaid, a program that controls cost by paying extremely low rates to health care providers and limiting access to services. Families who become newly eligible for Medicaid thanks to PPACA have an advantage over those who are already eligible. They will be entitled to “benchmark” coverage, currently unspecified but likely to provide more generous benefits than many existing state Medicaid programs. Families who are already eligible for Medicaid — primarily because they have lower incomes than the newly eligible — will have no such guarantee. States could potentially upgrade their benefits for every Medicaid enrollee, but they would do so without the additional federal subsidies available for newly eligible individuals under PPACA. As states are unlikely to take this step, Congress will face pressure to shoulder the full cost of making the new Medicaid rules more equitable.

Families with incomes between 133 and 400 percent of the poverty level will receive refundable tax credits for private insurance purchased through the exchange, but only if they are not already eligible for employer-sponsored coverage (whether or not they are already enrolled in such a plan). With limited exceptions, those who have the ability to buy health insurance through their employer will be required to do so. Individuals who buy employer coverage, regardless of income, will be eligible only for the tax exclusion. As will be illustrated below, the exclusion is less generous than the credit for most workers below 400 percent of the poverty level. These restrictions on access to the tax credits were imposed in an attempt to hold down the budgetary cost of PPACA.

PPACA’s tax credit policy avoids the political and budgetary risk that a more fundamental insurance market reform carries. The limitation on who is eligible for the credit buttresses the employer-sponsored insurance system to the detriment of low-wage workers whose employers offer coverage. Those workers will not be allowed to take advantage of the higher subsidies and potentially greater choice of health plans offered in the exchanges.

Steuerle (2009a) argues that this inequity violates the fundamental principle of equal justice: people in similar circumstances should be treated similarly. Alternatively, some might believe there is rough justice in such treatment. After all, the Kaiser Family

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2 The federal poverty threshold varies by family size and residence and is updated using the Consumer Price Index. In 2009, the federal poverty threshold for individuals living in the contiguous 48 states was $10,830. The poverty threshold for four-person families was $22,050.

3 Medicaid reimbursement rates for health services average about 30 percent less than prices paid by private insurers, according to Shatto and Clemens (2010). In addition, states have imposed a wide array of restrictions on the use of health services by Medicaid patients, with tighter limits in poorer states where, arguably, the need for medical assistance is greater. For example, Alabama limits Medicaid patients to 16 days per year for inpatient hospital services and three non-emergency visits per year to the hospital outpatient department, while Connecticut has no limits on inpatient stays and restricts outpatient hospital visits to no more than one a day. See Kaiser Family Foundation (2010) for an online database describing each state’s Medicaid benefit limitations.
Foundation and the Health Research and Education Trust (2009) found that employers on average contributed 83 percent of the premium for single coverage and 73 percent for family coverage in 2009. However, those employer contributions are not gifts unrelated to worker productivity, and they come at the expense of lower wages than the worker would otherwise receive. Instead of rough justice, PPACA creates rough injustice for low-wage workers forced to purchase their employer’s plan instead of shifting to the exchange.

An example inspired by Steuerle (2009b) illustrates the magnitude of the inequity. Consider a family of four with a single earner and a household income of $48,000 (or twice the federal poverty level in 2016) who purchases the “silver” insurance plan specified in PPACA. According to CBO (2009), the premiums for such a plan would come to $14,100. If the family buys insurance through the exchange, they would be eligible for a tax credit equal to $11,076. From the employer’s perspective, the cost of hiring the head of this family is the wage income ($48,000), the employer’s share of payroll taxes ($3,672), and the penalty incurred because the employee did not buy the employer’s coverage ($2,000), which equates to total compensation of $53,672.

If, instead, the family purchases the identical health coverage from the employer, they would save about $3,194 from the exclusion of the premium from income and payroll taxes. The exclusion savings, however, represent a $7,882 loss when compared to the tax credits available through the exchange, even though it is the identical family buying identical health coverage.

Buying employer coverage has another adverse consequence. If total compensation is to remain constant at $53,672, the full cost of the insurance must come out of wages — and money wages must fall. Once the market equilibrium has been established, the firm pays the worker $36,760 in wages, $14,100 in the health “benefit,” and $2,812 in the employer’s share of payroll taxes. In other words, instead of remaining at 200 percent of the poverty level, the requirement to buy employer coverage forces the family down to approximately 150 percent of the poverty level.

After buying health insurance, how do the situations of the two families compare? In the first case, the family buying insurance on the exchange receives wages of $48,000 and pays premiums of $3,024, leaving just under $45,000 to spend on goods other than

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4 This is known to economists as a compensating wage differential; see Rosen (1986).
5 PPACA specifies four levels of insurance according to the percentage of benefit costs paid by the plan. “Bronze” covers 60 percent of costs for the average enrollee, “silver” 70 percent, “gold” 80 percent, and “platinum” 90 percent. More generous coverage is required for lower-income enrollees.
6 Actual penalty amounts vary depending on firm size, whether the firm offers health benefits, and how many workers receive the tax credit in the exchanges.
7 This assumes a marginal income tax rate of 15 percent plus the employee’s share of the payroll tax. For simplicity additional savings from state and local income taxes are ignored.
8 In equilibrium, a worker is paid the value of his productivity regardless of how compensation is structured between wages and benefits. Reaching equilibrium in response to a policy change could be a lengthy process with some workers receiving significant rents over an extended period of time.
health care. In the second case, the family has only $36,760 to spend after buying insurance through the employer — an 18 percent reduction in disposable income.

That is not the end of the story, however. PPACA requires more generous insurance coverage for low-income people under the reasonable assumption that deductibles and copayments could be unaffordable for them. Low-income families are eligible for reduced cost sharing requirements, but only if they buy their insurance through the exchange. The “silver” plan available through the exchange must cover 85 percent of covered medical expenses for families between 150 and 200 percent of the poverty level. The “silver” plan from an employer need only cover 70 percent of expenses. Thus the plan offered in the exchange will save the family in our example $150 for every $1,000 they incur in out-of-pocket expenses.

In addition to the obvious inequities of this subsidy scheme, the new system creates strong incentives for employers to drop insurance coverage or structure their businesses to take advantage of subsidies in the exchange. Many small firms and companies with a primarily low-wage or part-time workforce that currently offer health insurance will be tempted to drop that coverage. Kaiser Family Foundation – Health Research and Educational Trust (2009) reports that 39 percent of firms with more than a third of their workforces earning less than $23,000 a year offered health benefits in 2009. Similarly, 32 percent of firms whose workforces were predominately part-time employees offered benefits. Those figures are likely to drop in 2014 when the reforms become effective.

Large firms will have an incentive to reorganize so that their workforces become more homogeneous, at least in terms of income. Such companies could reduce costs by contracting out housekeeping functions (such as security, office cleaning, and other jobs that do not require a high level of skill), perhaps by spinning off those jobs into new organizations set up solely to take advantage of the tax credits in the exchanges. The reshuffling would benefit the affected employees in the short run, but is likely to reduce their job security, productivity, and wage growth over the longer term.

There is no doubt that a great deal of time and money will be spent by workers and their employers trying to determine the best way to proceed through the complications of the new subsidy structure. The danger is that focusing on only a few prominent features of PPACA could drive decisions that will prove to be unwise when the broader picture (including aspects of the tax code that are not directly altered by PPACA) is taken into account. However, the inequities of the new tax subsidies cannot be erased by even the most astute strategic behavior.

B. Cadillac Tax Stalls Out

Developing a new (and ideally more sensible) subsidy for health insurance is only part of the policy challenge. An effective reform would also abolish existing subsidies that fail to meet policy objectives, such as promoting equity and efficiency in the health
market. PPACA failed to establish an equitable tax credit policy, and it also failed to
repeal the inequitable tax exclusion for employer-sponsored health insurance.

Economists have long recognized the budgetary and efficiency costs of the tax pref-
point out that the subsidy, “… causes a substantial revenue loss, distributes these tax
reductions very regessively, encourages an excessive purchase of insurance, distorts
the demand for health services, and thus inflates the price of these services.” The tax
exclusion has contributed in no small way to the difficult situation we find ourselves in
today: health spending is growing at an unsustainable pace and the incremental value
of that spending (in terms of its contribution to health and well-being) is falling behind
the cost.9

The tax exclusion promotes the purchase of health insurance through employers
and favors high-benefit, high-premium insurance over coverage that relies on either
managed care techniques or beneficiary cost-sharing to limit costs. The exclusion also
favors high-income workers, who arguably have more disposable income to pay for
their insurance coverage than workers earning less. Furthermore, the exclusion is an
open-ended entitlement — the greater the health insurance premium, the greater the
tax savings, without limit.

Under severe budget pressure to find funds necessary to pay for insurance subsidies
through a new refundable tax credit, policymakers agreed to limit the subsidy offered
through the exclusion. Congress could have capped the amount of the exclusion, treat-
ing as taxable income any contributions to premiums above the cap. Instead, PPACA
left the exclusion untouched and imposed an excise tax on high-cost insurance plans.
This “Cadillac tax” is a 40 percent levy on health coverage in excess of $10,200 (for
an individual policy) or $27,500 (for a family policy). Those thresholds grow at gen-
eral inflation plus one percent, which is substantially below the trend rate of growth of
insurance premiums.

Although both approaches would reduce the tax incentives to purchase more expensive
coverage, the Cadillac tax has serious drawbacks. First, the initial incidence of the tax
is regessive and would be paid by everyone in the firm, equally and without regard
to their ability to pay.10 Since PPACA requires workers to buy their employer’s plan if
one is available — and, as will be discussed below, a large majority of employers only
offer one plan — low-wage workers will not be able to avoid buying coverage that
could be beyond their means. The tax makes that coverage even more unaffordable.
Worse yet, by paying the same amount of tax, low-wage workers essentially subsidize
high-wage workers in the firm.

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9 Many have observed this connection between tax policy and health spending, including Aaron and Burman
(2008).

10 In equilibrium, firms will reduce the generosity of their health plans to avoid the tax. However, the tax
thresholds are indexed by the Consumer Price Index, which grows slower than health care spending. Hence
an increasing proportion of employer plans will be subject to the tax.
Low-wage workers will bear a disproportionate burden of the tax, relative to income, even in the long-run. If benefits in the employer’s plan are reduced to stay below the tax threshold, low-wage workers will have to pay a greater share of their income than an equally healthy high-wage worker to cover copayments and other out-of-pocket costs. In addition, the Cadillac tax creates a new issue at the collective bargaining table. The employer will be pressured to increase his contribution to the now-more expensive health plan, even though that contribution is paid for by workers who receive lower pay raises or who are not hired in the first place. A bolder and more sensible alternative is to eliminate the tax exclusion entirely rather than stopping at partial measures. Preferential tax treatment for employer coverage, even if reduced, perpetuates a system that has dampened wage growth, limited workers’ health plan choices, and fueled unsustainable growth in health spending.

Total compensation (wages plus benefits) cannot persistently exceed the value of the workers’ productivity. Rapidly rising health costs have depressed wage growth as employers have increased their contribution to premiums — a trend fostered by the tax exclusion, which makes a dollar of health benefits worth more than a dollar in wages. Moreover, most firms — 86 percent of those offering health coverage in 2009, according to Kaiser Family Foundation – Health Research and Educational Trust (2009) — offer only one type of health plan. The offering of only a single plan means their workers do not have the option to buy a more or less expensive plan unless they seek coverage elsewhere.

Wiping the slate clean of perverse tax incentives would allow policymakers to design a system of subsidies unburdened by the political deals of the past. However, some analysts believe such a policy could disrupt the employment-based insurance market. The main justification for either the Cadillac tax or a cap on the exclusion instead of outright repeal is to preserve employer-sponsored insurance as an effective way of organizing groups to share financial risks.

The claim that tax subsidies are necessary to maintain such coverage after more than six decades of experience seems strained. Such plans provide convenience to workers, as those workers do not have to go to the trouble of sorting out insurance options themselves, and they serve as a tool for firms recruiting and retaining good workers. However, it is likely that some firms would drop their plans if the exclusion was entirely eliminated. Such an exodus could create serious disruption if repealing the tax exclusion was the only policy change, without other insurance market reforms. PPACA, however, creates health insurance exchanges that are intended to facilitate the purchase of insurance, and it provides substantial subsidies in the form of refundable tax credits to make that coverage affordable. Such policies are intended to expand the non-group insurance market and make it function better.

Congress could have taken advantage of the impetus for reform to give all consumers more opportunities to purchase insurance that is right for them, converting the tax exclusion into a portable tax credit that could be used for either employer or non-group coverage. Instead, Congress required workers to purchase insurance from their employers rather than from the exchange, denying those workers access to the more generous
tax credits offered with the exchange. Thus an opportunity to rationalize the way health insurance is subsidized and purchased in this country was lost.\footnote{Replacing the exclusion with a portable tax credit is a necessary but not sufficient condition for rationalizing the subsidy for health insurance. The other element to consider is what one can purchase with that credit. Excessive regulation that limits the range of insurance choices reduces the value gained by consumers from being able to purchase coverage from any seller (including their employer).}

Will the Cadillac tax be implemented? That is far from certain. Labor unions have opposed changes in the tax exclusion because many of them have negotiated very generous and expensive coverage from their employers. The Senate bill passed in December 2009 included the Cadillac tax, with thresholds of $8,500 (individual) and $23,000 (family). The Washington Post (2010) reports that the President subsequently negotiated a deal that raised the premium thresholds and exempted collective bargaining plans until 2018. In the face of adverse public reaction, the thresholds were raised again and the tax was delayed to 2018 for everyone, giving ample time for a future Congress and President to avoid an unpopular policy.

C. New Taxes, New Problems

PPACA relies on a host of taxes (in addition to the Cadillac tax) levied on firms in the health sector, employers, and individual tax payers to finance insurance subsidies and Medicaid expansions. The burden of these taxes will fall more heavily on middle class families than has been claimed by political proponents. Moreover, the reform bill’s heavy reliance on tax financing exacerbates the more difficult challenges of slowing the growth of health spending and putting Medicare on a fiscally sustainable path.

1. Who Pays Health Industry Taxes?

Excise taxes on the pharmaceutical industry, medical device manufacturers, and insurers were justified by advocates as raising the “contribution” of those industries to reform. Beginning in 2011, manufacturers and importers of branded drugs will pay a fixed annual fee totaling $27 billion through 2019, according to the Joint Committee on Taxation (2010a). Domestic sales of medical devices ranging from bedpans to orthodontic appliances to surgical instruments will be subject to a 2.3 percent excise tax beginning in 2013, generating $20 billion in revenue over its first seven years. Insurers will pay an annual fee beginning in 2014, which will yield $60 billion in revenue through 2019. That tax continues to be collected when the Cadillac tax is imposed in 2018.

It may have been easier politically to tax health suppliers, but consumers — patients who use the taxed medical products and anyone who purchases insurance regardless of their health needs — bear most of the burden. Because insurance covers much of the cost of prescription drugs and medical devices, the tax on those products will raise insurance premiums and could push up consumer payments for deductibles, copayments, and other forms of cost-sharing.
The excise tax on insurers will also cause premium increases. However, because the tax is applied only to fully-insured plans, the burden will not be equally shared by everyone who buys coverage. That means insurance sold through the exchange and offered by smaller firms will be taxed. “Self-insured” plans, which are the most common type of plan among large employers, are exempt from the tax. According to the Employee Benefits Research Institute (2009), 88 percent of workers in businesses with three to 199 employees are in fully-insured plans and will be subject to the tax. Only 14 percent of workers in firms with 5,000 or more employees will have to pay the tax. Hence many middle class workers will face higher taxes as a result of health reform, contrary to the original assertions.

2. Will Employers Retain Health Benefits?

Business reaction to one of the new employer taxes has already caught some congressional Democrats by surprise. Changes in the tax treatment of federal subsidies to employers who offer prescription drug coverage to retirees enrolled in Medicare resulted in large write-downs by a number of high-profile companies. In the ensuing controversy, confidential company records obtained by House Energy and Commerce Committee Chairman Henry Waxman revealed that those firms have begun to reassess whether they should continue to offer health benefits in a post-reform world (House Energy and Commerce Committee, 2010).

When the Medicare Part D prescription drug benefit was enacted in 2003, Congress offered a tax-free subsidy to encourage employers to offer their own retiree drug benefit. According to Fronstin (2010), this subsidy will cost taxpayers $665 per eligible retiree in 2011 while Part D coverage will cost the federal government $1,209. By making the subsidy taxable at the 35 percent corporate rate, PPACA requires employers to pay an additional $233 in federal income taxes per retiree and creates an incentive for employers to drop their retiree drug coverage.

The loss of this tax break is substantial for large firms. AT&T recorded a $1 billion non-cash expense in the first quarter of 2010, Verizon wrote down $970 million, and Caterpillar reported a $100 million write-down. Reacting to these filings, Rep. Waxman called a hearing and asked for all documents relevant to the write-downs. Those documents reveal that the firms are assessing how PPACA will change their cost of providing health benefits to their workers. Companies could substantially reduce their compensation costs by dropping health benefits (for both active and retired workers), paying a $2,000 fine per worker, and allowing them to purchase insurance through the exchanges. Moreover, their lower-wage workers are likely to pay a lower premium in the exchanges than under the company’s plan.

That calculation does not necessarily mean large firms will drop coverage. Health benefits are an important tool in recruiting a company’s work force, and dropping coverage could be very disruptive to workplace morale. Furthermore, such an action would be subject to collective bargaining challenge in unionized firms. Nonetheless, this incident demonstrates the potential for adverse employer reactions to tax changes in PPACA.
Another major source of revenue to cover the cost of expanded federal subsidies for insurance is an increase in the Medicare tax paid by high-income families. Based on responses to previous tax provisions, we can expect high earners to take actions to minimize the tax consequences of these provisions, including shifting away from wage compensation, shifting investment portfolios to defer income, and reducing work effort.\(^{12}\) Because the new revenue flows through the Medicare Hospital Insurance (HI) trust fund before being spent, these provisions also provide the illusion that Medicare’s fiscal crisis has been delayed for a number of years. That reduces the chances that policymakers will take the responsible but difficult actions necessary to maintain the program’s finances.

PPACA increases the Medicare payroll tax rate by 0.9 percent, for a total rate of 3.8 percent, for individuals earning more than $200,000 annually, and for families earning more than $250,000. In addition, these tax filers will also be subject to a 3.8 percent tax on income from investments. These provisions take effect in 2013. According to the Joint Committee on Taxation (2010a), these higher taxes will increase federal revenue by $210 billion through 2019. With that much money at stake, high earners will take actions to reduce their tax burden even though such actions are likely to be economically inefficient.

The more pernicious impact of the new Medicare tax is on the political process. Foster (2010) reports that the tax (combined with reductions in payments for some services covered under Medicare Part A) will extend the trust fund’s solvency from 2017 to 2029. However, the revenue collected through the new tax will also be used to offset the cost of new insurance subsidies created by PPACA for people under age 65. Nevertheless, that does not mean each dollar can be spent twice. Money that is not needed to pay current Medicare outlays is spent by other programs (or, very rarely, used to buy back some of the government’s debt), and an IOU in the form of a special Treasury bond is issued to the HI trust fund. CBO (2010) estimates that PPACA adds $358 billion plus interest that accrues over time to the HI trust fund.

Higher trust fund balances do not accurately reflect the government’s ability to finance future Medicare benefits. One needs to consider the balance of spending and revenue across the entire government as reported in the unified budget. As CBO (2010, p. 3) observes, “… only the additional savings by the government as a whole truly increase the government’s ability to pay for future Medicare benefits or other programs.” PPACA channels most of the increased federal revenue into a new health care entitlement, some of the cost-saving provisions are unlikely to be fully implemented, and the legislation does not include other health spending increases (including increases in Medicare physician payments) that are virtually inevitable.

On balance, health reform probably decreases the government’s ability to pay for future Medicare benefits, with new spending commitments exceeding the likely new

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\(^{12}\) Feldstein (2008) discusses such behavioral responses to changes in tax rates and the deadweight loss, or loss of economic efficiency, that these tax-induced adjustments create.
revenue and cost savings. Unfortunately, a full and accurate accounting is very difficult to construct, and politicians are drawn to simple numbers that tell only part of the story. Medicare’s HI trust fund insolvency date is such a statistic, and its shift ahead by more than a decade will likely give credence to the erroneous view that serious attempts to restrain Medicare spending are not needed for years to come.

II. CONCLUSION

In fundamental ways, the tax system is the engine that drives health reform. Tax subsidies for health insurance promote health spending far in excess of the subsidy.13 The tax system is used to enforce the insurance mandate. New taxes generate about half of the money needed to finance the new subsidies. IRS interpretations will strongly influence how legislative provisions that do not directly affect the tax system will be implemented. However, the impact of the tax system on the health system is not easily predicted. What is more predictable is the urge that policymakers feel to go back to the tax well when the cost of the new health system exceeds the government’s fiscal capacity.

The health reform legislation already is adding to political pressure for a value-added tax (VAT) to help pay for the newly expanded government promises of more generous social programs. Layering on a new tax is an expedient to avoid facing difficult decisions about what level of government support Americans should expect and what they are willing to pay for. If we expect to solve our serious fiscal problems, we must take responsible steps to slow the growth of health spending.

The contradictions in current policy are striking. Increasing the demand for health services through greater subsidies for insurance will not solve the health spending problem. Raising revenue through an add-on VAT will not solve the health spending problem. At some point, policymakers will be forced to address the more fundamental issue, and changes in the tax incentives for health spending will be important tools in achieving a sustainable health financing system.

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13 According to the Joint Committee on Taxation (2010b), the exclusion from income taxes of employer contributions to health insurance premiums, the deduction of premiums by the self-employed and by certain displaced workers, and the premium subsidy for COBRA continuation coverage generated a tax expenditure totaling $107.6 billion in fiscal year 2009. Health spending paid for by private insurance was about $824 billion over the same time period (author’s calculations based on Truffer et al. (2010)).
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