DISPELLING MISCONCEPTIONS ABOUT THE EXCISE TAX

The excise tax would force a broad swath of the middle class to pay for health reform in the form of higher taxes, reduced coverage, and higher out-of-pocket expenses. The tax would thus violate two fundamental commitments of health reform: that workers should be able to keep the coverage they have, and that their health care benefits should not be taxed.

The excise tax would have a broad impact, even within its first decade. The excise tax would affect 34 percent of health plans for individuals and 31 percent for families in 2019, according to the Joint Committee on Taxation (JCT).

Over time the excise tax would affect lower and lower cost plans. Threshold levels would rise much more slowly than project plan cost growth, exposing more and more lower-cost plans to the tax. *Without hitting a broad swath of the middle class, the excise tax would not raise significant amounts of revenue*.

The intended effect of the excise tax is a massive reduction of employer-provided coverage, followed by a broad middle class tax increase. Insurers and employers are expected to cut plan costs to avoid the tax as soon as they are able to do so. CBO and JCT assume employers would then increase workers' wages to compensate for the benefit cut. Payroll and income taxes paid on these wages accounts for 81 percent of revenues generated by the excise tax.

The excise tax would reduce employer-provided health coverage by $130 billion in 2019, according to JCT figures. Insurers and employers are expected to reduce plan costs first by eliminating dental and vision coverage, then by requiring more cost-sharing in the form of higher co-payments, higher deductibles, and higher out-of-pocket maximums, then by restricting coverage of core benefits.

The excise tax is a backdoor way of taxing workers' health care benefits. Assuming employers replace these benefit cuts with higher wages, the result would still be a massive tax increase on the middle class—*because health benefits are not currently taxed and wages are*. This proposal would result in a tax increase for 31 million taxpayers—including one quarter of all taxpayers with incomes between $50,000 and $75,000—of over $1,300 on average in 2019, according to JCT.

Reducing employer-provided coverage is not the same thing as "bending the cost curve." The excise tax is not projected to bring down the cost of health care services or national spending on health care within the 10-year budget window in which employer-provided coverage would be eroded. It would simply shift more of the costs of health care onto the backs of workers. It is often assumed that making workers pay more for their health care is a good thing because it will get them to stop seeking wasteful and unnecessary care, but *the enormous waste in our health care system is not driven by consumers*. Eighty percent of health care spending is for the 20 percent of the population with the most severe health problems; these are not people who demand care because

their insurance covers it. Most treatments occur because doctors recommend them, regardless of coverage. *The key to reining in health care spending is to get providers to deliver care in more cost-effective ways*. Increasing out-of-pocket costs for workers may actually lead them to forgo necessary care and make counterproductive health care decisions, driving up national health care spending.

The excise tax would affect plans that exceed the thresholds for reasons that have nothing to do with "gold-plated" benefits. Within one year of implementation, the excise tax would hit the most popular single coverage plan under the Federal Employee Health Benefits Plan (FEHBP). And the actuarial consulting firm Milliman concludes, "Whether someone hits the [excise tax] ceiling is not so much driven by benefit richness as it is by age, gender, profession, health status, and the geography of the covered population."

Union plans especially are affected by these factors. Union workers are older than non-union workers. They are also concentrated in high-cost states: 16 of the 20 states with the highest health costs have above-average rates of union coverage. Union workers are concentrated in occupations with high incidence rates of work-related injury and illness that result in lost time from work. And with regard to 10 self-reported chronic diseases, union members have a 10 percent higher chronic disease burden, on average, because of their higher average age.

Union plans are not "gold-plated." Union members are 3 percent more likely than non-union members to be in HMO plans. The AFL-CIO's review of a sample of affiliate plans shows that they do not cover services that are medically unnecessary—such as botox, cosmetic surgery, or yoga classes. Their provisions for co-pays, deductibles, and co-insurance vary, but are roughly comparable to—or slightly lower than—the FEHBP Blue Cross Blue Shield standard option. They do have out-of-pocket caps that are significantly lower than FEHBP.

Households with the highest incomes should pay their fair share. Tax cuts since 2001 have disproportionately benefited the richest five percent of Americans. One alternative to the excise tax is an income tax surcharge that would effectively require the wealthiest one percent to give back some, but not all, of the Bush tax cuts. Another is the President's proposal to limit itemized deductions for the very wealthy, which would affect only the top 1.3 percent of taxpayers. Another is to apply the Medicare payroll tax to unearned income; 73 percent of this tax would be paid by the wealthiest one percent of taxpayers, and over 90 percent would be paid by the wealthiest 5 percent.

The public option and "pay or play" would reduce the cost of health reform. A robust public option would save $110 billion in the tri-committee House health reform bill. The requirement that employers "pay or play" would raise over $160 billion in the tri-committee bill.