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CHAPTER 5

The Politics of Taxes in the Affordable Care Act

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In 2010, Congress passed the Patient Protection and Affordable Care Act (ACA), often referred to (with President Obama's approval) as Obamacare. The stated intention of the law was to extend health insurance coverage to more uninsured individuals and to lower healthcare costs for everyone. This twofold goal presents an obvious challenge, because if more people have health insurance coverage, this by itself should cause healthcare costs to rise. Health insurers are third-party payers. If people pay their own healthcare costs out-of-pocket, they have an incentive to economize on their use of the healthcare system. If a third party pays, the marginal cost to the user goes down, so the user would be expected to demand more. Similar incentives exist on the supply side. If a doctor is deliberating about a treatment for a patient, the doctor and patient have an incentive to discuss the costs that would be imposed on the patient, but with a third-party payer, someone else bears the cost, so both patients and healthcare professionals have less of an incentive to control costs.

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The ACA's goal of broadening coverage requires an increase in revenues to fund it, regardless of the rhetoric of cost reduction, and the fact that the ACA includes new taxes appears to acknowledge that it will cost more.

Some provisions in the ACA might work to offset these supply and demand effects and to control prices, but the ACA does mandate new taxes and does not lower or remove any existing taxes. The ACA was controversial to begin with, and taxes are always unpopular. Thus, the architects of the ACA had every incentive to design the taxes to finance it in such a way as to minimize political opposition. They did this by designing the taxes in the Act so that it would appear to most people as if others would pay those taxes, and sometimes by claiming that taxes to finance the ACA were not actually taxes. This disguising of the taxes to finance ACA was done in several ways. One strategy, which Holcombe (1997) notes is frequently used, was to place taxes on groups who were a clear minority of the population, and often a minority that many people would say could afford the taxes and maybe even deserved to be taxed. Another strategy was to place taxes on the least visible, and least resistant, side of the market. And, as already noted, another strategy was to deny that the taxes were taxes.

The ACA was a very prominent and controversial piece of legislation, but the lessons in its passage are more generally applicable to the design of taxes to finance all government programs. When costs of programs are designed to be less transparent, political opposition from those who bear the costs can be reduced, which raises the chances of passing the programs. This chapter looks at the politics behind the design of the taxes that are used to finance the ACA. Many other aspects of the ACA have provoked controversy and discussion, including its mandated benefits and the fact that many people who had health insurance prior to the ACA had their policies canceled as a result of the Act's provisions. This chapter is more narrowly focused on how the taxes in the ACA were designed to maximize political support for the passage of the Act.

EXPERT COMMENTARY

While economists have developed an extensive framework for designing optimal tax policies, economists do not actually design taxes. Taxes are a product of the political process, so the taxes that actually exist are those that are most politically palatable rather than those that are the most equitable or economically efficient. The ACA was controversial enough that its designers did not want the tax cost of the program to stand in the way of its adoption.

They wanted the Act's tax provisions to be as inconspicuous as possible and to appear as benign as possible. The idea of hiding the costs of the ACA from those who are paying them was not lost on the designers of the Act. MIT Professor Jonathan Gruber, one of the architects of ACA,¹ was quoted extensively in the news media in November 2014, giving lectures in which he makes this clear.² In one talk, Gruber said,

This bill was written in a tortured way to make sure CBO [Congressional Budget Office] did not score the mandate as taxes. If CBO scored the mandate as taxes, the bill dies. Okay, so it's written to do that. In terms of risk rates subsidies, if you had a law which said that healthy people are going to pay in—you made explicit healthy people pay in and sick people get money, it would not have passed. . . . Lack of transparency is a huge political advantage. And basically, call it the stupidity of the American voter or whatever, but basically that was really really critical for the thing to pass. And it's the second-best argument. Look, I wish Mark was right that we could make it all transparent, but I'd rather have this law than not.³

Look at Gruber's statement sentence by sentence to see what he is saying about the design of ACA. The first sentence discusses the individual mandate—the requirement that everyone have health insurance or pay a penalty for not being insured. The penalty is the higher of \$695 per uninsured person or 2.5 percent of annual household income.⁴ The penalty is collected by the IRS, paid at the time that individuals file their tax returns. But note that even though the IRS is collecting the money along with income taxes, Gruber makes it clear that calling the mandate a tax would mean the political death of the ACA.

However, when the ACA was challenged on constitutional grounds, the Supreme Court upheld the law, with Chief Justice Roberts writing in his opinion, "The Affordable Care Act's requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax. . . . Because the Constitution permits such a tax, it is not our role to forbid it, or pass upon its wisdom or fairness."⁵ The Supreme Court says that for the ACA to be constitutional, the individual mandate must be interpreted as a tax, whereas Gruber says that if it were presented to the public that way, the Act would not have passed.

The next sentence refers to the rate structure that overcharges young policyholders, who tend to have lower healthcare costs, in order to undercharge older policyholders, who tend to have higher healthcare costs. The Act also prevents insurers from taking into account preexisting conditions when determining premiums. Again, Gruber says that if this subsidizing of policies for the old and sick by overcharging the young and healthy were made transparent, the ACA would never have passed. He notes, “Lack of transparency is a huge political advantage.” Gruber makes it clear that hiding the true costs of ACA was instrumental to its passage. He then goes on to call the American voter stupid.

In another presentation, Gruber said, “We have experimented with choice in public insurance: Medicare Part D. . . . Typical senior has 50 PDPs [Prescription Drug Plans] to choose from. . . . Seniors do a terrible job choosing [the best one].”⁶ In this case, Gruber is going further than calling voters stupid; he is calling consumers stupid. While the same physical people play the roles of voters and consumers, those people face very different incentives when they vote and when they buy things with their own money.

Referring to the tax the ACA places on so-called Cadillac insurance plans, Gruber said that part of the legislation was made more palatable “first, by mislabeling it, calling it a tax on insurance plans rather than a tax on people and we all know it’s really a tax on people who hold those insurance plans.”⁷ People are more sympathetic to taxing insurance companies, which they view as impersonal and profitable corporations, than they are to taxing people who are trying to buy health insurance. But, as noted below, there is more to this Cadillac tax than most voters realize.

SELLING THE ACA TO VOTERS

Economic models of taxes and public expenditures are heavily oriented toward deriving optimal policies and often ignore the political challenges that impede getting optimal policies designed and passed. Models of optimal taxation, like Ramsey (1927), Diamond and Mirrlees (1971a, b), and Mirrlees (1971, 1976), are oriented toward designing a tax system that minimizes the excess burden of taxation or that maximizes the well-being of society. In fact, real-world tax systems are not designed by economists who are trying to implement efficient or equitable optimal tax policies. They are designed by politicians who are trying to implement tax systems that will minimize political opposition so they can be approved through the political decision-making process, and that will not negatively impact those politicians’ brand name capital. Politicians

avoid politically unpopular taxes, and the economic efficiency of taxes is at best a secondary consideration. Politicians will not support taxes that will harm their chances to advance their political careers. Taxes are designed through the political process to maximize political support, not to maximize social welfare.

Thinking about the design of tax systems in a supply and demand framework, policymakers supply and voters demand public policy measures that contain tax provisions, like the ACA. Economic models are prone to derive optimal policies and implicitly assume that government is an omniscient benevolent dictator that will do what is optimal. But as Holcombe (2012) notes, government is not omniscient, it is not benevolent, and it is not a dictator. Government is a group that makes collective decisions by designing policies that maximize political support. As Jonathan Gruber noted, lack of transparency enabled the passage of the ACA, which would not have garnered political support had voters actually understood it. The ACA provides a good case study to see why, in general, economic models that depict government as an omniscient benevolent dictator are inappropriate for understanding public policy outcomes.

In most cases, policymakers cannot obtain all the information necessary to design an optimal policy, as Holcombe (1998, 2002) notes, so government is not omniscient. One reason, especially applicable to the ACA, is that the value of goods and services (e.g., health insurance provided under the Act) cannot be calculated in the absence of market prices, an argument that goes back to Mises ([1922] 1951) and Hayek (1945). With insurance companies acting as third-party payers, consumers do not face the full cost of their health care, and so they will demand a larger quantity than if they had to pay the full cost themselves. By the very design of the program, government cannot obtain sufficient information to design an optimal health insurance market.

Government is not benevolent. Policymakers often face incentives that go against the public interest, and policymakers, like everyone else, respond to incentives. Elected officials face the challenges of retaining political support and getting reelected. Bureaucrats are not residual claimants in the programs they oversee, so they do not have incentives to make them operate efficiently, and, as Tullock (1965) and Niskanen (1971) suggest, often have incentives to make them operate inefficiently. Applied to the ACA, the taxes incorporated into the Act were designed to enable it to get political support, as Jonathan Gruber noted, rather than to be economically efficient or optimal. The taxes were designed to be politically optimal, which is different from being economically optimal. The political realities were an explicit part of Gruber's second-best argument.

Government is not a dictator. This goes to the heart of the preceding discussion. To implement the ACA, its supporters needed to design it so that it would win the approval of the American public and get the support of a majority in Congress. As Professor Gruber's comments above indicate, the designers of the Act realized that they could not just write it as they thought was best—and most transparent—but had to disguise what the Act actually contained to make it politically palatable. The lack of transparency was an intentional trait of the Act's construction, to allow it to garner the support it needed to pass. If government was a dictator, it would just pass the Act it wanted, but because it is not, the Act had to be designed to get the political support of a number of groups, including a majority of those in Congress, and the general public.

Professor Gruber referred to the stupidity of the American voter, but a public choice approach to voter behavior might give a more charitable interpretation to voter behavior. Downs (1957) notes the incentive for voters to be rationally ignorant because the probability that they will cast a decisive vote is so small. Brennan and Lomasky (1993) note that because voters realize their individual votes will not be decisive, they tend to vote expressively. In this case, they might support the ACA not because of its specific provisions but rather because they want to express support for the general idea of providing more healthcare security to Americans. This might be a significant factor in the design and passage of the ACA. The Act was sold as a way to extend health insurance coverage to those who did not have it, who could not afford it, and who had preexisting conditions that made it unobtainable for them. These all sound like desirable goals, so voters might feel good about supporting those goals without having to consider whether the ACA could actually accomplish them, because they know they will not cast decisive votes. They can support candidates who campaign on desirable outcomes without having to consider whether they can implement policies that would actually accomplish those goals.

Caplan (2007) goes a step further to argue that because no election is decided by a single vote, so one voter will not change the election outcome, voters bear no costs from supporting policies that impose costs on them or are not in the public interest. Because they bear no personal cost from voting irrationally, they can and do vote to support irrational policies and those that can make everyone worse off. The idea that Congress can pass a law that will provide health insurance to more people and mandate an expansion on what insurance must cover while lowering healthcare costs would seem to be irrational. That is not intended to pass judgment on the overall desirability of the

ACA, but merely to note that it may be irrational to expect the ACA to both provide more coverage and do so at lower cost.

Perhaps voters are stupid, as Gruber suggests, but models of rational economic behavior indicate why voters have little incentive to understand the true costs of any legislation and why they can be easily deceived by architects of legislation. They have little incentive to be informed, they will often vote expressively, and they pay no price for voting irrationally. It makes sense, from a policymaker's perspective, to design legislation so that it hides the costs of legislation from those who will bear those costs. A more detailed analysis of the tax provisions of the ACA will illustrate how this was done.

TAX SHIFTING

A well-known principle of taxation is that the people who end up bearing the burden of a tax are not necessarily the people on whom the tax is initially placed. When a tax is placed on producers or consumers in a market, the tax is shifted toward the more inelastic side of the market. Furthermore, it does not matter whether the same tax (say, a 5 percent excise tax) is placed on the suppliers in a market or the demanders. The ultimate burden on suppliers is the same in either case, and the ultimate burden on demanders is the same in either case. If the elasticity of supply is the same as the elasticity of demand, the ultimate burden of the tax will be shared equally between suppliers and demanders. If the elasticities are different, the burden is shifted toward the more inelastic side of the market, and in extreme cases, a perfectly inelastic supply or demand would shift the entire tax to that side of the market while a perfectly elastic supply or demand would shift the entire tax to the other side of the market.

For political purposes, these principles of tax shifting suggest placing the taxes to help finance the ACA on the supply side of the market. One reason is that the typical voter does not understand the concept of tax shifting, so placing taxes on insurers and healthcare providers appears to them as taxing the people who are making all the money from healthcare provision. The insurance companies, doctors, and hospitals can afford the taxes; often, the healthcare consumers cannot. Thus the strategy is to design taxes so that it appears to most people that someone else is being taxed.

In fact, the demand for health care is inelastic, partly because when people have health issues, they are very inclined to address them, and partly because, as already noted, when third-party providers are paying for the health care so there is little out-of-pocket cost to the consumer, consumers will not be very

price conscious.⁸ Inelastic demand means that consumers will end up bearing the burden of those taxes. For this reason, even though the tax appears to be placed on the suppliers of health care, suppliers have less reason to put up political opposition than demanders would, because the taxes will be shifted away from the suppliers in any event. Consumers will have a hard time seeing this because it is not their out-of-pocket costs that will increase; it is the cost of their insurance. Ultimately, insurance companies must cover the cost of the payments they make with the premiums they collect. These principles of tax shifting and public choice can help illuminate the reasoning behind the tax provisions in the ACA. The next several sections examine some of the ACA's taxes using this framework.⁹

The Individual Mandate

The individual mandate was discussed above as having been deliberately designed to disguise its being a tax. Jonathan Gruber is quoted as saying that the Act would not pass if the individual mandate were called a tax, so the ACA's architects constructed the law so it would not appear so. Also, as noted above, the Supreme Court determined that the individual mandate was constitutional only if the charges that were to be levied on the uninsured were construed as a tax. This creates the curious situation (pointed out by critics) that the ACA's supporters claimed the individual mandate was not a tax to pass the legislation but claimed it was a tax to keep it from being ruled unconstitutional. In an interview prior to the Supreme Court's upholding the mandate, George Stephanopoulos asks President Obama, "But do you reject that it's a tax increase?" to which the president answers, "I absolutely reject that notion."¹⁰

On the healthcare.gov website, the mandate is referred to as a fee, and the site answers the question "What happens if I don't pay the fee?" by saying "The IRS will hold back the amount of the fee from any future tax refunds. There are no liens, levies, or criminal penalties for failing to pay the fee."¹¹ The fee is collected by the IRS, and if not paid, the government will collect it only by increasing one's future taxes (reducing a tax refund). Does this make it a tax?

Reference to the public choice literature on voter behavior explains how the ACA's supporters can have it both ways. Voters are rationally ignorant, so many may be unaware of the dual claims of the ACA's supporters that the individual mandate is, for some purposes, not a tax, and for other purposes, it is. Voters vote expressively, so those who favor the ACA's coverage will support it regardless of inconsistent claims. That support in the face of inconsistent claims is a good example of Caplan's (2007) rational irrationality.

The individual mandate requires that individuals obtain health insurance, or pay a tax (according to the Supreme Court) of \$695 or 2.5 percent of their household's income to the IRS.¹² For many young healthy low-income individuals it may be less costly to pay the tax than to obtain health insurance, although these individuals may also be eligible for subsidized policies from government healthcare exchanges. The political appeal of the tax is apparent: most Americans have health insurance, and realize that the minority who do not impose costs on those with insurance if, as is often the case, they do not pay their medical bills in full. So most Americans will see this as a justified tax that will be paid by other people as a consequence of making an irresponsible choice.

The Employer Mandate

The ACA requires that employers of more than fifty employees provide health insurance to employees working 30 hours or more a week, or pay a tax of \$2,000 per worker. The most obvious effect of this tax is that employers will shift employees from full-time to part-time work. For low-wage full-time workers, employers will find it less costly to pay the tax than to provide them with health insurance.¹³ As with the individual mandate, this will push those who want health insurance toward government-subsidized health insurance exchanges to buy their insurance. The employer mandate and individual mandate are both designed to provide incentives to use the government exchanges.

Because employer-provided health insurance is not taxed (it is an expense to the employer and a nontaxable benefit to the employee), most health insurance is provided by employers, creating an expectation of employer-provided health insurance and making those employers who do not provide it appear to be stingy toward their employees. The same motivations that provide general support for minimum wage laws, sick leave, and paid vacation time make employer-provided health insurance look like something an employer that treats employees fairly would do. People who do not understand the marginal productivity theory of wages often conclude that employers are profitable and can afford to pay for health insurance for their employees. Even if this is true, employers still will not pay more to hire an employee—including the cost of health insurance—than the employee can produce in income for the employer. Whether employers can afford to pay for health insurance for their employees is an irrelevant economic argument, but a relevant political one.

If many people see things this way, the tax, which appears to be paid by someone else (the stingy employer), will be politically popular. Many voters

will not perceive the secondary effects, such as that mandated benefits will tend to lower wages and will cause part-time employment to be substituted for full-time employment.¹⁴ The tax is fairly well hidden, and it appears to most people to be paid by someone else, making it a politically viable policy.

Annual Fee on Health Insurance Providers

The ACA specifies that health insurance providers pay an annual fee, determined by the share of total policies they write divided into the total amount of fees to be collected as specified in the Act. The Act has a fee schedule specifying the total dollar amounts to be collected through 2018; after 2018, the current year's fee total will be last year's total adjusted for the rate of premium growth. For example, the total amount of fees collected in 2014 was \$8 billion, scheduled to increase to \$14.3 billion in 2018 and adjusted by premium growth after that. For 2018, an insurer's fee will be \$14.3 billion times by the fraction of total policies issued by that insurer. Thus, in 2018, an insurer that issued 10 percent of health insurance policies would pay a fee of \$1.43 billion ($\$14.3b \times .1$).

One issue insurers could have with this fee is that they will not know what their fee is until the end of the year. Because the fee is a cost to the insurers, they will have to estimate this cost as they price their policies. One might say that any insurer is always facing unknown costs, because they do not know what losses their policyholders will have in the upcoming year. Still, this fee adds another layer of financial risk to writing health insurance policies, so could be expected to drive up the cost of a policy by more than the fee associated with the policy.

Because purchasers of health insurance policies will have very inelastic demands for coverage, tax shifting theory suggests that this tax will be passed on to policyholders in the form of higher premiums, as Gruber noted in his comments on the ACA. The individual mandate makes the demand for health insurance even more inelastic, because people who do not buy it are subject to the tax. Placing the tax on insurers rather than on policyholders means the tax is less visible—likely invisible—to most policyholders. The tax lowers the political cost of financing the ACA, because buyers of health insurance will not mind a tax being put on insurers (and some will even favor taxing that profitable industry). Most buyers will not realize that the tax is shifted to themselves. Meanwhile, insurers will offer less political resistance to the tax, because they can pass it on in their premiums. One thing they cannot pass along, however, is the uncertainty about how much they will have to pay, because of the way

the tax is calculated. The big advantage here goes to the federal government, which knows exactly how much in tax revenues it will collect.

Medical Device Excise Tax

The ACA specifies a 2.3 percent medical device excise tax on “certain medical devices.” The tax was scheduled to begin being collected in 2013 but was postponed and is now scheduled to begin in 2018.¹⁵ This tax, like any excise tax, will be shifted at least partly to the purchasers of those medical devices, and because many medical devices are paid for by insurance, the consumers of these devices will often bear no direct cost as a result of the tax. Insurance rates will have to rise to cover the increased cost, but that cost increase is indirect and is spread among all policyholders rather than applied to just those who use the taxed devices. As a result, most people will be unaware of how much they are paying for this tax.

The tax has a “retail exemption” that offers further evidence that the tax was designed to be hidden from those who ultimately pay it. The retail exemption specifically exempts eyeglasses, contact lenses, hearing aids, and “the sale of any other devices that are of a type generally purchased by the general public at retail for individual use.”¹⁶ If consumers could see that they are directly paying the tax, then the device is exempt. The tax is only placed on devices for which the consumer cannot tell how much, if any, tax they are paying, and because insurance will pay for most of the devices, even the ultimate user will not bear the cost of the tax directly. Ultimately, this is a tax on insurance policies, which few policyholders will recognize. It would be difficult to design a tax that is better hidden from those who ultimately will pay it.

Excise Tax on Indoor Tanning Services

The ACA provides for a 10 percent excise tax on indoor tanning facilities that went into effect in 2010. This excise tax appears completely unrelated to health care. It was included as an excise tax on a consumer service that would face relatively little opposition. The provision excludes from taxation “phototherapy services performed by a licensed medical professional on his or her premises,” so medical use of such services escapes taxation, while nonmedical use is taxed. The tax also exempts “physical fitness facilities that offer tanning as an incidental service to members without a separately identifiable fee.” The obvious motivation for this exemption is to avoid levying a tax on a large number of people who might object to it. Many more people have memberships at gyms

and fitness facilities than patronize indoor tanning facilities, so the exemption keeps those gym members from being taxed and therefore eliminates one reason for them to have a direct objection to ACA.

This tax is unusual among ACA taxes in that it is levied directly on the consumers who will bear the burden of the tax. This speaks to the low level of political clout that the ACA's designers perceived could be wielded by those who provide or use indoor tanning facilities, perhaps because they were unaware of that provision in such an extensive piece of legislation. The Tax Foundation reports that revenues from the tax were slightly more than one-third of the revenues projected when the ACA was passed, likely from a combination of tanning salons going out of business and noncompliance from those in business.¹⁷

Patient-Centered Outcomes Research Trust Fund Fee

Provision 6301 in the ACA established a Patient-Centered Outcomes Research Institute (PCORI) that will undertake research to help clinicians and policy-makers make informed health decisions. PCORI is funded by an excise tax on insurance policies and self-insured health plans. The amount of the tax is calculated by multiplying the number of people covered by a plan times the applicable dollar amount for that year. For 2015, the amount was \$2.08 per person covered, and the fee increases by the “inflation in National Health Expenditures, as determined by the Secretary of Health and Human Services.”¹⁸ Because healthcare expenditures rise more rapidly than the general level of prices, this provision means that PCORI tax revenues will rise faster than inflation.

The tax is placed on insurers, providing yet another case in which the tax is hidden from the people who will ultimately pay it. If healthcare expenditures increase by an average of 5.5 percent a year and inflation is 2 percent a year (the Federal Reserve's target rate), this tax, per policy, would increase by 3.5 percentage points more than the rate of inflation. The inflation-adjusted tax per policy would double in about 20 years (using that modest assumption of increases in healthcare costs), and because of population growth, funding for PCORI would much more than double.

This back-of-the-envelope calculation illustrates what is likely a conservative estimate of the real increase in tax revenues for PCORI, but the larger point is that the program is designed so that the revenues funding PCORI will grow every year. The initial tax appears to be modest, and few observers

will calculate the future growth that is built into it. The tax is designed to take advantage of the rational ignorance of voters.

Annual Fee on Branded Prescription Pharmaceutical Manufacturers and Importers

This tax is very complicated. It is calculated by dividing the aggregate amount to be collected under this provision by each taxpayer's share of prescription pharmaceuticals sold. The aggregate amount to be collected varies by year; for 2015 it is \$3 billion, rising to \$4.1 billion in 2018, and then falling to \$2.8 billion for 2019 and thereafter. Like the fee on health insurance providers, the ACA specifies the total revenue to be collected by the tax, which is then divided among the taxpayers.

A complicated formula determines each seller's covered sales during the year, and then a progressive rate schedule determines the percentage of these sales that is counted in calculating the seller's tax liability. Sales below \$5 million carry no tax liability. Sales between \$5 million and \$125 million mean that 10 percent of the seller's sales are covered by the tax. Sellers with sales between \$125 million and \$225 million count 40 percent of their sales; those with between \$225 million and \$400 million count 75 percent of their sales; and those with more than \$400 million count 100 percent of their sales. The total amount of sales subject to tax is summed, and each firm pays the percentage of the aggregate amount to be collected that corresponds with that firm's sales subject to tax.

For example, assume that for a year after 2019, a firm calculates that it has made \$200 million in covered sales. Its sales taken into account for tax purposes is 40 percent of \$200 million, or \$80 million. Now assume that its \$80 million is 10 percent of the total for all firms. The aggregate amount of collections for the year is \$2.8 billion, so this firm would owe a fee of \$280 million.¹⁹ Note that the progressive tax schedule does not adjust for inflation, so the longer-run effects of inflation alone will push these taxpayers into higher tax brackets over the years.

As with the fee on healthcare providers described above, the firms paying the fee cannot predict what their tax liability will be, because the ACA specifies only the total amount to be collected. Each taxpayer's liability is determined by its share of that total amount, which is determined by its share of total sales and cannot be calculated ahead of time.

Ultimately, consumers will end up paying this tax, because demand for prescription drugs is very inelastic. One reason this is true is that the people

who consume the drugs are not the ones who pay for them, because a large share of prescription drugs are covered by insurance. That also means that the consumers of the drugs are the demanders, while it is the consumers of health insurance who pay the costs, further diluting any incentive for drug users to be price sensitive. The demanders of the drugs are not the ones who pay for them. One can see how a tax like this will face relatively little opposition from either suppliers or demanders. On the supply side, two factors weigh in: the ability to shift the tax to demanders, and the fact that there are few sellers of pharmaceuticals, so only a small group of firms would object to the tax. On the demand side, the tax is hidden as a component of everyone's health insurance, and because demanders are unlikely to perceive that the tax is shifted to them, they do not object to taxing the sellers of pharmaceuticals, which are highly profitable corporations.²⁰

Excise Tax on "Cadillac" Health Plans

Beginning in 2020, a 40 percent excise tax will be levied on high-priced health-care plans, which the ACA defines as costing more than \$10,200 for an individual plan or \$27,500 for family coverage.²¹ This tax was originally scheduled to go into effect in 2018 but has been delayed by Congress. The excise tax applies to any amount of the premium that exceeds those limits. The stated idea behind this tax is that excessively generous insurance plans insulate policyholders from the true cost of health care and so encourage overuse of healthcare services. (Of course, the purpose of any insurance is to insulate the policyholders against the costs for which they have purchased insurance.) The individual mandate in the ACA requires everyone to have a minimum amount of coverage, and this excise tax on high-cost plans would appear to be an attempt to also limit the maximum amount of coverage. The designers of the ACA appear to have in mind some correct amount of insurance coverage and do not want people to have too much or too little. In anticipation of this tax, some employers are already raising deductibles and co-pays for their plans, and limiting coverage to the extent that the law allows such limits.

Another argument supporting this tax is that the people most likely to have high-priced health insurance are upper-income people who get this coverage through their employers. Because employer-provided health care is not taxable, this amounts to a tax subsidy to the (employed) rich, which is not available to lower-income workers who are more likely to have less generous insurance plans. A "tax the rich because they can afford it" argument tends to receive political support, because many voters question whether the rich pay

their fair share in taxes, and because the rich are a small percentage of voters. With regard to the ACA, many of those who would oppose the tax would not be supporters of the Act anyway, so this provision causes little change at the margin with regard to voters who would support it.

The limit that determines high-cost plans adjusts for inflation. The ACA specifies that in 2018 and 2019, the limit will rise by the increase in the Consumer Price Index (CPI) plus 1 percent; in 2020 and beyond, the limit will increase only by the same percentage as the CPI. Because healthcare expenditures tend to rise faster than the CPI, over time, more and more plans will fall into the high-cost category. It is not much of a stretch to see that if this Cadillac tax remains as currently designed, almost every health insurance policy eventually will be taxed by it. But it is also not much of a stretch to foresee that as more plans are taxed, there will be a political backlash leading to a modification of the tax. Politically, it works if it appears to be a “tax the rich” tax, but does not if it appears to be a tax on the median voter’s health insurance.

The obvious popular appeal of this excise tax is that for most taxpayers, it will appear to apply to other people, not to themselves. As an increasing number of plans are covered, it will be interesting to see whether a political backlash will require a redefinition of high-priced, or whether the provision will stick and bring in tax revenue. A public choice viewpoint would suggest the former.

As the tax is currently designed, it amounts to a simple income tax on plans costing more than the limit. Employer-provided health insurance is not taxable, but the 40 percent tax rate on Cadillac plans is very close to the 39.6 percent highest marginal income tax bracket. In effect, for people in that bracket, an employer-provided plan is not taxed up to the limit, and after that the cost of the plan is taxed as ordinary income.

CONCLUSION

The taxes incorporated into the Affordable Care Act provide a good example for illustrating how taxes are designed more generally. The economics of taxation rests largely on models of optimal taxation, where theoretical models are developed to illustrate how to minimize the burden of taxes or to maximize some definition of social welfare. The implied policy implication of optimal tax models is that policymakers should design tax structures so that they conform with those models. The reality is that taxes are a product of the political process, and policymakers actually design taxes to minimize the political resistance to

getting them approved—not to meet some economists’ standards of optimal taxation.

Whereas optimal tax models deal with efficiency and equity in taxation, the more important application of tax theory to the politics of taxation is tax shifting. The key insight behind tax shifting is that the ultimate burden of a tax does not necessarily fall on the people initially targeted by the tax but can be shifted to others. Tax shifting is relevant to the politics of taxation, because knowledgeable taxpayers will resist a tax less if they perceive that the burden of the tax will be shifted to others and will resist more if they realize the burden of the tax will be shifted to them. Most voters, however, are rationally ignorant of the effects of taxes. Rationally ignorant constituents may resist taxes that are placed directly on them, because the taxes are visible, but will offer less resistance—and perhaps will even support—taxes that are levied on others. In short, knowledgeable taxpayers will offer more political resistance to a tax when they are on the more elastic side of the market, while less knowledgeable taxpayers will offer more political resistance when a tax is placed directly on them rather than on the other side of the market. The taxes embodied in the ACA provide good examples of this fact.

Suppliers in the markets for health insurance and healthcare products have a concentrated interest in the healthcare market, and so will be knowledgeable taxpayers. Demanders in those markets have inelastic supply schedules, partly because the demand for health care is, in general, inelastic, and partly because third-party payers shift the cost away from those who directly demand the services. Because demand is more inelastic than supply, the bulk of the burden of taxes in these markets will be shifted away from knowledgeable suppliers, toward rationally ignorant demanders. Thus, to minimize political resistance, taxes in the ACA were deliberately put on suppliers, who resist less because they can shift those taxes to demanders, and were not placed directly on demanders.

A review of the taxes in the ACA shows that almost all are taxes on providers, who the general public views as profitable businesses that can afford to pay those taxes. More than just limiting opposition to the taxes, this placement even leads to a degree of public support, because it appears that the taxes are being paid by others who are profiting from healthcare provision, who can afford to pay them, and who are impersonal corporations rather than real people. Opposition from those who ultimately bear the burden of the taxes is minimized in this way. Meanwhile, the more knowledgeable corporations, while they are not necessarily in favor of the taxes, offered less of a political roadblock to the passage of the ACA because, first, they understand that

ultimately most of the burden of the taxes levied on them will be shifted toward others, and second, because corporations represent fewer voters than the healthcare consumers on the demand side of the market.

The taxes in the ACA offer an interesting case study into the politics of taxation. The generally applicable lesson is that taxes are designed to minimize political opposition. They are not designed to minimize the welfare losses from taxation, promote equity, or maximize some characterization of social welfare, as is so often implied in economic models of taxation.

NOTES

1. After Professor Gruber made comments like those quoted below, members of the Obama administration were quick to distance themselves from both Professor Gruber and the statements he made.
2. Professor Gruber gave at least five public talks in which he was recorded delivering a message similar to the one that follows, and the recordings were shown on television news programs and were available on many websites. The talks were addressed to academic audiences and not intended for the general public, so the comments ought to be viewed as Gruber's explanation to his academic peers about the political decisions that were behind the selling of the ACA to the general public. One reviewer thought I was being too hard on Gruber and that Gruber had backed off of some of the comments he made, but he did make similar comments repeatedly and only sought to "clarify" what he meant after substantial public criticism.
3. A video containing this quotation can be found at www.forbes.com/sites/thebothecary/2014/11/10/aca-architect-the-stupidity-of-the-american-voter-led-us-to-hide-obamacares-tax-hikes-and-subsidies-from-the-public/#d008d52779b.
4. See www.healthcare.gov/fees-exemptions/. The fee listed is for 2016 and is adjusted for inflation in years after 2016.
5. National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al., 567 U.S. (2012).
6. This quotation can be found at www.dailycaller.com/2014/11/16/gruber-seniors-do-a-terrible-job-choosing-health-plans/.
7. This quotation can be found at www.cnn.com/2014/11/18/politics/gruber-obamacare-promises/.
8. Ringel et al. (2002) review the literature and find that the price elasticity of demand for health care is very inelastic—less than -0.2 —but the larger point is that when healthcare costs are paid for by third-party payers, consumers will be very insensitive to the real cost of their health care.
9. A summary of the ACA's tax provisions is given at www.irs.gov/uac/Affordable-Care-Act-Tax-Provisions, and the individual descriptions of those provisions have links to more detailed explanations. Unless otherwise noted, the facts about the ACA's tax provisions come from that website.
10. See www.abcnews.com/blogs/politics/2012/06/obama-in-2009-its-not-a-tax/ for this statement and additional statements by President Obama arguing that the individual mandate is not a tax.
11. See www.healthcare.gov/fees/fee-for-not-being-covered/.
12. This is the 2016 amount, which will be adjusted for inflation in future years.

13. For some evidence on this, see www.fivethirtyeight.com/features/yes-some-companies-are-cutting-hours-in-response-to-obamacare/. Because the ACA is relatively new and academic studies take some time to complete and go through a review process, one would expect more academic studies on the subject in the future.
14. Leibowitz (1983) and Baughman et al. (2003) provide statistical analyses showing that higher levels of fringe benefits are offset by lower wages.
15. See www.irs.gov/uac/Medical-Device-Excise-Tax-Frequently-Asked-Questions.
16. The quote is from www.irs.gov/uac/Newsroom/Medical-Device-Excise-Tax.
17. See www.taxfoundation.org/blog/five-years-later-indoor-tanning-excise-tax-revenues-are-below-2010-aca-projections.
18. See <https://www.irs.gov/uac/patient-centered-outcomes-research-trust-fund-fee-questions-and-answers>, accessed June 27, 2017.
19. The description of the calculation comes from Department of the Treasury, IRS memorandum RIN 1545-BJ39, Final Regulations, Temporary Regulations, and Removal of Temporary Regulations, published in the Federal Register, July 28, 2014. The memorandum explaining the fee is sixty-one pages long.
20. The arguments of Caplan (2007) about irrational voters come into play here.
21. See “Excise Tax on ‘Cadillac’ Plans,” *Health Policy Briefs*, September 12, 2013, found at www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=99.

REFERENCES

- Baughman, Reagan, Daniela DiNardi, and Douglas Holtz-Eakin. 2003. “Productivity and Wage Effects of ‘Family-Friendly’ Fringe Benefits.” *International Journal of Manpower* 24 (3): 247–59.
- Brennan, Geoffrey, and Loren Lomasky. 1993. *Democracy and Decision: The Pure Theory of Electoral Preference*. Cambridge: Cambridge University Press.
- Caplan, Bryan. 2007. *The Myth of the Rational Voter: Why Democracies Choose Bad Policies*. Princeton, NJ: Princeton University Press.
- Diamond, Peter A., and James A. Mirrlees. 1971a. “Optimal Taxation and Public Production: I.” *American Economic Review* 61 (March): 8–27.
- . 1971b. “Optimal Taxation and Public Production: II.” *American Economic Review* 61 (June): 261–78.
- Downs, Anthony. 1957. *An Economic Analysis of Democracy*. New York: Harper & Row.
- Hayek, Friedrich A. 1945. “The Use of Knowledge in Society.” *American Economic Review* 35 (4): 519–30.
- Holcombe, Randall G. 1997. “Selective Excise Taxes from an Interest-Group Perspective.” In *Taxing Choice: The Predatory Politics of Fiscal Discrimination*, edited by William F. Shughart II, 81–103. New Brunswick, NJ: Transaction.
- . 1998. “Tax Policy from a Public Choice Perspective.” *National Tax Journal* 51 (2): 359–71.
- . 2002. “The Ramsey Rule Reconsidered.” *Public Finance Review* 30 (6): 562–78.
- . 2012. “Make Economics Policy-Relevant: Depose the Omniscient Benevolent Dictator.” *Independent Review* 17 (2): 165–76.
- Leibowitz, Arleen. 1983. “Fringe Benefits in Employee Compensation.” In *The Measurement of Labor Cost*, edited by Jack E. Triplett, 371–94. Chicago: University of Chicago Press.
- Mirrlees, James A. 1971. “An Exploration in the Theory of Optimum Income Taxation.” *Review of Economic Studies* 38: 175–208.

- . 1976. “Optimal Tax Theory—A Synthesis.” *Journal of Public Economics* 6 (4): 327–58.
- Mises, Ludwig von. [1922] 1951. *Socialism*. New Haven, CT: Yale University Press.
- Niskanen, William A. 1971. *Bureaucracy and Representative Government*. Chicago: Aldine-Atherton.
- Ramsey, Frank P. 1927. “A Contribution to the Theory of Taxation.” *Economic Journal* 37: 47–61.
- Ringel, Jeanne S., Susan D. Hosek, Ben A. Vollaard, and Sergej Mahnovski. 2002. “The Elasticity of Demand for Health Care: A Review of the Literature and Its Application to the Military Health System.” Santa Monica, CA: Rand.
- Tullock, Gordon. 1965. *The Politics of Bureaucracy*. Washington, DC: Public Affairs.

