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Funding Health Care For All Americans: An Economic Perspective



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A substantial change in the U.S. approach to funding is central to any sustainable, comprehensive reform of health care. This change must cover all Americans with insurance for a decent standard of care and provide for the rational control of expenditures.

Section I of this paper summarizes crucial statistics on the growth of health care spending relative to the rest of the economy, reviews the reasons why more than 45 million Americans are currently uninsured, shows what is necessary to achieve universal coverage, and explodes the myths of “shared responsibility” and “government assistance for the middle class.”

Section II looks at considerations relevant to evaluation of health care funding, provides a menu of funding instruments, and discusses in some detail why health care needs dedicated funding and why mandates in effect impose taxes.

Section III calls attention to major distortions in current funding of health care and discusses the effects of changing from the current system to more simplified tax funding.

Section IV provides a summary of the paper.

Section I

Health Care and the Economy

“Long-run fiscal policy is a health policy problem.” Thus writes Alice Rivlin, whose past service as Vice Chair of the Federal Reserve Board, Director of the White House Office of

Management and Budget, and Director of the Congressional Budget Office, gives her a unique and commanding view of the problem. Rivlin continues, “The principal challenge to achieving a sustainable long-run fiscal policy turns out to be reducing the rate of growth of health spending – all health spending, not just the federal or the federal/state portion.”¹ We agree.

The basic data on current funding of U.S. health care as well as past trends are presented in Appendix A. The most important findings can be easily summarized:

- § In 2005, national health expenditures were two trillion dollars, approximately 16 percent of GDP.
- § Over the past 30 years (1975-2005), health expenditures have grown 2.79 percent per annum faster than the rest of the economy.
- § If this differential were to continue for another 30 years, health expenditures would be 30 percent of Gross Domestic Product. This is the share of GDP now accounted for by **all** government - Federal, state, and local -- for **all** purposes.
- § Governments (federal, state, and local) account for approximately one-half of national health expenditures. Direct outlays are 42 percent, tax expenditures are over 6 percent, and purchase of health insurance for government employees is over 1 percent..
- § Expenditures by the private sector as a share of the national total are accounted for by group insurance 32 percent, individual insurance 2 percent, and out-of-pocket 12 percent.
- § In 2006, 47 million Americans had no health insurance, up from 38 million in 2000. Among Americans 18-64, one out of five is uninsured.

Covering the Uninsured

Covering all Americans is a major goal of health care reform. To pursue that goal in a rational and efficient way it is useful to know who the uninsured are, why they are uninsured, and what it would take to make sure that everyone is covered. The demand for health insurance, like the demand for any product or service, depends on the consumer's ability and willingness to pay for it. Some of the uninsured cannot afford health insurance; others are unwilling to acquire it. To obtain universal coverage, there are two necessary and sufficient conditions:

subsidization and compulsion.

We can see this clearly by looking at the different reasons people are uninsured.

The poor. The largest group of uninsured consists of individuals and families whose low income makes it infeasible for them to acquire insurance, either on their own or as a condition of employment. One-fourth (25%) of the uninsured have incomes below the Federal poverty level, and another one-fourth (28%) have incomes between 100 and 200 percent of that level. About one-fourth (26%) of the uninsured have no connection with the workforce; the rest are either employed or are the dependents of employed persons.

Almost half (47%) of uninsured workers are employed in firms with fewer than 100 workers. But the frequently heard explanation, "Small employers can't afford health insurance," is somewhat misleading. Many workers in small firms can't afford health insurance because they are low wage workers. Lawyers, accountants, physicians, and other highly paid professionals working in small firms usually do have health insurance. It is true, however, that insurance premiums are higher for coverage of workers in small firms.

The sick and disabled. Some men and women who are not poor are still unable to afford health insurance because they have special health problems; they face very high premiums or are excluded from coverage entirely.

The “difficult to reach.” Some individuals are neither poor nor sick but have difficulty obtaining coverage at average premiums. They may be self-employed, work in small firms, or be out of the labor force entirely. To insure such individuals, insurance companies incur abnormally high sales and administrative costs. They also encounter the problem of adverse selection: if an insurance company offers a policy to individuals or small groups at an average premium, those who expect to use a great deal of medical care are likely to buy; those who do not expect to use much care are less likely.

The low users. There are many individuals who do not expect to use much medical care. They may be young, or in particularly good health. They may dislike going to physicians or, if Christian Scientists, they may not believe in the efficacy of medical care. For them health insurance is a “bad buy” unless they can acquire it at a below-average premium. This group is not negligible in size. Of those adults without insurance more than half (50%) are at age 18-34; most of them are quite healthy. One-fifth (19%) of all uninsured are under age 18.

The gamblers. Most people buy health insurance in part because they are risk averse. They would rather pay a fixed known premium (even above the actuarial level) than risk a huge expense in the event of serious illness. But not everyone is risk averse about health expenditures or risk averse to the same degree. People in this category prefer to take their chances about the need for care and save the premium payment.

The free riders. The final category consists of individuals who remain uninsured because they believe that in the event of serious illness, they will get care anyway, and others will pick up the bill. They save the cost of insurance and “ride free” on the coat tails of those who pay into the health care system. There may be elements of free riding in the behavior of the low users and gamblers as well; it is often difficult to distinguish among the three categories of individuals who are able to pay for insurance but are unwilling to do so. There are millions of such individuals. More than one-fourth (28%) of all uninsured have incomes that exceed 300% of the Federal poverty level.

This overview of the uninsured shows what is needed to achieve universal coverage. For the poor and sick the answer is subsidy. The only way they can be covered is if those who are more affluent are willing to pay part or all of the costs. Because the income and health status of individuals changes from time to time, sometimes suddenly, it is important to have a system of subsidies that is flexible, accurate, and inexpensive to administer. For those uninsured who are difficult to reach, the solution is some kind of collective purchasing arrangement that eliminates excess administrative costs and deals with the problem of adverse selection. For those uninsured who are able to acquire insurance but unwilling to do so voluntarily, compulsion is necessary. No nation achieves universal coverage without subsidization and compulsion. The basic question that each country faces and the U.S. must face if it wants universal coverage is how to arrange for the subsidization and compulsion.

The Myth of “Shared Responsibility”

Most of the current proposals for universal coverage rely on the myth of “shared responsibility” to make subsidization and compulsion sound more palatable. The usual statement reads something like this: “Responsibility for the cost of care will be shared by employers, the Federal government, state governments, and individuals.” Sounds fair. Sounds good. But it is a marketing slogan that is at odds with economic reality. There is no magic wand that can keep the cost of care from being borne by Jane and John Q. Public – one way or another.

Consider employers. Numerous econometric studies have concluded that the cost of employment-based insurance is passed on to the firm’s employees through foregone wage increases. [Newhouse and Culyer *Handbook*] Sometimes the costs are borne by the firm’s customers. Consider Stanford University, an employer we know well. In 2006, Stanford paid approximately \$100 million for the health care of faculty and staff. (By comparison, total undergraduate tuition income at Stanford provided only \$150 million.) Where did Stanford get the \$100 million from? The pockets of the deans, provost, or president? Impossible. The members of the Board of Trustees? Again the answer must be “no.” Although several trustees are affluent, it would be absurd to expect them to pick up the tab. Much of it represents funds that would otherwise have been paid to faculty and staff as salary. Some of the money may have come from tuition and fees. Indeed the sharp rise in health care costs that Stanford has experienced in recent decades probably helps explain the sharp rise in tuition. A third possible source is the overhead Stanford collects on grants and contracts. The exact distribution of the cost is not clear. What is clear is that the employer, Stanford University, does not bear the cost of its employees’ health care in any meaningful sense.

What about other employers? Most of them are, unlike Stanford, for-profit firms. Theoretically, the cost of employer “provided” care could be coming out of profits – but the evidence points strongly against that view. Just like Stanford, the cost of the employee health care in for-profit firms appears to be borne by the employees in the form of foregone wage increases and by consumers in the form of higher prices. During the past three decades, when health insurance premiums have increased by about 300 percent (adjusted for inflation). Consumer prices have increased by 258 percent. The real wages of many workers have barely increased at all. Corporate profits (adjusted for inflation) have increased by 232 percent (pre-tax) and 284 (after-tax). With ingenious strong assumptions, it is possible to reconcile these data with the belief that the cost of employment based health insurance comes out of corporate profits, but it seems more like the decision of a thrice-divorced person to wed for the fourth time, “the triumph of hope over experience.”

Not only is it difficult to reconcile the trends in aggregate statistics with the view that the rise in health care costs has come out of profits, but data for individual companies also makes that conclusion implausible. Consider the case of Wal-Mart, the world’s largest retailer. This non-union giant is well-known for low costs, low prices, and skimpy health benefits. In 2004-06, Wal-Mart’s after-tax profits averaged 1.9 percent of sales.² Its competitor, Safeway, a highly unionized supermarket chain with generous health benefits that cost more than two percent of sales, had after-tax profits in 2004-06 of 1.8 percent of sales. If health benefits came out of profits, wouldn’t Safeway’s profit rate be much lower than Wal-Mart’s? Or suppose Wal-Mart was required to offer Safeway level health benefits, would their profit rate plunge toward zero?

Isn't it more likely that they would cut wages and employment, and raise prices to the extent that competition permits?

In the long-run for-profit firms don't bear the cost of health care anymore than Stanford does: the cost comes out of the wages of employees or is passed on to the firm's consumers. The distribution of the cost of care between foregone wage increases for workers and higher prices for consumers will depend in part on the extent of competition facing the firm. For example, when AT&T was the largest private employer and had a virtual monopoly on telephone service, higher health insurance premiums were typically passed on to consumers.

The myth of "shared responsibility" also says that government picks up part of the bill for health care. And it is true that the national expenditure data show government paying for a large share of the total. But where does the government's money for health care come from? Not from Governors, Senators, Representatives, or the President. It comes from taxpayers, or from cuts in government expenditures for other goods and services, or from borrowing – which means future taxpayers.

Payment for health care must come from the public (regardless of the intermediaries), but it is **shared** among households and individuals. Given our limited knowledge of the incidence of employment-based insurance on individual workers and the incidence of some taxes, it is difficult to say exactly how much redistribution actually occurs. Although the public must pay for health care one way or another, it does not follow that the method of funding is of little importance. On the contrary, the choice of funding method or methods can have significant effects on the efficiency of labor markets, the efficiency of the medical care sector, the

distribution of the cost of care, the Federal budget deficit, and other important aspects of the economy.

The Myth of “Government Assistance for the Middle-class”

In any population with a normal distribution, a large proportion of the population will be in the middle and a relatively small proportion at the extremes. No surprise, then, that many politicians believe the path to victory lies in promising benefits (but not costs) to the “middle class.”

But can this be anything more than an empty promise? Not likely. “Middle class” must mean “middle income”; otherwise this is just a word game. But by and large, middle income individuals and households must wind up paying for what they get. Who else will subsidize them? In any reasonable system, high income households will pay more in taxes than they receive in benefits, but most or all of that excess will be used to subsidize those with below average income, especially those who are very poor.

When health plans propose subsidies for households with incomes up to 400 percent of the federal poverty level (as the Massachusetts Plan does), they will be claiming to help households with incomes well above average. Where does that help come from? Surely those with above average incomes must be, on balance, a supplier of funds for the system, not a recipient.

There may be good reasons why the provision of health insurance up to some level should be collectively funded through taxes. We think there are, but they are based on improvements in efficiency and security for all classes, not special benefits for the middle class.

The redistributive feature of such a system should focus on transfers from the affluent to the poor. It should not indulge the myth that someone, somewhere, will transfer funds to those in the middle.

Section II

Relevant Considerations in Funding Health Care

Jean-Baptiste Colbert, minister of finance under Louis XIV, summarized the politics of tax policy as “How to pluck the most feathers with the fewest squawks.” Without denying the relevance of this observation, our focus in this paper is on funding from an economic perspective. In evaluating alternative instruments for funding health care for all Americans, we believe the effects on the overall economy and on the health care sector deserve major attention.

Effects on the overall economy: Because the health sector accounts for such a large and growing share of the total economy, the instruments chosen for funding this sector can significantly affect the performance of the economy in many ways. First, there is the potential effect on the Federal budget. Some projections show deficits rising sharply in the future, fueled in large part by health expenditures. State budgets are also significantly affected by the way health care is funded.

Efficiency considerations are also important. What is the effect of health care funding on the supply of labor and the supply of capital? Do the funding instruments result in an efficient mix of factors of production – capital vs. labor – or skilled vs. unskilled labor? What are the effects on labor markets? Are workers free to choose the kind of work they prefer: Full-time or part-time? Self-employment or home production? Are they free to change jobs to find a better fit

for their abilities? Are employers free to make decisions about hiring, firing, promotion, and retirement based on efficiency and independent of health care costs?

The funding instrument(s) should provide for stability in the short-run and flexibility in the long-run. This implies that health funding should not be dependent on sources subject to strong cyclical fluctuations, for example, corporate profits or capital gains. In the long-run, the level of funding might require a large adjustment as a result of new medical technologies or major changes in the health problems of the population. This implies the need for an instrument or instruments that can easily be adjusted to meet the requirements of the new situation.

The cost of administering the funding instrument(s) deserves considerable attention, as does the incentive to evade and the ease or difficulty of evasion. Transparency and salience should also be considered.

Effects on the health sector: A critical question for the health sector, and for the rest of the economy, is whether the funding instrument(s) results in a level of health care spending such that its incremental value is commensurate with that provided by other sectors of the economy. Does the last one percent of health expenditures provide as much benefit to society as the same amount spent in some other way, such as enrolling an additional two million children in Head Start or increasing the number of police officers by 50 percent?

Does the funding instrument(s) result in an efficient use of resources within the health sector, e.g., hospitals vs. physicians vs. drugs or does it bias decision-making one way or the other?

How effective is health care funding in reducing the financial risk facing individuals? Because individual uncertainty regarding the need for medical care is so much greater than for

most other goods and services, risk reduction must be a major consideration in the evaluation of funding instruments.

Since one of the goals of funding reform is to subsidize some individuals and households and to compel others to be covered and bear the cost of subsidization, alternative funding instruments must be evaluated in terms of how efficiently and how fairly the subsidization and the compulsion is accomplished.

A Menu of Funding Instruments

The menu of possible ways for the federal government to fund health care for all is limited by the very size of the expense. While the amount depends on the details of the plan, something like six percent of GDP is the right order of magnitude. Any tax to raise this much money will have to have a big, broad base. The first issue we discuss is the choice between using general revenue finance and a dedicated tax for the sole purpose of financing health insurance. We will argue that there are compelling reasons to favor separately financing health insurance with its own tax. That raises the issue of which separate tax to use. We will cover what we believe are the main alternatives: the income tax, a consumption based tax, a retail sales or value added tax, and a payroll tax. We will discuss taxes on income from capital as an alternative to taxes on income from labor. We will also discuss indirect taxation such as tax expenditures for health insurance, and income related user charges, and mandates.

Health care funding needs dedication. Before discussing how federal health insurance expenditures should be financed, we review how they are financed today.

The big ticket items for federal health costs are Medicare, the federal share of Medicaid costs, and the cost of health insurance for federal employees. Here we discuss the funding for Medicare and Medicaid. Medicare is divided into four parts, conveniently labeled parts A, B, C and D. Part A is the Hospital Insurance program and is almost completely financed with a dedicated or “earmarked” payroll tax of 2.9 percent, split in two even 1.45 percent parts paid for by the employer and the employee. Our take on it is that this split between the employer and employee is mostly for appearances sake, and that the true incidence of the full 2.9 percent tax falls on the worker. The key point we want to make here, however, is that Medicare Part A has a single dedicated source of finance and over the long-run it must live within the means of the proceeds of that tax. Part B, which covers physician and hospital outpatient services, is financed quite differently. Three-fourths of Part B’s costs are covered by the federal government through a claim on general revenues, whereas one-fourth is covered by monthly premiums and out-of-pocket co-payments of participants. General revenues are the combined proceeds of the personal income tax, the corporation income tax, excise taxes and a host of smaller sources of government revenues.

The distinction we want to highlight is Part B’s claim on general government revenues in contrast to Part A’s claim on the proceeds of a particular tax source. Why the difference and what difference does it make? Before attempting to answer the question, we should complete the story by noting that Part D follows the pattern of Part B, with roughly three-fourths of the cost financed by general revenues and one-fourth by participants’ contributions. Part C, the Medicare Advantage Plan, allows Medicare recipients to opt for a private managed-care health plan as an alternative to Parts A and B. About 16 percent of Medicare participants choose the Part C

approach and the funding is a blend of the 2.9 percent payroll tax and general government revenues. Finally, to finish the existing funding assignments, the federal funding for Medicaid is a claim on general revenues rather than the proceeds of a dedicated tax.

We know of no rationale for the current mix of a dedicated payroll tax for Part A Medicare and claims on general revenues for the rest of federal health insurance spending, but have given thought to which system might be superior. One can't help but notice that the link between benefits and costs is weak to nonexistent with general revenue financing. Two examples make the point. First, consider the introduction of Part D of Medicare in 2004. This valuable and costly new drug insurance benefit was added to Medicare without an increase in any tax – no increase in the personal income tax, corporation income tax, payroll tax, or any other federal government tax. Sure there were some estimates of how much the introduction of this program would add to the long-run deficit, but it is difficult to believe that most voters or members of Congress understand or appreciate the long-run consequences of such additions to deficit spending. Politicians could claim to have delivered this benefit without any corresponding tax increase. To most voters, this new benefit may have appeared to be free.

Second, we all have seen graphs about the long-run shortfall in the funding of entitlement programs. Many of these graphs refer to the shortage of funds for Social Security and Medicare Part A. What they compare is the projected costs of these programs under the current benefit structures with the revenue generated by the dedicated payroll taxes financing each of them (12.4 percent for OASDI and 2.9 percent for HI). What is missing from these assessments of money shortfalls to finance federal healthcare programs is Medicare Parts B, D, some of C and Medicaid. Why are the financial outlook of Parts B, D, and Medicaid so often

missing? The answer is that they have an open-ended claim on general revenues. With such an open-ended claim, they never can be short of money. Of course, in reality, the health insurance costs of the general revenue financed portions of the programs are just as much out of control as Part A. General revenue financing amounts to a loose or nonexistent budget constraint for federal spending on health insurance.

We don't think that every spending category in the federal budget should have its own dedicated tax, but we do think that federal health insurance spending is such a large spending category and is often projected as overwhelming the entire federal budget, that a separate and dedicated tax should be considered. The advantage of tax dedication is to make the cost consequences of program improvements salient and transparent.

We think enlightened health policy must include an assessment of value for money, even at the federal government level. As a country, we cannot continue to pursue a policy of providing all health treatments that might be helpful and we need to replace that standard with one where we provide the best health system *that we are willing and able to pay for*. The link between benefits and costs must be made; a natural way to do this is to use a dedicated tax source to pay for federal health insurance outlays. Consider how the debate about introducing Part D drug coverage would have gone if all federal Medicare and Medicaid expenses were paid for by a dedicated tax, perhaps a payroll tax. Say the rate had been 8.0 percent before the introduction of Part D and that it would have to be raised to 9.0 percent in order to finance the new benefit. Now the political debate would have been is the new drug benefit worth the one percent increase in the payroll tax rate. While we are not convinced that the payroll tax is the best dedicated tax instrument, this debate about balancing the extra benefits against the extra

costs is exactly the right debate to have. Politicians would have to weigh the vote-getting appeal of enhancing benefits with the vote-losing action of raising taxes. If people vote with their own welfare (including the welfare of others) in mind, then indirectly, politicians are weighing the welfare gains generated by the new program with the welfare costs of the new taxes. The process is inexact to be sure, but these are the right factors to weigh against each other.

Effectively, the dedicated tax rate would act like a price for federal health insurance spending. At an aggregate level, the connection between benefits and tax rates that would be created with a dedicated tax source simulates the tradeoffs in everyday consumer choice. You can buy a more expensive computer rather than the cheaper one, but you must pay more for it and might decide that the extra benefits aren't worth the extra costs. Similarly, we can collectively choose to have a deluxe health insurance plan or a more basic one and we would make a better decision about that important choice if the cost differences were made more apparent. A dedicated tax source would tend to force the choice to be faced. It is tough to hide the cost differences in a regime of dedicated taxes, but it is easy to hide them with general revenue financing.

The idea is that financing federal health insurance spending with a dedicated tax source imposes budget discipline on the system. In the end, we might choose to have the deluxe plan and the high taxes or we might choose to have the more basic plan with lower taxes, but we wouldn't be fooled into thinking we could have the deluxe plan and the lower taxes. It is our contention that general revenue financing greatly weakens the link between benefits and taxes and makes for inferior decision making. It allows politicians to improve benefits and defer and

disguise how the costs are going to be covered. In some cases, the improved benefits may not be worth their costs.

Choices for a dedicated tax. If we are going to finance federal health insurance spending with a dedicated tax, which tax should it be? In public finance, there has been a general debate about the relative efficiency of consumption based taxes and income taxes. Within consumption based taxes, direct personal taxes on income less saving are contrasted with indirect sales and value added taxes. The general consensus of the literature is that consumption taxes are more efficient than income taxes because of their neutrality regarding the timing of consumption. An income tax changes the relative price of consumption today versus consumption in the future, because the taxes on interest income, dividends, and capital gains create a wedge between the before- and after-tax return to capital. Consumption taxes still distort labor supply (by not taxing leisure) but are neutral about the timing of consumption. The relative efficiency of consumption taxes is not established by simply counting the number of distortions, but the evidence appears to favor consumption based taxes.

Another problem with using the income tax as the dedicated tax is that it already is the largest source of general government revenues. There is a serious question of whether one part of the income tax can be separately directed to health insurance while other parts are used for general spending.

Among consumption taxes, sales and value added taxes feature flat rates and can be relatively efficient. It is our position that sales and value added taxes are very similar in their economic effects, with a VAT effectively being a particular means of collecting a sales tax. There are a couple of arguments in favor of a sales tax in the U.S. context. It is a well known

and understood tax. It is also very visible to taxpayers. Typically, the tax is added to the price of purchased items at the time of payment. Since the whole reason that we are advocating a dedicated tax is to allow people to weight the tax costs against the insurance benefits of a federal program, it is important that the tax be understood and apparent. The value added tax is considerably less transparent because it is usually embedded in the posted price of merchandise and services. One advantage of a VAT is that it is an unused tax instrument in the United States which makes it particularly attractive for a new dedicated revenue source. Its introduction might be simpler than a sales tax because more than forty states already have sales taxes.

The payroll tax is already used for Medicare Part A as was just described. It could be expanded to become the dedicated source for all federally financed health insurance. There are a couple of considerations against this idea, however. First, consider two alternatives: the introduction of a new VAT to finance federal health insurance vouchers vs. the introduction of a substantially expanded payroll tax for the same purpose. The first alternative would increase the price of consumption to everyone, including the retired. The second alternative would primarily impact workers, leaving the initial generation of retired off the hook. We tend to favor a system where everyone contributes including the retired at the time of the introduction of the new system. The second reason not to choose the payroll tax is that it is already claimed as the dedicated tax for Social Security. Tax dedication works best when there is a simple assignment of the revenues from a particular tax to a single purpose.

In public finance, there is separate consideration of the taxation of capital income and the taxation of labor income. Every state in the U.S. and every country in the world is now quite

aware that capital is quite mobile. A disadvantage to taxing capital income is that “capital is on wheels” and can easily locate elsewhere. Sales and value added taxes indirectly tax both capital and labor, but independent of where production takes place and independent of the choice of factors of production. An idealized income tax could also be independent of where the capital is located. Perhaps the worst possible tax for our purposes would be the corporation income tax. It is notoriously inefficient, but even more than that it is the opposite of transparent and salient. The incidence of the corporation income tax is neither well-known nor widely understood. The consensus of economists is that it is borne by owners of capital in general, but in some cases it may be borne by workers or consumers. We are suggesting tax dedication so that the costs and benefits of health insurance (and improvements in health insurance) can be weighed against one another. If the costs of the tax itself cannot be determined, then the whole concept won’t work.

Current federal support uses a mechanism which could be called “none of the above.” Instead of taxing all personal income and then spending some of the proceeds on health insurance, most of employer based health insurance is a form of compensation that escapes taxation in the first place. The foregone revenue, revenue that the government doesn’t collect but otherwise would, is termed a “tax expenditure.” As it has been implemented, we think that this tax expenditure has been responsible for sustaining the unnatural and inefficient linkage between employment and health insurance. Even more generally, we think that tax expenditures fail the transparency and salience test. Most people are unaware of the enormous taxes that aren’t collected (and thus effectively spent) due to the tax treatment of employer based health insurance. Still, tax expenditures belong on the menu of options of how health insurance could be (and currently is) financed. They would be near the bottom of our list, however.

Another roundabout or indirect tax source is often proposed in the name of “income related user charges.” To give a concrete example, someone might propose that nobody should have to pay more than ten percent of their income for health insurance. Such a proposal sounds good, certainly to voters and therefore politicians. As economists, we would note that what is being proposed amounts to an additional ten percent income tax on lower income households. Consider what happens if the health insurance voucher is worth \$3,500 for someone with \$20,000 in income. Under the ten percent rule, they would be asked to pay \$2,000 for their health insurance voucher. However, if they were to work harder and earn \$25,000, then their voucher would cost an additional \$500. These income related user charges can add up. For instance, many public housing programs are based on people contributing 25 percent of their earnings towards rent. That amounts to a 25 percent tax on income. Food stamps work similarly. What happens when you combine the effects of these programs of income related user charges is that the poor end up facing the highest marginal tax rates in the economy. We think that they should not be used when funding health insurance.

Finally, there are mandates. Several universal health insurance plans feature mandates of one form or another rather than direct government provision of the insurance or a voucher to be used for insurance purchase. The approach is appealing to those who want a smaller role for the government, but we think much of the claimed efficiency of using mandates rather than taxes is simply a matter of labeling. For all practical purposes, mandates are taxes. There are three principal types of mandates: some require individuals to obtain insurance; others require employers to provide insurance or pay a tax (“play-or-pay”); and others require insurance

companies to provide insurance at a uniform premium for everyone who applies. Some reform proposals (e.g., the Massachusetts Plan) have all three mandates.

Let's start by considering an individual mandate. Say it takes the form of the government requiring everyone to acquire insurance that meets at least a minimum standard of coverage. The similarity to a tax is that families and individuals lose some of the freedom to allocate their money. The government requires everyone to purchase health insurance, a situation which may be similar to a tax of the same amount with the government making the insurance available in return. However, for those individuals who would have bought the insurance without the mandate, it does not distort their behavior. The mandate has absolutely no impact if you are required to do something that you would want to do anyhow. At the other extreme, for those individuals who place no value on the insurance, its entire cost is equivalent to a tax. Most individuals are probably somewhere in between.

Employer mandates have many of the same effects as individual mandates. First, there is the issue of the incidence of employer provided health insurance, whether it is mandated or not. Most economists who have studied the issue have concluded that the incidence of employment-based health insurance falls largely on workers, not employers. So, an employer mandate begins to look like a worker mandate or individual mandate. Second, there is the interaction of an employer mandate and the minimum wage. Forcing employers to offer health insurance to minimum wage workers effectively amounts to increasing the minimum compensation, with the usual problem of increasing unemployment for workers whose marginal product is lower than the increased minimum compensation. Finally, not everyone is employed, so if the goal is

universal coverage employer mandates won't do it. Such a mandate would have to be accompanied with a policy to cover those not in the workforce.

Insurance company mandates have their own problems. While it is possible for the government to force insurance companies to cross-subsidize participants by mandating that they offer insurance to everyone at the same premium, they cannot require the company to remain in the health insurance business. In other contexts, insurance companies have decided not to do business in particular states that seem unattractive for them. It is likely that an insurance company mandate would turn out to be similar to a tax and subsidy program with people with low-expected health costs subsidizing those with high-expected health costs. However, this type of cross subsidization is not an effective way to help the poor afford health insurance.

There is another problem with mandates. As we said in the introduction, any successful universal coverage health insurance program must have two features: compulsion and subsidization for the poor and the sick. Mandates only do half the job. They meet the compulsion standard all right, but they fail the subsidization standard. With mandates, the amount one pays for health insurance is independent of income or earnings. Remember that one of the important categories of the currently uninsured are those who can't afford health insurance. How will a mandate help them? Proponents of individual mandates usually propose to provide subsidies based on income. Some plans would subsidize households up to 400 percent of the poverty level. But where does the money for subsidies come from? Taxes. This further reduces the difference between the mandate approach and an explicit tax-financed approach.

Section III

Distortions in Current Methods of Funding Health Care

It is a staple of public finance theory that taxes distort behavior, resulting in “dead-weight loss” to society. The estimate of the loss, at the margin, say 30 percent, is calculated by comparing the economy with the tax with one that **has no distortions**. In our view, the relevant comparison should be the distortions created by the tax versus the distortions in the system which the tax-financed program replaces. In the case of the current system of funding health care, these distortions are considerable. We focus here on the two principal sources of current funding for ages under 65, employment-based insurance and income-tested insurance (e.g., Medicaid).

Employment-based insurance. One major source of distortion is the tax-exempt status of employer (and increasingly of employee) contributions to health insurance premiums. This lowers the price of insurance by as much as 40 percent (the price distortion varies with income). The result is greater purchases of insurance. Many economists believe that the excess insurance drives up the cost of care.³

Another distortion arises because employers who sponsor insurance are required to offer it to all full-time employees. This constrains job opportunities for minimum wage workers because the wage plus the cost of insurance may well exceed their value to the firm. A similar distortion may be operative with regard to older workers who tend to have high utilization of medical care. In general, when there are constraints on a firm’s ability to pass on the cost of health insurance to workers through wage adjustments, the firm’s hiring, firing, promotion, and retirement policies will be distorted.

For workers or potential workers seeking health insurance, the high premiums in the individual market attributable to insurance company fears of adverse selection and to high sales and administrative costs make individual insurance a very poor substitute for group policies obtainable through employment-based insurance. It is also a poor substitute for self-insurance, the option chosen by most large employers and many medium size ones. Thus, employment and health insurance becomes a tied package, with all the distortions that usually accompany such constrained choices. “You can’t get one without the other.” Some workers might prefer part-time employment, or self-employment, or dropping out of the labor force entirely, but are constrained from those options by their desire for insurance.

Workers who wish to be employed in an industry dominated by firms with 200 or more workers must face the “package” because 99 percent of the firms in that category offer health benefits.⁴ True, the employee could decline the health benefit, but that would leave part of his or her compensation on the table because wage rates are typically set lower to reflect the overall cost of health benefits to the employer. Legal and institutional constraints probably prevent employers from making an upward wage adjustment for a worker who declines the health benefit.

When health problems develop, there is a distortion through reduced job mobility (“job-lock”). A worker with a health problem and employment-based insurance may be reluctant to move to a more desirable job because health coverage in the new job may exclude the “pre-existing condition.” The same combination of a health problem and employment-based insurance may constrain couples to stay married when they would prefer to divorce (“wed-lock”).

Income-tested insurance. Many millions of Americans obtain health insurance from the federal and state governments if their income is below a certain level. Medicaid and S-CHIP are the best known of these programs. They impose implicit high marginal tax rates on income, discouraging recipients from trying to get a better paying job, or a second job because they would lose their insurance. To avoid such loss, some beneficiaries may take employment in the underground economy, even though they might prefer a regular job (which would report their income).

An Evaluation of Current Methods Vs. Tax Financed Basic Insurance

One of the principal purposes of this paper is to evaluate comprehensive reform of health care funding in pursuit of the goals of efficiency and universal coverage. To get a sense of the overall potential welfare gains and losses that would be entailed by such a reform, it is necessary to choose a specific example of such a reform. Because the Emanuel-Fuchs universal voucher plan has an explicit funding method – a VAT – and because we are very familiar with the details of this plan,⁵ we compare it with current methods of funding. The key features of the plan are: 1) Everyone gets a voucher good for enrollment in a plan with benefits comparable to the federal employees health benefits. 2) The plans receive a risk-adjusted capitation payment based on enrollment. 3) Revenue is generated by a dedicated value added tax. 4) Administration and accountability are the responsibility of national and regional health boards, analogous in structure to the Federal Reserve System. 5) Consumers are free to purchase more than the basic plan with after-tax dollars. We ask how economic efficiency would be affected relative to the status quo if the Emmanuel - Fuchs universal voucher proposal financed by a dedicated VAT (or

sales tax) were adopted. We only use the Emmanuel-Fuchs plan as an example. Many of the arguments about replacing the existing health insurance with a new universal health insurance system would apply to other tax-financed reform.

In order to begin to address the question, we divide the non-Medicare population into four groups: (1) those in the labor force with health insurance, (2) those in the labor force without health insurance, (3) those not in the labor force who currently obtain health insurance and (4) those outside the labor force who are currently uninsured. We assess the possible welfare gains and losses for an average person in each of these four groups. By focusing on people in average circumstances, we are deferring consideration of the equity or redistributive aspects of the policy change. At the end of this section we will look at how those whose income and wealth are above and below average are treated and how those who are more or less healthy than average would fare under the new policy.

The first group, those average earners with health insurance, may be subdivided into three categories. First, there are those that obtain their health insurance through their own employment; second, there are those that get their health insurance through their spouse's employment; and finally, there are those that get their health insurance on their own without any connection to employment. We can refer to these cases as 1a, 1b and 1c, with the "1" denoting that these are people in the work force with health insurance.

We begin with case 1a, those who obtain their health insurance through their own employment. We must immediately confront the question of the incidence of employer provided health coverage. We agree with the conclusion of nearly all economists who have studied this question that collectively workers at most firms bear the burden of most of the cost of the health

insurance supplied through their employer. We think that most employment markets are reasonably competitive and that firms have an incentive to hire workers until their total compensation is equal to the value of their marginal product. However, even if this condition holds precisely (that is, all of the burden of health insurance falls on workers collectively at each employer), it still leaves open the question of how it works at the level of individual employees. Economists don't know much about this. There may be considerable cross subsidizations among workers at a given firm. For example, married employees may receive more valuable insurance than singles -without a compensating offset in terms of other compensation. Workers in excellent health may subsidize those who are in sub par health, and so on. To some extent, there are legal and institutional constraints that limit offsetting adjustments to individual compensation that are more binding than the firm's determination of the general level of wages. There also is the question of whether the offsets that do take place affect other benefits (e.g. retirement benefits, tuition benefits, etc.) or lower hourly wage rates. The exact nature of the offsets certainly differs widely across employers.

The main point, however, is that those who have been getting insurance through employment, at least on average, have been paying for it. Plans such as Emmanuel-Fuchs would substitute one way of paying for health insurance, through higher prices due to the new federal sales or VAT for reductions in wages or other forms of compensation. As a first approximation, the cost would be the same for the average worker with employment related health insurance. Other compensation would be higher due to the elimination of health insurance related to the job, but consumption prices would also be higher due to the new tax. There would

probably be other considerations. For instance, a universal voucher plan would almost certainly feature lower administrative costs than employment based health insurance.

Our first conclusion is that the average worker who has been getting health insurance through employment would have about the same real income after the introduction of tax financed universal vouchers. There are, however, several ways in which the individual would be better off. For instance, many would have more choice of plans (currently they are limited to what their employer offers), they would have more mobility between jobs, and they would have more security in their insurance coverage (their insurance coverage would not depend on their continued employment and on their employer continuing to offer coverage).

What would happen to the labor supply by this group? Some people are undoubtedly currently working or working more in order to obtain health insurance benefits. If the job and health insurance were unbundled, they would choose to work less. Their individual welfare would increase with the new and separate options, but social welfare could easily be reduced. The primary reason for the opposite signs for social and individual welfare is the personal income tax. Individuals choose their work hours by comparing the after-tax wage with the value of leisure, whereas the social benefit of working is given by the gross-of-tax wage. While it is likely that the reduction in work hours would be relatively small in aggregate, this reduction in work would tend to harm social welfare.

Group 1b, those working but getting health insurance from their spouse's employer would experience two effects. The worker may have chosen their job because it doesn't have health insurance attached to it, health insurance that might have been redundant given their spouse's coverage. Thus their welfare may increase now that jobs and insurance access have

been separated. Their real wage will be lower as they would not expect a higher salary (they were not paying for health coverage at their employer), but they will face the new taxes. This lower real wage would tend to cause lower work hours and probably a decrease in social welfare. Their spouse, on the other hand, had been paying for the health insurance, perhaps for two people depending on how the offsets work at a micro-level. The spouse's real wage could actually increase and they might react with increased labor hours. Overall, we would not expect a large labor supply response from this family. Again, the family's real income would to a first degree of approximation be unchanged as they would substitute one way of paying for two health insurance policies with another.

One group whose welfare would be increased is those that are employed but obtain coverage on their own, namely the ones we dubbed 1c. The individual market for health insurance is so imperfect that they would face a marked reduction in the cost of insurance. This would be due both to decreased administrative costs and to the elimination of the severe adverse selection in private insurance markets. These people also are not benefiting from the fact that health insurance obtained through employment effectively can be bought with before-income tax dollars. The individual purchase market requires after-tax dollars. The cost savings from not having to buy private insurance would more than offset the increased taxes under the new policy, meaning that the real wage from working would be higher after the introduction of an Emmanuel-Fuchs style policy. Work hours should increase in response to the higher real wage. This would contribute to higher individual and social welfare. We recognize that this is a small category of households and so we don't believe that these gains in welfare amount to much in aggregate.

The second big category of people that we examine are the employed but not insured. The question is why aren't they insured? Many of these people are low income and cannot afford to pay for insurance whether or not it comes via the employer. Most minimum wage workers would fit in this category. However, we have been looking at average income people. Those that are employed but uncovered would include the hard to reach, the gamblers and the free riders, and those whose pre-existing health conditions may make insurance unavailable. What we know is that given the price that they face for health insurance, they are choosing not to buy it. The new regime would mandate that they obtain health insurance, but at a cost that is substantially below the price in the individual market today. Some of these people will be better off because they value the insurance at more than the new cost but less than the existing cost. Others will be worse off, because they value it less than the new, lower cost of a universal voucher system. To the extent that some of these people have been free riding on the generosity of others, social welfare may go up even if individual welfare goes down. In terms of their labor response, they are likely to reduce their work hours if they adjust their labor supply at all. The reason is that the new policy is unlikely to change their wage rate, but lower their real wage due to the price impact of the new taxes. We are assuming that labor supply functions are upward sloping, so that lower real wages will correspond to less labor supplied.

Analysis of the effects on individuals not employed is relatively simpler. Those who aren't in the labor force but who obtain health insurance anyway, can be divided into two groups. There are those who get their health insurance through their spouse's employment and those that buy insurance on the individual purchase market. If someone has average income, is not in the workforce and gets their insurance through their spouse's employment, the main impact may be

on the labor supply of the spouse. The spouse's nominal wage would be expected to go up once the employer no longer supplies health insurance benefits. The real wage would also likely go up, but this would depend on the individual level incidence of the benefit, about which little is known. Overall, the labor supply of the spouse would probably slightly increase. Those that aren't in the labor force but purchase health insurance on their own would benefit from the new policy. It would amount to a significant price reduction for something that they are already buying.

Finally, there are those that are not in the labor force and not insured. If they really are of average means, this gets back to the question of why they don't buy the insurance. What we know is that this product that they were not buying has been reduced in price rather substantially. This may make them better off because they would choose to buy it at the new lower price or it may make them worse off because they still wouldn't buy it on their own but under the new policy, they are forced to.

It is difficult if not impossible to add these welfare gains and losses up for people of average means. Our overall impression of the analysis, however, is that the average change in welfare for people in average circumstances would be small. The overriding fact is that most of these people have been obtaining and paying for health insurance and health services all along and the switch from one means of payment to another leaves only second order effects in terms of economic welfare.

The main social benefit of a universal voucher type of plan would come from the coverage of the poor and the unhealthy and from the separation of the insurance from employment. Amongst the poor, there are those with Medicaid and those without it. Those with

Medicaid would benefit in a number of ways. First, they would face the new sales or VAT, instead of facing the sudden notch of disqualifying for Medicaid if their earnings exceed the qualifying limits. Since they are poor, the tax burden would be substantially less than the value of the insurance. The dedicated tax would involve a net transfer from those with above average consumption (who would pay more than the cost of their coverage) to those with less than average consumption. If the efficiency costs of the tax can be kept modest, such transfers would presumably increase social welfare.

Those with sub par health would benefit greatly from the universal coverage benefit. Currently, if they cannot get employment based insurance, they face the very unfavorable individually purchased market, with all of its problems. It seems obvious that one of the key social benefits of universal coverage is that it permits those who need coverage the most to indeed be covered.

Most non-elderly Americans obtain their health insurance through employment; the principal explanations are the favorable tax treatment of health insurance benefits and the advantages of group over individual insurance markets. Both the employee and the employer contributions to employment based health insurance are usually excluded from taxable income. This makes health insurance cheaper than most other consumption, such as food, clothing, and transportation expenses. Clearly it distorts behavior in favor of more health insurance and more health spending. It also distorts work behavior, since the favorable tax treatment is generally not available for those who don't obtain their health insurance through work. The Emmanuel-Fuchs proposal would separate the work and insurance markets completely and thus eliminate the distortions. Health insurance would be financed with the proceeds of the VAT, but the VAT

payments would be made with after-income tax money. Health insurance would no longer be cheaper than almost all other consumption items.

When we reflect on the welfare gains and losses of universal vouchers, we think that most of the gains from the shortcomings of the current system linking insurance and employment for most non-elderly Americans. The biggest drawback of the current situation is probably that lack of truly secure insurance. People are covered only as long as they keep their job and only as long as their employer continues to offer insurance. Their insurance choices are limited by their employer. Some people choose who to work for or even which career to pursue based on health insurance benefits. This linkage between employment and insurance clearly is inefficient. The system arose partly largely from the wage and price controls during and after World War II and was perpetuated by tax preferences. If we are to separate employment and insurance and if we are going to move to universal coverage with its required compulsion and subsidization, then the federal government is going to have to be involved in a large way, either providing financing or by using mandates. We have argued that mandates are another form of taxation. Our goal here has been to examine alternative tax sources to finance an expanded federal role in health insurance. We have argued that sales and value added taxes are relatively efficient and that there are important advantages for the federal health insurance system to rely on a separate dedicated tax for its funding.

Section IV

Summary

Despite numerous imposing political obstacles, the United States will, sooner or later, have to undertake comprehensive reform of the health care system. Erosion of employment-based insurance, growth in the number of uninsured, and especially, an increase in health expenditures that outpaces the rest of the economy will make such reform practically inevitable. To succeed, reform must lead to greater efficiency in medical practice, eliminate gross lapses in quality, and tame but not destroy the development and diffusion of new medical technologies. The success of reform will depend heavily on an approach to funding that covers all Americans for basic care, restrains expenditure growth to a rate that the public is willing and able to pay for, and does so in an equitable and efficient way.

With this as background, we summarize the main points of the paper:

- § If the growth of health expenditures exceeds the growth of the rest of the economy by as much in the next 30 years as in the last 30, health care will consume 30 percent of the gross domestic product.
- § To cover everyone with health insurance there must be subsidies for those who are unable to acquire it and compulsion for those who are unwilling to do so.
- § “Shared responsibility” and “government assistance for the middle class” are myths propounded to make reform proposals appear more attractive. In the end, the cost of care is borne by the public in the form of lower wages, higher consumer prices, or higher taxes. The affluent and healthy subsidize the poor and the sick; the middle class, on the

whole, is not likely to provide or receive subsidies.

§ There are many different instruments available to the Federal government to fund health care – taxes, tax exemptions and credit, mandates, and others. The economic goal should be to find the instrument (or instruments) that would be most efficient and most equitable. The political goal, not discussed in this paper, is to find the instrument (or instruments) that maximizes political support.

§ Mandates seem to be politically popular. They are often presented as an alternative to taxes. Properly understood, they are a form of taxation.

§ Public finance theory suggests that general revenue taxes are usually preferable to dedicated taxes. In the case of health care, however, there are strong reasons for preferring a dedicated tax that enables the public, through its representatives, to balance the value of additional expenditures against the cost of additional taxes. Dedicated funding also forces the health care delivery system to focus on an overall budget.

X All things considered, we believe the dedicated tax should be on consumption – either on value added (VAT) or on retail sales (RST).

§ Evaluation of the costs and benefits of changing from the current system of funding care to a single dedicated tax requires consideration of many likely effects. This paper does not attempt a quantitative evaluation, but it appears that the simple assumption that the substitution of additional taxes for the current system must cause a big increase in dead-weight loss is incorrect because there are so many distortions attributable to employment-based insurance, income-tested insurance, and other aspects of the current system.

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[Appendix tables, charts, and figures to be added/sent later.]

Endnotes

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