

Financing the U.S. Health System

Issues and Options for Change

A PROJECT OF THE



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PREAMBLE

The Bipartisan Policy Center (BPC) is a public policy advocacy organization founded by former U.S. Senate Majority Leaders Howard Baker, Tom Daschle, Bob Dole, and George Mitchell. Its mission is to develop and promote solutions that can attract the public support and political momentum to achieve real progress. The BPC acts as an incubator for policy efforts that engage top political figures, advocates, academics, and business leaders in the art of principled compromise.

This report is part of a series commissioned by the BPC to advance the substantive work of the Leaders' Project on the State of American Health Care. It is intended to serve as an analysis of potential financing options for the nation's health care system and does not necessarily reflect the views or opinions of the four Leaders or the BPC. The Leaders' Project is creating a framework to accelerate constructive discussion and implementation of policy solutions to address the delivery, cost, coverage, and financing challenges facing the nation's health system. To accomplish this goal, the four Leaders will host several public policy forums across the country and release a final report with comprehensive policy recommendations on the issues defined in the project's four "pillars" of health care reform. The report and recommendations will be released early in 2009.

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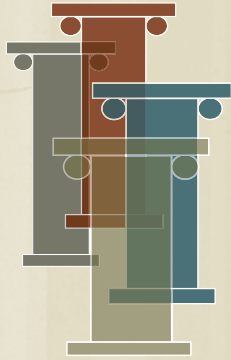
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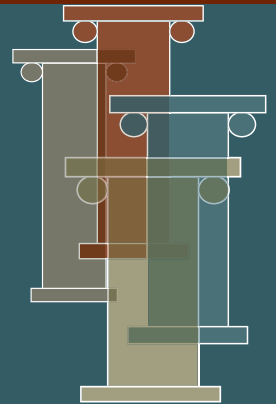


FOUR PILLARS OF HEALTH CARE REFORM

The Leaders' Project is structured around four "pillars" that, taken together, the Leaders believe represent the foundation of a solid policy needed to achieve quality, affordable health care for all Americans. The four pillars are:

- Preserve and improve quality and value
- Increase the availability and accessibility of affordable coverage options in a reformed insurance market
- Promote the individual's role in health care coverage and cost
- Secure a workable financing mechanism for the nation's health care system

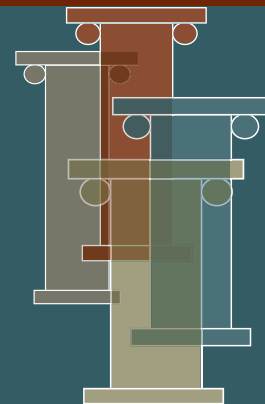
Executive Summary



Health reform proposals across the spectrum have included changes in how the U.S. health system is financed. The goals of such changes include using financing incentives to promote system goals, replacing insufficient financing mechanisms with more sustainable ones, and increasing Federal subsidies for a reformed health system. Irrespective of their specific design and independent of the delivery system changes they support, these options have policy implications that have received little public attention. This paper examines the implications of different options for financing the health system. Specifically, it describes recently proposed policies including continuing current financing and redirecting health spending to more effective uses, rolling back high-income tax cuts, modifying the current tax exclusion for health benefits, a play-or-pay model, and a value-added tax. Their effects on individuals, employers, and the health system are explored.

INTRODUCTION

The Need for Change in the Health System



Across the spectrum, from boardrooms to living rooms, problems in the health system are a top concern.¹ This is not a surprise: health care costs are high, and rising even higher. The United States spent about \$2.1 trillion on health care in 2006, an amount that is twice what it was in 1996 and half as much as is projected for 2017.² Health costs strain American businesses, which directly finance about one-fourth of health system spending.³ Employer-sponsored health insurance premiums rose by 98 percent between 2000 and 2007—four times faster than cumulative wage increases.⁴ This in turn affects families. The average cost of a family, employer-based insurance policy in 2007 was \$12,105, nearly the full-year, full-time earnings of a minimum wage job.⁵ In addition to high premiums, people are paying higher amounts for deductibles and service use. Between 2001 and 2004, the number of non-elderly Americans spending more than 10 percent of their income on premiums and cost-sharing jumped by six million, or about 15 percent.⁶ The issue also has a profound impact on seniors: the typical couple may have to save nearly \$300,000 to pay for health costs not covered by Medicare alone.⁷

The cost problem has contributed to an access problem. The number of non-elderly Americans covered by employer-based health insurance fell from 66 percent to 61 percent between 2000 and 2006, with small business employees affected disproportionately.^{8,9} Indeed, in 2007, only 45 percent of firms with three to nine employees offered health benefits, in contrast with 99 percent of firms with 200 or more employees.¹⁰ Firms that are less likely to provide health benefits also tend to have a significant part-time or low-income workforce, are not unionized, and are in non-manufacturing sectors.^{11,12}

With few affordable alternatives, people losing employer coverage often become uninsured. In 2006, 47 million Americans, nearly 16 percent of the population, were uninsured, up roughly eight million since 2000.¹³ Approximately 80 percent of the uninsured are in families with at least one worker. If trends continue, another seven million will be added to the ranks of the uninsured by 2012.¹⁴ While most uninsured have low incomes, more middle-income working Americans are falling victim to this trend. Nearly half of the increase in the uninsured population between 2005 and 2006 occurred among middle-income families.¹⁵ About 18 million of the 47 million uninsured have a household income that exceeds \$50,000.¹⁶ The uninsured are less likely to seek needed care, leading to decreased workplace productivity and a greater risk of illness or death, with a cost by some estimates of \$65 to \$135 billion per year.^{17,18,19}

Finally, the problem of access to quality care extends beyond the uninsured, to how health care financing may affect the delivery of care for insured patients. A comprehensive study found that care demonstrated to be effective is provided only 55 percent of the time.²⁰ In fact, the Institute of Medicine estimated that roughly 100,000 deaths per year result from low-quality care.²¹ The United States also lags behind other nations in the use of error-reducing techniques, such as health information technology.²²

CONSENSUS ON URGENCY AND GOALS OF HEALTH REFORM

These cost, access, and quality challenges in the health system have fostered broad-based agreement on the urgency of change, and the types of changes needed. Perhaps the best barometer for the sense of urgency is the emerging business and bipartisan policy support for health reform. Leaders of such companies as AT&T, General Mills, Intel, Kelly Services and Wal-Mart have joined forces with SEIU and the Communication Workers of America to form the Better Health Care Together (BHCT) coalition. BHCT is seeking health reform that promotes quality, value-based coverage for all Americans, with an emphasis on shared responsibility, and an implementation goal of 2012.²³ Similarly, policy leaders have put aside partisan differences—at the most difficult time to do so, an election year—to advance health system change. A bipartisan coalition has formed in the Senate around one vision for reform,²⁴ and the presidential candidates have embraced major health proposals.²⁵

On the policy itself, most media coverage and policy debates focus on the key differences that persist. Policymakers disagree on whether individual market competition or group purchasing can best achieve cost containment while promoting access to valuable innovations in care. For example, some seek to change how people get insured, supporting a shift from employer-based and public coverage to the individual (i.e. non-group) market. In contrast, others seek to reform current coverage options by building on existing sources of coverage. Still, others support a shift from private to public insurance (e.g., a single-payer system).

Beyond these differences, health reform proposals are similar in their goals of improving the value, sustainability, quality, and coverage of health care for all Americans. They often include policies that promote best practices and sharing of information through health information technology; make useful price and quality information available to patients, providers, and purchasers; and invest in health services research to better guide public policy decisions. Most support expanding disease prevention and wellness promotion and agree that additional public assistance is needed to make health insurance affordable for low-income and high-risk individuals.

Perhaps most critically, the need to constrain health care costs is an overarching theme of many health reform proposals. That, in turn, has yielded support for policies such as aligning financial incentives for providers and patients toward early and effective

therapies; managing the care of people with multiple chronic conditions; and making value a priority in purchasing of goods and services, especially in Medicare. The imperative to improve the affordability of health care for individuals, employers, and taxpayers places health reform high on the agenda of the next president and Congress.

EMERGING INTEREST IN HOW THE HEALTH SYSTEM IS FINANCED

In 2008, an element that has not been fully present in prior debates emerged, that is, agreement to examine how the health system is financed, publicly and privately. Part of this is driven by practicality. Most employers currently offer health benefits; on average, health benefit costs represent 10.7 percent of total payroll.²⁶ With health costs consistently rising, employers' expenditures on health benefits are affecting their ability to invest and expand their businesses, compensate employees, initiate new hiring, and meet long-run liabilities (e.g., retiree health benefits). Most businesses fear that they cannot sustain their financing of health benefits, but also do not want to abdicate their role in ensuring health coverage for their workers.²⁷

The high and rising cost of health benefits limits firms' ability to increase wages and make other investments. It distorts competitiveness in the labor market between large and established firms, which typically offer benefits, and small and new firms, which frequently do not. Firms with retiree coverage are particularly affected, as their promises to workers end up costing more than anticipated. And businesses that offer non-traditional and service jobs struggle to provide health benefits to workers who are part-time, part-year, or are otherwise difficult to insure. These diverse challenges facing American businesses have led to support for changing the financing of health care, while recognizing that businesses will want to continue to have a role in financing and managing health benefits.²⁸

Similarly, Federal lawmakers concerned about the long-run budget deficit are increasingly turning to health policy for solutions. The director of the Congressional Budget Office named health care cost growth as "the single most important factor determining the nation's long-term fiscal condition."²⁹ The cost growth of Medicare, Medicaid, and other Federal health spending exceeds that of general revenue and economic growth, placing pressure on Congress and the President to either reduce costs or raise revenue. Increasingly, policymakers realize that these approaches are interconnected: changing how the health system is funded can be a tool in improving the efficiency and quality of that system. Many also believe that reducing long-term health spending requires an up-front Federal investment. Consequently, a diverse set of financing options is now in play, and they are being considered in conjunction with their potential impact on the delivery of care.

These interests manifest themselves in recent proposals.³⁰ On the campaign trail, both Sens. McCain and Clinton proposed changes to the current tax exclusion for health

benefits. Sen. Obama and Gov. Schwarzenegger from California support a “play-or-pay” model to capture revenue from firms that do not offer health benefits. Both Sens. Obama and Clinton support the rollback of some of President Bush’s tax cuts to finance their reform.

THE CONTEXT FOR CHANGING HEALTH SYSTEM FINANCING

An understanding of the implications of financing options depends first on an understanding of the current system: the sources of funding for health spending, the lost revenue associated with health-related tax policies, and projected trends in health spending over time.

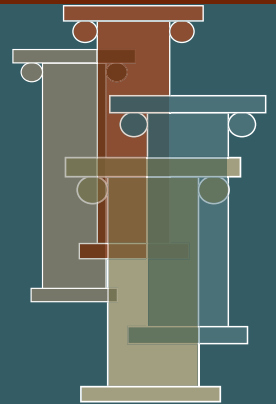
Sources of Funding of the Health System: As mentioned previously, the United States spent \$2.1 trillion on health care in 2006. Of this amount, \$1.1 trillion, or 54 percent, came from private sources of funding; \$705 billion (34 percent) came from the Federal government; and \$265 billion (12 percent) came from state and local government. Dividing further by major source of funding, the majority stemmed from private insurance, at \$723.4 billion in 2006. Medicare was the next largest source at \$401.3 billion, a rise of 18.7 percent from the prior year largely due to the introduction of the Part D drug benefit. Medicaid spending totaled \$308.6 billion, and out-of-pocket spending comprised \$256.5 billion.³¹

In addition to government spending for health services through Medicare, Medicaid, and public health programs, tax codes provide subsidies for over 90 percent of private health insurance and certain health care expenses.³² The most significant of these is the Federal and state individual income and payroll tax exemption for all employer premium contributions and many employee premium contributions. Under the codes, these premium contributions are not included as part of employee taxable income. The cost of these exemptions, in lost Federal and state revenue, was estimated at \$208.6 billion in 2006.³³ This is by far the nation’s largest tax expenditure. The Federal tax exemption alone is equivalent to nearly half of what the Federal government spends on Medicare.³⁴ The effect of these tax provisions extends beyond the impact on Federal revenues. In 2007, tax breaks were associated with \$732 billion in employer and employee contributions toward health insurance.³⁵

The other major Federal health-related tax expenditures include deductions for medical expenses (\$3.8 billion in 2006), self-employed medical insurance premiums (\$4.0 billion), and health-related charitable contributions (\$4.2 billion). A tax break also exists for Health Savings Accounts (HSAs) tied to high-deductible health insurance. Consumers can make tax-deductible contributions to an HSA account that is then used for health-related expenses. The associated Federal tax expenditure for HSAs totaled \$280 million in 2006.³⁶

Future Trends in Health Care Spending: Historically, health care costs have grown faster than the economy, rising from five percent of GDP in 1965 to 16 percent in 2006; and, they are expected to continue climbing. The Congressional Budget Office projects that spending on health care will rise to 25 percent of GDP in 2025—and that includes an assumed slow-down in health care growth, as finances become increasingly constrained. Much of this surge comes from growth in health spending per capita throughout the system rather than demographic trends. This is apparent in comparing Federal health programs and Social Security. Assuming no changes in current Federal law, the proportion of spending attributable to Medicare and Medicaid in the health system is expected to rise from four percent of GDP in 2007 to 19 percent of GDP in 2082. In contrast, Social Security is expected to rise from four percent of GDP today to six percent of GDP in 25 years, and stabilize thereafter. If these trends continue, health spending is predicted to be the main force behind rising Federal spending in the decades to come.³⁷

Options for Change



A wide-range of policy options have been proposed to replace, modify, or supplement the current health care financing system. Here, we explore those options that have been discussed in the past two years as part of proposals for health reform. We do not explicitly consider changes in Medicare and Medicaid financing, although any of the new financing methods potentially could be extended to cover those programs. All financing options would be linked to policies that would reduce health care spending and increase the value of health care, to lessen the demand for revenue. These proposals are generally intended to increase affordability of public and private health insurance premiums and access to care. A discussion of those critical issues is beyond the scope of this paper, but will be addressed by other reports commissioned by the Bipartisan Policy Center as part of the Leaders' Project on the State of American Health Care.

The various financing options have a number of implications for the economy broadly, and the health system specifically. One set of economic questions relates to each options' impact on individuals. Do low-income or high-income people pay a higher share of their income under the proposal—that is, is it “regressive” or “progressive”? Will it affect all people equally or certain segments of the population (workers, seniors, people with coverage and those without) disproportionately? Given their large role in financing the health system, employers also will likely be affected by the various financing options considered for health reform. Specific questions regarding the impact on business include: will the option change businesses' direct costs for health benefits? How will different types of firms be affected? The answers to these questions are incomplete in the absence of details on the delivery system changes that they would support. For instance, a regressive tax policy linked to a health reform proposal that expanded benefits to the poor could be considered progressive overall. In addition, the reaction of individuals and businesses to these types of proposals is uncertain; we offer informed guesses here, but further research is needed.

Changing the way health care is financed could have a major impact on our health insurance system. New financing approaches could affect health spending in several ways, by changing where people get health insurance, the nature of the health coverage they buy, transparency and awareness of pricing, and the share of health spending borne by government. These implications are discussed as well.

CONTINUE CURRENT FINANCING STRUCTURE

Description: One way to finance health reform is to keep the current mix of revenue intact and try to redirect the funds to more effective uses. Federal health programs would continue to be funded largely by general revenue (which is primarily collected from income taxes) and payroll taxes, with additional funding from premiums and cost-sharing paid by enrollees in the programs. Increases in Federal spending for new or existing health programs would be offset by reductions in other spending (including lower-priority health spending), or would increase the Federal deficit. Private insurance would continue to be financed through premium contributions from employers and individuals, and through out-of-pocket spending by individuals. Proponents of this approach argue that the health system does not need substantial funding increases, but instead that the money should be spent more wisely. The first step, then, to financing health reform is making health care delivery more streamlined and efficient, reducing unnecessary costs wherever possible.

Examples: Proposals for adding a prescription drug benefit to Medicare were first introduced in 1999 when there was a Federal budget surplus. By the time the benefit was passed with bipartisan support in 2003, there was a Federal budget deficit. The estimated cost of the drug benefit was partially offset by public program savings. However, at the time of passage, the benefit was estimated to increase the Federal deficit by \$400 billion from fiscal years 2004 to 2013.³⁸ Subsequently, proposals have been advanced that intend to improve the effectiveness of Medicare spending, making existing funds go further. Examples include pay-for-performance, paying for episodes of care rather than individual services, and not paying for avoidable medical errors.

Other examples come from the campaign trail. Gov. Mitt Romney of Massachusetts proposed expanding insurance at a state level by redirecting Medicaid and uncompensated care funding.³⁹ Gov. Bill Richardson of New Mexico claimed his health plan would cost \$104 to \$110 billion per year and would be fully offset with reductions in Federal health spending, plus the elimination of “tax shelters for high-risk health plans,” presumably HSAs.⁴⁰

Economic Implications. The option of continuing the current financing structure assumes that improvements in health insurance coverage and the delivery of health services can be made within the financing resources that are available now, without increasing tax rates or driving up costs in the private sector. While reform policies that successfully contain the spending growth by avoiding unnecessary health care costs would ameliorate some of these economic challenges, there is no clear way at present to recover those costs and use the resources in more productive ways. Moreover, improving quality, access, and value in the health system would likely require an up-front investment. Such improvements are likely to require additional spending by the private and public sectors, at least in the near term and perhaps longer, before system improvements are implemented and any savings begin to be realized.

Health System Implications: If health cost growth continues to outpace overall wage growth and productivity gains, continuing the current financing system would likely result in a decline in employer-based health insurance.^{41,42} Public program enrollment would likely rise with the further erosion in employer-based coverage. This has been the experience in the State Children’s Health Insurance Program, which has increasingly insured children affected by the decline in dependent coverage in the private insurance market.⁴³ Nonetheless, the number of uninsured would likely rise.

Employers who continue to offer coverage would maintain an interest in keeping costs low, although this incentive is muted by the current tax exclusion policy that gives individuals a greater tax break the more expensive the health plan. Individuals facing an increasing share of their income dedicated to health care may be motivated to modify their behavior or benefits. However, changes in health care or coverage would be almost exclusively driven by associated health care reform policies, as this approach does not use changes in financing as a tool to advance other health system goals.

ROLLBACK HIGH-INCOME TAX CUTS

Description: Some proposals would pay for new health care subsidies or system investments using revenue generated from allowing certain tax cuts to expire (thus raising income taxes for some individuals). Three major pieces of tax legislation were supported by President Bush and enacted by Congress in his first term of office. In 2001, there were significant reductions in income tax rates and the estate tax, targeted toward education, savings, families, and married couples. In 2002, tax breaks were provided for new business investments, and in 2003 reductions were made to the tax rates for dividends and capital gains.⁴⁴ These tax cuts are generally scheduled to expire under current law in 2010. Instead of extending all of the tax cuts, some health care reform proposals would return to the higher income tax rates that were in effect in 2000 for high-income people, so that some of the increased Federal expenditures could be financed without creating a larger fiscal gap.

Examples: Sen. Obama’s proposal would restore the tax rates from 2000 for the top two personal income tax brackets (from 33 to 36 percent and 35 to 39.6 percent respectively)⁴⁵ as well as for dividends and capital gains. It also would maintain the estate tax with a \$7 million exemption rather than letting it expire. Campaign advisors estimate that this would raise about \$65 billion per year, compared to making the tax cuts permanent.⁴⁶ During her campaign, Sen. Clinton proposed similar changes for the same purpose.⁴⁷

Economic Implications: Reversing the tax cuts requires no new tax collection mechanism, unlike some of the other financing options. Because rates would be raised only for high-income taxpayers (representing about two percent of the population),⁴⁸ the proposal would be progressive in nature. However, increases in marginal tax rates could retard economic growth by reducing the incentive for productivity and innovation.

Although a repeal of tax cuts would generate additional revenue compared to making them permanent, the fact that the cuts are scheduled to expire raises questions about the way this financing option would be scored in the Federal budget. The Congressional Budget Office assumes that the tax cuts will expire as written in the original law, so that it would not treat the rollback as a source of new revenue to finance health care reform or any other Federal spending initiative.⁴⁹ The Office of Management and Budget incorporates a continuation of the tax cuts into their projections. Because budget baselines aim to capture likely future revenue and spending, and letting some policies expire is unlikely, both budget offices include in their projections the continuation of certain expiring excise taxes and programs like the welfare block grants. Proposals for a rollback of part of the tax cuts address the concern that if the tax cuts continue, and there are no other changes in policy, the baseline projection will be for substantial deficits in the outyears. However, even with a partial rollback, significant expansions of Federal health care programs without slowing the growth in health care spending would still likely add to deficits.⁵⁰

Health System Implications: The rollback of the tax cuts represents a one-time change with revenues that may not sustain health spending in the long run, without successful cost containment initiatives. It largely continues the current reliance on general revenue, employer, and individual financing for health care.

REFORM THE HEALTH BENEFIT TAX EXCLUSION

Description: A number of proposals have been made to limit or eliminate the exclusion of employer premium contributions from employees' taxable income. This tax exclusion comprises the single largest Federal tax expenditure and plays a major role in how health insurance is financed in the United States. Some proposals would limit the amount of the employer contributions that can be excluded from individuals' income for tax purposes. Others would eliminate the tax break altogether.

Examples: Limiting the health benefits tax exclusion has been proposed by a number of policymakers, going as far back as the Reagan administration. In 2005, the President's Advisory Panel on Federal Tax Reform recommended capping the tax exclusion across the board at an amount equal to the national average premium.⁵¹ Sen. Clinton's campaign health care plan proposed to cap the tax exclusion based on a standard benefit, only for those individuals who earn more than \$250,000 per year. This proposal was estimated to generate \$2 billion in revenue.⁵²

Others have advocated the elimination of the health benefit tax exclusion, replacing it with different types of tax deductions or credits. President Bush supported this option in his Fiscal Years 2008 and 2009 budgets, using the revenue for a new standard tax deduction for individuals and families who purchase health insurance.⁵³ The health benefit tax exclusion is similarly eliminated in the bipartisan Healthy Americans Act, which also includes sliding-scale subsidies, insurance reforms, and a requirement that

individuals get and keep coverage.⁵⁴ Sen. McCain's health care plan eliminates the exclusion and replaces it with tax credits for everyone who purchases health insurance.⁵⁵


Economic Implications: Because the value of the health benefit tax exclusion increases with income, and because high-income workers are more likely to have higher cost policies, limiting or eliminating this tax expenditure would result in more revenue from high- than low-income workers unless they switch to less-expensive coverage. Some middle-income workers may also have high cost insurance as part of their compensation, and they could also see an increase in their taxes if they did not change coverage. Nonetheless, after the rollback of tax cuts for high-income individuals, this financing option is the next most progressive.

From the employer perspective, modifying the health benefit tax break could make workers more sensitive to employer spending on health insurance on their behalf, and thus lead to reductions in non-wage labor costs. That is, if the tax exclusion is no longer available, raising wages for workers would no longer face a “tax disadvantage” compared to contributing to employee health premiums.⁵⁶ Assuming health benefits are adequately funded through companion health reforms, this financing option would allow firms to focus on forms of employee benefits with more predictable costs.

Health System Implications: Because of its link to health benefits, the tax exclusion is considered “within-the-system” financing. In other words, it is a source of revenue with a connection to health spending. The tax exclusion has been a major factor in the development of the U.S. system of employer-based health insurance. A critical policy question is, what will happen to employer-sponsored insurance if the tax exclusion is changed?

If the exclusion is capped, employers would likely scale back benefits (and reduce premiums), but not necessarily drop it at any greater rate than what is occurring currently. However, if employers' contributions to health benefits were no longer tax preferred, employers would not have the tax incentive to provide benefits, although the labor-market demand for it may persist.⁵⁷ Policies that eliminate the exclusion are generally linked to proposals to provide alternative coverage, but even a small percentage shift of the 158 million Americans who have employer-sponsored insurance yields a large number of people who would no longer have coverage through their employers.

This erosion of the employer-based system of health insurance would mean some workers would no longer be in a community-rated, employer-managed, health insurance pool. While the deduction of premium payments from wages lowers sensitivity to the price of coverage, it also results in a relatively simple system for predictably paying for health care. The literature on active versus passive enrollment and people's decisions about benefits suggests that this delinkage of health benefits from compensation could result in fewer people being insured in a voluntary system. This is because, depending on how the reform is enacted, individuals would have to



affirmatively find insurance on their own and pay for it out-of-pocket.^{58,59} Moreover, most employer plans typically charge enrollees the same premiums regardless of age or health risk, offer them the same set of benefits and consumer protections, and have relatively low administrative costs—features not easily found in individual or small group market insurance products.

Some proponents of a full repeal of the exclusion aim to promote the individual insurance market by eliminating the tax inequity: people who purchase individual market insurance currently do not receive any tax benefits while those with employer-sponsored health insurance do.⁶⁰ Eliminating the special tax status of employer-provided plans would put its premium payments on par with those in the individual market. Proponents of this policy assert that the individual market offers coverage that does not depend on job status and, by definition, promotes individual involvement in health coverage decisions.

Capping the tax exclusion, as opposed to eliminating it, could change the nature of coverage, if not the source. The current policy provides a tax incentive for employers to both offer high-cost health coverage and finance a large share of it. This distorts price signals and contributes to employee insensitivity to the costs of health care. Capping this tax break at some standard (e.g., a national average premium) decreases the bias toward high-cost plans. Furthermore, policymakers could condition the receipt of the employer exclusion on the employer's purchase of coverage with particular attributes, such as an emphasis on prevention and wellness, quality reporting, or use of health information technology—although conservatives would argue that the market should determine what kinds of insurance are sold.

Some premiums are higher than average due to geographic variation in health costs or differences in firm demographics. For example, some firms have high concentrations of older workers or retirees, which could potentially lead to an unfair targeting of certain high-premium plans. The cap could be adjusted for geography or other idiosyncratic cost factors to avoid these problems, although doing so complicates the administration of the proposal.

By changing the nature of coverage, capping the health benefit tax exclusion could ultimately alter price sensitivity and/or population cost awareness for health care. Employees would have an incentive to choose a plan with a premium contribution at or below the cap, replicating the type of competition envisioned for Medicare managed care plans. If capping the premium tax exclusion results in less expensive plans with higher deductibles and coinsurance rates, consumer price sensitivity could increase, bringing health care decisions more closely in line with individual willingness-to-pay, particularly if those decisions were supported by good information and guidance from health professionals. This in turn could reduce health spending by the privately insured.⁶¹ However, unless coupled with other health reforms, increased cost-sharing could also deter consumers from using appropriate services, such as preventive care.

INSTITUTE A PLAY-OR-PAY MODEL

Description: Under play-or-pay models, employers would be required to offer insurance to their employees (and contribute at least a specified minimum amount) or pay a tax equivalent to support the cost of insuring workers through an alternative source. This “payment” could take a number of forms, from a payroll tax to an amount per full-time equivalent employee.⁶² The play-or-pay model provides a direct way for companies that do not provide health benefits to pay to otherwise insure their employees, thereby strengthening the link between health coverage and employment.

Examples: A Yale political scientist proposed a play-or-pay model called Health Care for America that was similar to John Edwards’ campaign plan.^{63,64} Employers that do not provide a health plan comparable to a new comprehensive standard (and contribute 75 percent of the premium for workers, and 66 percent for family coverage) would pay a 6 percent payroll tax. The revenue generated from this payroll financing has been estimated at \$106.8 billion in 2007 dollars, coming both from firms that do not now offer coverage and firms that discontinue coverage in light of the new system. The estimate assumes that about one-third of people currently covered by employer-sponsored insurance (51.8 million out of 154.7 million) would be covered under a new Medicare-like public plan option, because the payroll tax would be less than the cost of coverage for the employer.⁶⁵

Gov. Schwarzenegger incorporated a play-or-pay model for the financing of his health reform plan in 2007. Under his proposal, employers with 10 or more employees who do not offer health care coverage would have to contribute 4 percent of payroll, which would complement other sources of financing needed to implement the plan.⁶⁶ The revenue from the play-or-pay model was estimated at \$1 billion, levied on 7.5 percent of California businesses representing 5.7 percent of workers.⁶⁷ Sen. Obama has similarly proposed a play-or-pay model to help finance his health care reform plan, with an exemption for the smallest businesses.^{68,69}

Economic Implications: The play-or-pay approach broadens the pool of employers that would contribute to health financing. Theoretically, it increases equity across firms by ensuring that all pay a comparable minimum amount for health benefits. It also could improve competition among firms within sectors by putting health benefit costs on a more equal footing. Payroll taxes are already used to finance Social Security and Medicare; an extension to help fund health benefits is relatively straightforward.

The play-or-pay model would primarily affect those firms that do not offer health insurance. Firms unlikely to provide health insurance in the current system tend to be small and/or new, operate in the service sector, and are not unionized. Faced with new or higher costs for health insurance under play-or-pay, affected employers would tend to pass through the additional health financing costs onto employees through lowering wages, cutting employment, or making other adjustments in the firm’s operations.⁷⁰

This financing option may, therefore, be regressive, as firms that do not currently offer health coverage tend to have a low-wage workforce. Setting the assessment based on a firm's payroll rather than a flat amount per worker would lessen the impact on low-wage workers. Exempting or decreasing the rate of "payment" under the play-or-pay model for the lowest-wage businesses would improve its progressivity, although doing so would erode potential revenue from the proposal.⁷¹

The expectation that health benefits are built into the cost of doing business may create barriers to starting or expanding businesses, particularly for small or new firms that otherwise would not finance health benefits. Businesses would have less flexibility than they do today in determining how to compensate their workers, as health benefit financing would be expected. The play-or-pay model may also require firms that already offer coverage to upgrade benefits to new standards, or pay new costs for compliance and reporting. Higher costs of labor in turn could adversely affect wages, employment, product prices, and profit. As firms that now offer coverage know, there is a limit to how much firms newly affected by the play-or-pay model can pass on through lower wages, employment reduction, price increases, or profit reduction. At the same time, the associated health reform could ultimately lead to an alleviation of the strain of rising health care costs.

Health System Implications: As with the tax exclusion reform, the play-or-pay model also has a health system impact, although the nature of that impact depends on its design. One goal of a play-or-pay model is to stop and possibly reverse the decline in employer-sponsored insurance, while preserving the mechanism by which many people obtain coverage. Firms that offer coverage now will be less likely to drop coverage if faced with an assessment for doing so.

On the other hand, if the assessment is set low and grows slower than health inflation, some firms will be likely to pay the assessment rather than "play," exacerbating the erosion of employer-based health insurance and potentially increasing public expenditures on coverage. Even if the assessment is set high, the cost of employer-based coverage for high-risk worker groups, such as older workers and early retirees, could be more expensive than the required tax. There is concern that this may lead to a disproportionate increase in unhealthy individuals who cannot obtain insurance through their employer, potentially creating a strain on any government or other-source insurance provider. Proponents of the play-or-pay model, however, maintain that there are enough firms that do not offer health insurance to counter this effect.⁷²

Additionally, the play-or-pay model could encourage employers to continue their efforts to control costs and improve health care quality for their employees, but only to the extent that they "play" rather than "pay." The design of the model matters; if the required payment is linked to insurance premiums, even employers that choose to

“pay” will care about the rising trend of health spending. However, to the extent that the “pay” insurance designs and costs are determined at a level much broader than that of individual employers, firms are unlikely to invest much effort in promoting health system improvements because their actions would not have much impact on cost and quality.

IMPLEMENT A VALUE-ADDED TAX

Description: Several proposals incorporate a Value-Added Tax (VAT) as a method of financing health reform. Some use it to supplement existing forms of financing, while others propose that it replace major forms of financing for the system today (e.g., replace the payroll tax as a source of financing for Medicare). Generally speaking, a VAT is collected at each stage of the production process, in contrast to a retail sales tax which is collected only at the final sale. There are several ways to administer it, with the “credit-invoice” being the most common. Here, each step of manufacturing pays VAT to the government. For example, a retailer pays VAT on his or her wholesale purchases, then receives the VAT from retail sales, and subtracts the two to calculate the amount owed to the government.⁷³ For each percentage point levied, a VAT would yield approximately \$37.8 billion in revenues.⁷⁴

Examples: A proposal from the Center for American Progress would fund the up-front, Federal costs of health reform with a VAT of between three to four percent, with targeted exemptions for small businesses, food, education, and health care.⁷⁵ Rep. Dingell has long sponsored legislation to create a five percent VAT (with targeted exemptions) in support of universal coverage.⁷⁶ A similar plan would create a 10 to 12 percent, earmarked VAT to insure all Americans under age 65.⁷⁷ Another proposal from an Urban Institute expert would use a VAT to link the health and tax reform debates. The VAT would replace current sources of health financing, with the existing sources being used to simplify the income tax system.⁷⁸

Economic Implications: A VAT is an example of a flat tax that is viewed by many economists as an efficient way to finance government programs. Unlike an income tax, a flat tax on consumption does not discourage saving and investment. Therefore, a VAT may be more likely to encourage savings than the other financing options considered here.⁷⁹ Because a VAT is collected at each stage of the production process, as opposed to just at final sale, it is considered easier to administer than a retail sales tax.⁸⁰ It also provides a better audit trail because it tracks each stage of production,⁸¹ and is more difficult to evade than corporate income taxes.⁸²

In addition, VAT applies to a broad base, essentially anyone who purchases goods in the economy, thus spreading the burden of health care financing across the whole population. It is collected from both the working and nonworking population, unlike the rollback of the tax cuts, modifying the health benefit tax break, or the play-or-pay model. Given that the working population tends to be healthier and younger than the

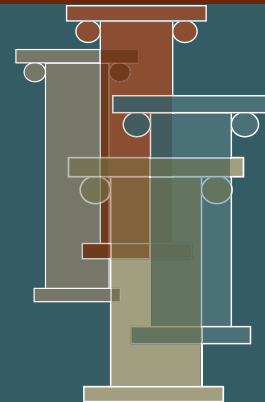
nonworking population, the VAT collects revenue from the unhealthy as well as the healthy, and from the old as well as the young. Thus, it counterbalances some of the intergenerational transfer of funds for Medicare and Social Security, a transfer that will grow as the ratio of retirees to workers rises.

Because it taxes consumption, the VAT is regressive. Lower-income individuals tend to spend a higher percentage of their income, particularly on staple items such as food, health care, and housing. This regressivity could be alleviated with lower tax rates or tax exemptions for necessary items, but this also could complicate administration.⁸³ On the other hand, shifting the burden of health financing from labor costs to consumption could help low-wage workers, promote investment, and increase wage growth.

Additionally, since the VAT would decrease sales through increased prices, it may disproportionately affect those businesses that offer price-sensitive goods and services, such as the restaurant and entertainment industries. Decreased business income could in turn negatively affect hiring and investment. In addition, a new administrative system would be needed to implement a VAT,⁸⁴ and a small VAT may not be worth this cost.

Health System Implications: The VAT has no direct connection to health reform, but it is the primary source of support for the health systems of our global competitors. Some have argued that creating a VAT might connect the health reform and tax reform debates, as new revenue can allow for fixes in existing, flawed taxation mechanisms. If earmarked for health care, it could increase public awareness of the costs of the system.

Charting a Path Forward: Key Considerations



The current problems with America’s health care system—rising health care costs, the uninsured, access to and quality of care—make health care reform imperative in the next few years. It is vital to critically consider the various options for slowing the growth of health spending and funding needed reforms. This paper examines financing options without considering the health spending and delivery system changes that would be their companions. As such, the picture is partial and shows more of the “pain” than the “gain.” However, the financing options could also economically benefit society. If financing changes contribute toward an increase in health care coverage, improved population health could result, as could increased workplace productivity.^{85,86} Assessing these macro-economic effects is important, but cannot be done in the absence of detailed policies and the accompanying health reforms.

In addition, this analysis mostly focuses on the options at a point in time. A challenge that faces all of the financing options is whether they will generate enough money in the long run to maintain generous health benefits, even with policies intended to slow the growth of health spending. Health care cost growth already has and will continue to outstrip growth in the economy, wages, and inflation unless there is major reform. As such, opting for a slow-growing financing source may require generating increased revenue or reducing benefits in the future, unless other reforms improve efficiency in health care delivery and reduce spending growth. The revenue connected to the rollback of high-income tax cuts and the play-or-pay model would grow with wages. Revenue from the VAT and the current system would grow with the economy. Only projected revenue from eliminating the health benefit tax exclusion would grow with health costs.

Beyond the specifics discussed above for each financing option presented, there are several fundamental questions policymakers will need to face. Some of the answers will be informed by policy analysis and tradeoffs described in this paper. The answers will also be shaped by policymakers’ goals, values, politics, and circumstances.

SHOULD CHANGES BE INCREMENTAL OR COMPREHENSIVE?

Policymakers who undertake health care reform face a large and complicated set of problems. Solving these problems may be best achieved by laying a foundation for changes that take place gradually. This would mean that financing options should be incremental in size and scope. Such options would build upon existing financing

schemes rather than replace them, and associated health reforms would supplement employer-based health insurance rather than eliminate it. As discussed above, financing options can influence employer and employee behavior regarding employer-based health insurance. Sensitivity to these effects will be pivotal in ensuring that changes do not erode existing health system structures.

An alternative approach is to consider health care reform as a rare opportunity for major change. In this case, health care financing can be viewed with an eye toward consolidating or replacing existing fragmented sources of financing, or indeed toward revamping the entire system of federal tax collection to promote greater economic efficiency. Given vested interests in the current system, the political capital needed for comprehensive changes in health policy may not be that much higher than that required for incremental changes. This assessment involves equal doses of well-grounded policy analysis and political strategy.

HOW SHOULD PUBLIC AND PRIVATE FINANCING BE BALANCED?

The United States currently lies at the low end of the spectrum of developed countries in terms of the proportion of health care financed by public programs.⁸⁷ Policymakers have direct authority over public financing, and thus typically focus on the impact of policy on the Federal budget. The repeal of the high-income tax cuts and VAT are examples of policies that would directly affect public revenues, but not necessarily affect the level of private health spending. However, public and private financing are, in some cases, inextricably linked. For example, as can be seen with the tax exclusion, a public tax break leverages private premium spending over three times its size; consequently, the reform of this exclusion could have a substantial impact on private health care spending. Requiring people to purchase health insurance could also increase private financing for health benefits, which, in turn, could have an indirect impact on public financing. Different proposals can be calibrated to have the same overall effect, but whether the financing is public or private has both policy and political implications. The public-private mix can send a strong message about the focus of financial responsibility for our nation's health care.

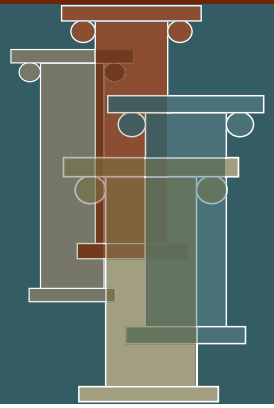
SHOULD FINANCING CHANGES BE TIGHTLY LINKED TO DESIRED HEALTH SYSTEM CHANGES?

As described above, financing options such as reforming the health benefit tax break could have significant health-spending implications, while repealing the recent high-income tax cuts would have no direct effect. In between these extremes, some policymakers have sought to use financing to impose health spending change. For example, some proponents of the VAT suggest that its revenue would serve as a cap on public spending on health coverage. Because its revenue would lag behind health spending growth, and because the public would be loathe to raise the VAT rate

to keep pace, the constraint on public financing could yield a constraint on health spending.^{88,89} Similarly, capping the health benefit tax exclusion could encourage the selection of less costly health plans that entail more cost sharing. This could increase consumer price sensitivity in health care decision-making or, if this fails, shift costs from the risk pool to individuals. Expecting health-financing changes to yield major health system changes, independent of other reforms, may be wishful thinking. Given the tight fiscal outlook and the growing evidence of opportunities to improve the efficiency and value of health care spending, however, the case for considering financing reforms in conjunction with other policy initiatives to improve health-system performance continues to grow stronger.



Conclusion



Options for increasing funds for health reform do not stand alone: each would only be enacted as part of a plan that also improved the efficiency, accessibility, affordability, and quality of health care—and reduced unnecessary spending. These types of reforms would have a critical economic impact that should be considered a backdrop to the economic implications of the financing options. The issue that will need to be addressed with any health care reform plan is whether the societal and economic costs of the investment in the nation’s health care system are worth the benefits gained.

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