

Funding Health Care for All Americans
DRAFT Comments on Oberlander "The Politics of Paying for Health Reform"
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In addressing how we should pay for health care reform - and, more specifically, how we should pay for universal health insurance coverage - Oberlander provides an overview of the current political and institutional landscape, detailing both the appeal of and the constraints upon each of the main policy options. As a snap shot of the existing political impasse, as a map of the dominant political fault lines, Oberlander's description is comprehensive and compelling. But as an analysis of how the process of political change might (or should) come about, as a suggestion of how the plates could be made to shift, it is less compelling and the key conclusions seem to beg the question of what it might take for a politics to emerge that could redistribute the costs of health care and finance reform.

The obstacles are formidable. The current mix of public and private sources of funding are politically entrenched; universal coverage will require new revenues in an environment hostile to new taxes; PAYGO rules will make it even harder to finance an expansion of coverage; and reform will have to overcome the fragmented power structure in Washington. The policy choices are either worn out (limiting the tax exclusion for employer sponsored insurance; employer mandates; and general revenues and deficits) or politically infeasible (new payroll taxes; a value-added tax; sin taxes; and individual mandates). In all of this, Oberlander is balanced and accurate, telling us of the considerable obstacles in the path of financing reforms.

Among the options, I was gratified to see the honest inclusion of general revenues, and deficit financing, as one of the policy options for financing an expansion of coverage, as this is undoubtedly the most likely in terms of pure odds. I was discouraged, but not surprised, that repeal of Medicare Part D was not included as an option in itself, as this is

both a personal favorite and offers a large and growing PAYGO opportunity. Only in discussing the feasibility and importance of rolling back the tax-exclusion for employer-provided insurance do I feel that the analysis was incomplete (as explained below).

In drawing his conclusions, Oberlander recognizes the roles of contingency and chance in determining political outcomes, observing that the feasibility of any given health care financing strategy depends on who is in power in Congress and the White House, how they exert their leadership, the shape of any broader reform package, how the economy is performing, and how much our political bandwidth (and revenues) can be devoted to a domestic reform agenda. This is undoubtedly true.

But by treating the role of political leadership (in framing, sequencing and timing a reform agenda) as exogenous to the process, the paper seems to by-pass the heart of the subject. Here “feasibility” seems to mean only that which is likely to happen spontaneously in the current political environment rather than what could plausibly be brought about to change the environment by the exertion of political leadership.

Oberlander’s first conclusion, that it seems “highly unlikely that the U.S. will replace its patchwork, mixed financing system with a single-source public financing system,” is well put and should be heeded by all reformers. It reflects the fact of our existing system and the experience of other countries. This is also dictated by the breadth of our health care system’s malfunctions: so many of the existing incentive structures and financing arrangements are part of the problem that a number of fixes will be needed.

I was surprised by the paper’s second conclusion, that “in the short to medium-term, politically viable proposals for financing universal coverage probably have to build on employer-sponsored insurance.” First, my own observation is that there are

considerable shifts now taking place in the plates of the political economy. Second, the analysis understates the importance of removing this incentive to over-consumption of health care as both part of reform itself and as a means of redistributing the costs among the stakeholders.

As a matter of financial engineering, locating long-term commitments to pay for personal health care (and retirement) inside the balance sheets of industrial and commercial enterprises has always been a particularly bad idea. The volatility that these balance sheets are routinely expected to weather from the economic cycle, combined with their shareholder-driven mission, leaves the funding of long-term benefits as a third-tier objective.

Only a few years ago, uttering such thoughts was deemed politically out of bounds. But now that the UAM and GM have embraced the view that these benefits can be shed from the employer-corporate balance sheet, the debate will be much wider. It has even become possible for a Republican candidate for President to support limiting the tax-exclusion for employer-sponsored plans. So the political fault lines are shifting and, in my view, a well-timed shove from an astute leader could make a big difference.

There is nothing irrational, mystical or ideological about seeking to reduce the tax-exclusion for employer-sponsored plans as a part of health care reform (as suggested by the label "Holy Grail"). Reducing or eliminating the exclusion is important not only - or even principally - because it might be a funding source but because it is at the core of the problem. We do not only have a problem of "too little", we have simultaneous problems of "too little and too much." We have too little coverage and too little health care expenditures in parts of the population and too much coverage and too much expenditure in other parts.

Incentives matter and the tax incentive for employer-sponsored health plans necessarily means that we get more health care consumption than we would otherwise have without it. Thus, I see the issue the other way around: unless we reduce the incentives for over-consumption of health care services in the top half of the income distribution, as one means of slowing the growth of health care as a share of GDP, it is unlikely that, as a society, we will find the resources to pay for universal coverage. While as Oberlander points out, the political price for ending the illusion that employers pay for their employees' health insurance premiums may be high, there is little analysis of whether the price might be worth the reward.

In this third conclusion, Oberlander may be correct that politicians are likely to place too much faith in cost controls as a means as means of funding expanded coverage, but this may not be a function of the actual availability of cost reductions. Instead, this more likely reflects the reality that political words are cheap and that substantive changes in the costs of delivery of health care, however promising, are unlikely to score well in the PAYGO budget process at their inception.

The final conclusion, "that the political fortunes of universal health care depend on redistribution" is certainly correct but unsurprising. Most of what Congress does with money is redistribution, of one form or another. The question is precisely *how can* politicians be induced to undertake a redistribution that will address both the problem of too little and the problem of too much. Debunking the illusion that someone else pays for our health care and finding a path to a redistribution of the financial costs is indeed the challenge for our political leaders.