

Comments at FRESH-Thinking Conference

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These are two excellent papers that complement each well and are sure to provoke lively discussion. Rather than critiquing them in detail, I would like to concentrate on two issues. The first is making sure that we are addressing the most important question and putting it in a realistic context. I contend that the right question is: “How are we going to pay for health care (including care for the currently uninsured)?” not “How are we going to pay for covering the uninsured?” The context is that we CAN’T pay for all the health care we want now and are going to want in the future. Hence, we need to make some drastic changes in the health care delivery system to make it as efficient as possible and constrain spending growth in as fair a way as possible. The way we finance health care can contribute to efficiency and fairness—or not. The second issue is whether a dedicated consumption tax is the best way to finance health care or a significant portion of it. There are lots of positive arguments, but I would like to focus on some of the downsides.

Getting the Question Right

Since the conference is focused on “funding health care for all Americans,” it would be easy to assume that we are here to talk about how to pay for extending health insurance coverage to the uninsured. Indeed, current parlance tends to equate “health care reform” with expanding coverage to the approximately 47 million people who don’t have coverage now. But it is a mistake to equate “funding health care for all Americans” with paying for an add-on to a system that covers most people already. The United States, like all countries with advanced economies, faces a huge problem of paying for health care, whether we reform it or not: indeed, especially if we do not. If upward trends in public and private health spending continue—and no one has a convincing story about why they

would slow on their own--the funding sources we now rely on will not be adequate. As Fuchs and Shoven point out, health spending has been rising 2.79 percent faster than GDP for thirty years. Federal spending goes up at about the same rate as the total. Hence, funding current benefits under Medicare and the federal share of Medicaid will entail spending that rises substantially faster than GDP or federal revenues. Just paying for these built in spending increases will necessitate continuous increases in tax rates or continuous reductions in other spending or some combination of the two. Off-loading this rising spending onto lower levels of government and/or the private sector just shifts the burden onto other stressed systems and will accelerate the increase in the uninsured. Hence, the most fundamental set of reforms have to be those that slow the rate of growth of health care spending.

There is a large menu of reforms that might make the health care system more efficient and help slow the growth of spending. (Joe Antos and I put together a long list in our recent book.) Aggressive action on multiple fronts will be needed to excess of health spending growth over GDP growth down to, say, two percent or 1.5 percent. The excess is unlikely to get anywhere near zero, given the nifty new interventions being promised by gene therapy and other breakthroughs in the laboratory.

On consequence of this upward spending pressure is that the number of uninsured will continue to grow as the federal government seeks to restrain spending by cutting Medicaid and employers bail out of increasingly costly sponsored plans--unless we reverse the trend by moving toward universal coverage. The case for extending coverage to the involuntarily uninsured (those who can't get coverage they can afford) is currently largely one of humanitarian or communitarian concern for the disadvantaged. The uninsured are not a major political force. But that could change, as spending pressures rise and their numbers grow. (The case for covering the voluntarily uninsured is to get them and their contributions into the insurance pool and prevent free riding.)

The other consequence is that, even with aggressive spending restraint, we are going to need an additional source of revenue just to keep federal programs funded in anything

like their current form. Loading these increasing costs on the income and payroll taxes makes neither political nor economic sense. The only major tax that the federal government does not have in its funding arsenal now is a broad-based consumption tax (sales or VAT), which all other developed countries rely on heavily. We can think of this new federal consumption tax as necessary to balance the budget in the face of escalating spending for Medicare and Medicaid (even with aggressive cost saving and cuts in other federal spending). Or we can think of it as necessary to fund the federal subsidies required to cover lower income people in a new universal health insurance plan. The point is that we are going to need it.

Downsides of a federal consumption tax dedicated to health care

If the increase in health spending is necessitating a new tax, why not make this clear by dedicating the proceeds of the new tax to paying for health care? Any new tax will be resisted, but the public is less negative when a tax is directly linked to a specific benefit that is widely regarded as necessary. Increases in the payroll tax have occurred easily over the years, despite economists' objections that the tax is regressive and discourages work. Although most workers pay more payroll tax than income tax, the payroll tax is apparently accepted because it is directly linked to the benefits of Social Security and Medicare. (It helps that workers think they only pay half of it and that many think of it as an insurance premium, not a tax.) The argument for enacting a broad-based new consumption tax and dedicating its proceeds to health care boils down to this: taxing consumption is less distorting and therefore less of a drag on growth than other taxes that might be considered; it is the only tax the federal government does not have now; and we could sell it to the public if we dedicate it to health care. The further argument is that dedication will actually restrain health spending, because unforeseen increases in spending will necessitate raises the dedicated tax rate, which will precipitate an explicit debate about whether the benefits are worth the cost.

What worries me is that the dedicated consumption tax may have the opposite effect and may contribute to the current problem of health spending, especially health spending for older people tending to dominate the budget and squeeze out investment in everything

else. The “everything else” that I am afraid will get squeezed out includes investment in the skills of the workforce, research and development, infrastructure, and environmental protection. The current situation is that Medicare and Medicaid, like Social Security, are “entitlements” that do not receive the same scrutiny as appropriations. There is no moment in the budget process for deciding whether we want to put the marginal hundred billion in Medicare or invest it in future economic growth. The entitlement programs are on auto pilot unless an entirely new benefit is being added (such as Medicare Part D). The fact that they have a dedicated revenue source in the payroll tax has generally reinforced this auto pilot aspect of the major entitlement programs. Over the years, we have shifted a larger and larger portion of the federal budget into entitlement programs for seniors and squeezed the rest—and this has occurred before senior became the potent political force that they are on track to become in the next few years. If we dedicate a broad new tax to health care--which inevitably means dedicating it to caring for seniors, because they consume the most health care—I worry that we will tip the balance more and more toward the old at the expense of the young. Science is going to give us an infinite number of attractive ways of extending life, but they won’t be cheap. We have to have the courage to question whether these procedures are worth more than other ways of using the resources.

The problem with dedicated taxes is that they take particular categories of spending out of the conversation about priorities. In the past they have arguable resulted in overspending for highways, Medicare and Social Security. Proponents of dedicating the consumption tax to health care argue that dedication will have the opposite effect in the future. Since health care spending is growing faster than the economy, a consumption tax (which grows at about the same rate as the economy) will tend to restrain health care spending by forcing periodic reconsideration of the tax rate. But I am afraid it will be all too easy to justify raising the rate once this new tax is on the books and dedicated to a popular benefit to a growing share of the electorate.

I do not disagree that the federal government should enact a broad based consumption tax, either a VAT or a national sales tax (it doesn’t much matter). We can’t finance future

obligations of the federal government without it and it is better tax than the alternatives. The proceeds of the consumption tax should be shared with the states so as not to compete with their traditional major source of revenue. The federal contribution to the reformed health system should have a firm global budget, subject to PAYGO rules, and periodic reenactment, but this contribution should be forced to compete with other federal spending out of the general revenue pot.