

# Funding Health Care for All Americans

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# “Long-Run Fiscal Policy is a Health Policy Problem”

- National Health Expenditures hit \$2 trillion in 2005 (16% of GDP)
- NHE grew 2.79%/year faster than everything else combined from 1975-2005
- NHE will reach 30% of GDP by 2035 if trends continue
- 47 million Americans uninsured

# Two Essential Elements for Universal Coverage

- Subsidization
- Compulsion

# Who Are the Uninsured?

- The poor. 25% below poverty, another 28% between 1X and 2X poverty
- The sick and disabled
- The difficult to reach (e.g. self employed, unattached to work force)
- The low users
- The gamblers
- The free riders
- More than half are young (18-34)

# Myth of “Shared Responsibility”

- Typical claim by political sponsors of health reform proposals – “Responsibility for the cost of care will be shared by employers, the Federal government, state governments, and individuals.”
- Fails basic incidence analysis
- Costs may be shared across groups of individuals, but there is “nobody here but individuals.”

# Myth of “Government Assistance for the Middle Class”

- To paraphrase Willie Sutton, the middle class is where the money is.
- The rich may be asked to subsidize the poor, but there aren't enough of them to subsidize the middle class.

# Current Funding of Medicare and Medicaid

- Medicare Part A – largely funded with 2.9% dedicated (i.e. earmarked) payroll tax
- Medicare Parts B and D – 3/4ths of costs funded by claim on general revenues, 1/4<sup>th</sup> by premiums and co-payments
- Medicaid – federal share funded by claim on general revenues

# Examples of the Disadvantages of General Revenue Financing

- Financial problems of entitlement programs often concentrate on Social Security and Medicare Part A (HI). Why? Because of the open-ended claim of the rest of federal health expenditures on general revenues
- The introduction of Part D. It appeared to be free to taxpayers in that no tax was increased.

# The flipside – the advantages of tax dedication

- Potential improvements and extensions of federal health insurance programs would have a price – higher taxes
- The debate between whether the improvements are worth the cost of higher taxes is the right benefit-cost debate to have
- A dedicated tax imposes budget discipline on health spending
- Replaces the current standard (provide all treatments that might be helpful) with a new standard (provide the health system *that we are willing and able to pay for*)

# Choices for a Dedicated Tax

- Need for a lot of revenue limits choices to taxes with a broad base
- Candidates: personal income, consumption, payroll, and corporate income
- Roundabout taxes: tax expenditures, income related user charges, mandates

# Consumption vs. Income Taxes

- Consumption taxes cause less distortions, particularly regarding saving
- Income taxes are the primary source of general revenues...therefore not available as a dedicated tax
- Three types of consumption tax – sales tax, VAT, direct consumption tax (income less saving)

# VAT vs. Sales Tax

- Close relatives. VAT is a particular way to collect and implement a sales tax
- More than 40 states already have sales taxes
- VAT is the one unused broad based tax available to the federal government
- VAT financed universal health vouchers would be very progressive

# Other alternatives

- Payroll tax: Already taken by Social Security
- Corporate tax: terrible idea. Inefficient, unknown incidence, hidden
- Tax expenditures: Lack of salience a drawback from our point of view
- Income based user charges: amount to taxes. Low income already face high marginal tax rates

# Mandates

- Individual mandates, employer mandates, insurance mandates
- Incidence analysis makes employer mandates similar to individual mandates
- Insurance mandates: companies can leave business entirely
- Mandates provide compulsion, but fail subsidization. If you subsidize the poor, then you need taxes again.

# VAT financed Vouchers – More or less distortionary than the status quo?

- The existing arrangements – employment based insurance with large tax subsidy are very distortionary
- The bundled product – job and insurance – is unnatural. Distorts job choice, job mobility, choice between part-time and full-time, and diminishes the protections of the insurance (lose your job, lose your insurance)

# Incidence of “Employer Provided” Insurance

- Workers collectively bear the burden of employer provided insurance through reduced wages, salaries and other forms of compensation
- Incidence is not widely understood
- Precise individual incidence – between singles and marrieds, between those who work 30 hours per week and 50 hours per week, etc. is unknown

# VAT also introduces distortions

- Work-leisure. Real wage would be lower because prices would be higher
- Actual VAT would almost certainly not cover all consumption, introducing distortions between covered and uncovered products and services

# Consider Those Who Currently Have Work Related Insurance

- Their take home pay would go up if their employer can drop health insurance
- They would face a new VAT
- For the average person, the income effect is close to a wash
- The security of their health insurance is enhanced leading to an increase in welfare
- The incentive to work or work more is reduced leading to loss in welfare

# Winners from VAT financed Universal Vouchers

- The poor. Value of insurance would exceed extra taxes
- The difficult to reach (including those victims of adverse selection)
- The sick (those with pre-existing conditions who can't afford coverage today)
- Similar groups to today's uninsured

# Final Thoughts

- Need for budget discipline
- Myth of shared responsibility
- Myth of assisting the middle class
- Advantages of tax deduction
- Distortions of employment-based health insurance with tax subsidization
- The currently insured trading one distorted situation for another... their welfare change may be small. The uninsured, the poor and the sickly stand to gain considerably from tax financed universal vouchers