

The Politics of Paying for Health Reform: Zombies, Payroll Taxes, and the Holy Grail

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How should we pay for health care reform? That simple question has long defied any easy answers. To be sure, paying for health reform is an economic and normative issue, and solutions that variously satisfy efficiency and equity considerations can be identified, at least in theory. But health care financing is ultimately a political issue: no funding scheme will be adopted on the basis of economic merit alone. Anyone doubting that proposition need only look at the current U.S. health care system for ample evidence that sound economics often does not serve as the foundation for public policy.

The formidable task of designing a workable financing system and grappling with the accompanying economic and technical issues is, by comparison, the easy part. The hard part is designing a health reform funding scheme that can survive the American political process.¹ Indeed, what appears to be a straightforward issue (where to find the approximately \$100 billion a year it would cost to cover the uninsured within the current system)² inevitably opens up a Pandora's Box of politically thorny questions: who should pay for reform?; how (much) should they pay?; and who will emerge as the financial winners and losers? Nor can reform proposals that seek more ambitious system overhauls, so that universal coverage is funded through savings rather than additional spending, evade these issues. Such plans hold out the promise of health reform that pays for itself, yet they still require politically daunting changes in the financing status quo and flow of money.

Funding universal coverage, then, is much more than a simple search for money because it inevitably raises questions about redistributing existing funding sources and

¹ Jonathan Oberlander, "The Politics of Health Reform: Why Do Bad Things Happen to Good Plans?," *Health Affairs* web exclusive W3, 391-404 (August 27, 2003).

² The \$100 billion estimate is from Uwe E. Reinhardt, "Is There Hope for the Uninsured?," *Health Affairs* web exclusive W3, 376-390 (August 27, 2003).

introducing new ones in an economic sector that accounts for over \$2 trillion.³ Those questions in turn invite political debates about the size of government, the economic consequences of taxation, and the desirability of progressive funding. Comprehensive health reform, in other words, entails financing reform and financing reform triggers debates over both money and ideology. And therein lies a major reason why comprehensive health reform perennially fails in the U.S.: reformers have yet to fashion a politically acceptable solution for funding universal coverage that can win those debates. Indeed, the last effort at comprehensive reform, the Clinton administration's ill-fated Health Security Act, imploded in large part because the administration could not secure a Congressional majority for its financing strategy.

This paper explores the politics of paying for health reform.⁴ I begin by briefly sketching out the political and institutional contexts that shape reformers' efforts to finance universal coverage. Next, I set out the menu of available funding options and analyze their political feasibility. Finally, I examine the political consequences of different funding arrangements and the potential implications for cost control.

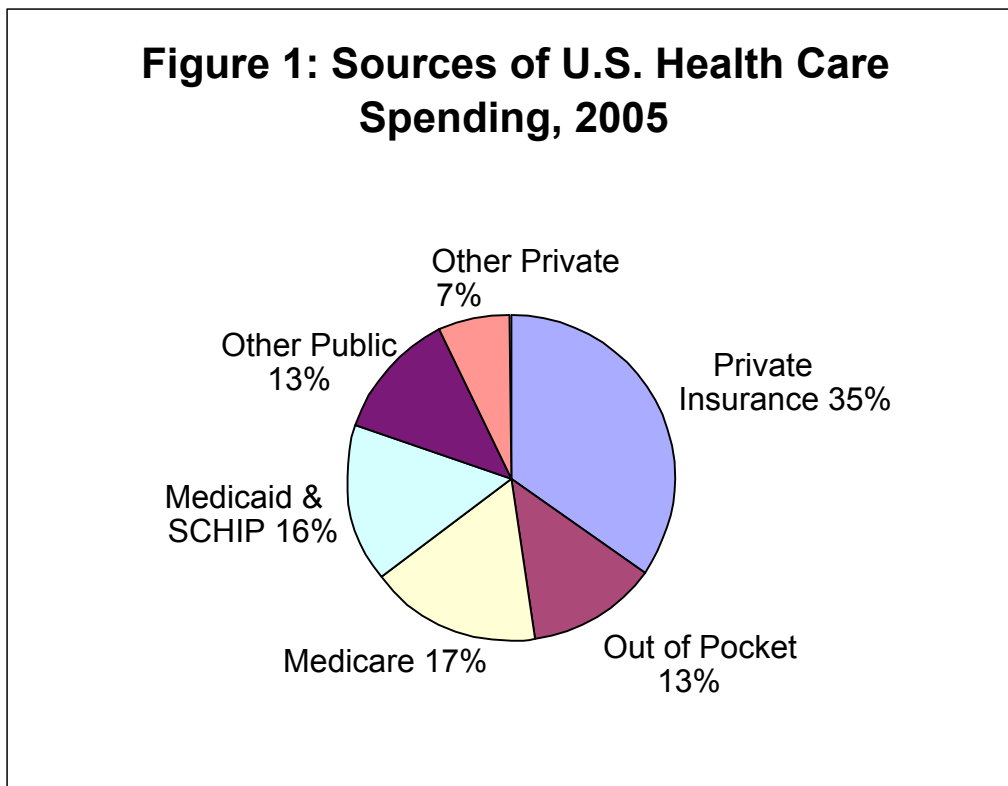
The Political and Institutional Contexts for Financing Reform

Health reformers looking for new revenues to pay for universal coverage face a challenging political environment that is loaded with constraints and short on easy money. First, it is worth highlighting the status quo in U.S. health financing if only

³ Jack A Meyer and Elliot K. Wicks, *Options for Financing Health Coverage Expansion* (Washington: Economic and Social Research Institute, April 2003): 3.

⁴ For an excellent analysis of the politics of financing health reform during the early 1990s, see Lawrence D. Brown, "Who Shall Pay? Politics, Money, and Health Care Reform," *Health Affairs* 13, no. 2 (1994): 175-184.

because that status quo has proven so resistant to change. The U.S. currently finances medical care through a mix of public and private sources, and via a wide array of funding instruments including employer and employee-paid health insurance premiums, earmarked payroll taxes, federal and state general revenues, sin taxes, and out of pocket payments. That mix may not be ideal but it is politically entrenched; various constituencies are accustomed to and benefit from (or believe they benefit from) current arrangements, making dramatic shifts in health care financing difficult.



Second, universal coverage requires raising new revenues from existing sources or introducing new taxes, yet the political environment of tax policy suggests that neither requirement is easily attainable. Tax revenues comprise 25.5% of GDP in the U.S., 3rd

lowest in the OECD, with the OECD average at 35.9% and OECD Europe at 38.3%.⁵ Tax revenues' share of the U.S. GDP today is virtually identically to their share (25.6%) in 1975. Simply put, the U.S. raises fewer revenues than other industrialized democracies, which complicates efforts to adopt and pay for public programs, including universal health insurance.⁶

Recent tax policy does not offer much encouragement for those seeking to buck the trend. Since the 1970s, anti-tax sentiment has played an influential role in American politics. Walter Mondale's lopsided defeat in the 1984 presidential election (he had campaigned on a platform of raising taxes) and the controversy over George H.W. Bush's breaking his 1988 "read my lips" pledge not to raise taxes cast a shadow over contemporary tax politics.⁷ The political equation of tax policy is by now familiar: Republicans often intensely oppose tax increases and Democrats are often intensely fearful of sponsoring tax increases. That equation resonated strongly in recent years, as George W. Bush sponsored a series of major tax cuts that decreased federal revenues by \$2 trillion over a decade, with the benefits skewed towards high-income Americans.⁸

The Bush tax cuts have important implications for any future effort at health reform. Not only will reformers have fewer revenues to draw on to pay for universal coverage, they will have to grapple with the political consequences of the scheduled expiration of the Bush tax cuts in 2011. A high-stakes debate over the future of U.S.

⁵ OECD data are for 2004. <http://www.oecd.org/dataoecd/8/4/37504406.pdf>

⁶ Sven Steinmo, "Why is Government So Small in America," *Governance* 8, no. 3 (1995): 303-334.

⁷ Theda Skocpol, *Boomerang: Clinton's Health Security Effort and the Turn Against Government in U.S. Politics* (W.W. Norton, 1996): 33.

⁸ Greg Leiserson and Jeffrey Rohaly, *The Distribution of the 2001-2006 Tax Cuts: Updated Projections*, November 2006 (Washington: Urban Institute and Brookings Institution Tax Policy Center, 2006). See also C. Eugene Steuerle, *Contemporary U.S. Tax Policy* (Washington: Urban Institute Press, 2004).

fiscal policy is likely, since making the tax cuts permanent would increase the federal budget deficit (which now stands at \$248 billion) by \$3.2 trillion from 2008-2017.⁹ While there will be fiscal pressures to let the tax cuts expire lest they exacerbate the deficit, there surely will be political pressure to maintain some of the cuts lest members of Congress suffer at the ballot box. Health reformers will also have to compete for revenues in coming years with everything from AMT reform to spending on the wars in Iraq and Afghanistan. Furthermore, the long-term budget outlook is for growing federal deficits that could constrain efforts to pay for universal coverage. If fiscal discipline reappears in Washington, deficit reduction will make a sizable claim on any new tax revenues.

None of this is to say that increasing taxes to fund universal coverage is impossible. The current political environment for tax policy is not permanent: Presidents and Congresses change, and so too does fiscal policy. President George H.W. Bush and a Democratic Congress agreed to a significant tax increase in 1990 and President Clinton won enactment for a series of tax increases in 1993 (both increases were part of deficit reduction legislation).¹⁰ Moreover, reformers can argue that growing federal deficits require health care reform, since those deficits are driven in no small part by rising Medicare and Medicaid outlays. And the Bush tax cuts provide reformers with an extraordinary opportunity inasmuch as universal coverage can be paid for by canceling (or letting expire) select cuts for higher-income taxpayers. Yet it is also evident that tax increases have not come easily in recent decades: the 1993 Clinton budget plan won

⁹ Alan J. Auerbach, Jason Furman, and William G. Gale, "Still Crazy After All These Years: Understanding the Budget Outlook," *Tax Notes*, May 21, 2003: 765-778.

¹⁰ C. Eugene Steuerle, *Contemporary U.S. Tax Policy* (Washington: Urban Institute Press, 2004).

enactment only after Vice President Al Gore broke a tie in the Senate (it passed the House 218-216), and George H.W. Bush faced a backlash in the Republican party after abandoning his 1990 no taxes pledge. Moreover, Americans' trust in government has declined sharply over the past three decades, which could make it harder to gain public acceptance for raising taxes to pay for a new federal program.¹¹ If universal coverage is to be secured, health reformers will have to overcome the legacies of anti-tax politics as well as flagging faith in government.

A third constraint is the reemergence of pay-as-you-go (PAYGO) rules in Congress. PAYGO, first adopted as part of the 1990 Budget Enforcement Act, required that new mandatory spending and revenue laws had to be budget neutral.¹² The costs of any new entitlement programs and tax cuts had to be offset through higher taxes or spending cuts. In the Senate, PAYGO rules could be waived only with 60 votes. PAYGO rules were in place during 1990-2002, were not renewed during 2003-2006, and were reinstated in 2007.¹³

The return of PAYGO makes it harder to finance universal coverage.¹⁴ As the Clinton administration learned, PAYGO means that proposals to expand coverage must be paid for with real revenues and real savings. During the 1990s, PAYGO gave the Congressional Budget Office a prominent role in health policymaking as CBO scored

¹¹ In a July 2007 CBS News/New York Times poll, only 24% of respondents trusted government "just about always" (2%) or "most of the time" (22%).

¹² Peter S. Orszag, "Issues in Reinstating a Statutory Pay-As-You-Go Requirement," Statement Before the Committee on the Budget, U.S. House of Representatives, July 25, 2007.

¹³ Richard Kogan, "The New Pay-As-You-Go Rule in the House of Representatives," *Center on Budget and Policy Priorities*, January 12, 2007.

¹⁴ PAYGO rules could also make it harder to extend the Bush tax cuts, since the cost of extending them would have to be offset.

different reform proposals' budgetary impact.¹⁵ If PAYGO results in a similar process in coming years, the temptation for reformers to count savings from “cutting waste” or “improving quality” and other laudable but vague aims (with uncertain fiscal consequences) could run head-on into CBO's preference for savings that can be credibly scored. Budget rules thus could compel comprehensive health reforms to have tighter (and more controversial) cost controls than reformers believe is politically desirable, making it that much more difficult to buy stakeholders' support. Democrats are reportedly already chafing under reinstated PAYGO rules that limit their ability to pursue various legislative aims.¹⁶ If PAYGO remains in place in 2009 and beyond, and if it is strictly enforced, universal coverage plans will have to explicitly confront taxing and spending tradeoffs, and make zero-sum choices to pay the bill.

Finally, any comprehensive health reform legislation must overcome a host of institutional obstacles, including the limited power of the president to secure his (or her) own agenda even if the president's party holds a Congressional majority (witness the fate of President Bush's Social Security reform plan); shared authority between the House and Senate; fragmentation of power among numerous Congressional committees and their chairs (many of whom have their own ideas about health reform); and the need to have 60 votes in the Senate to bypass a potential filibuster. Not surprisingly, then, Congress has repeatedly proven to be the “graveyard” of health care reform.¹⁷ In a system with so

¹⁵ I am drawing here on Joseph White's excellent “Budgeting and Health Policymaking,” in *Intensive Care: How Congress Shapes Health Policy* (Washington: American Enterprise Institute and Brookings Institution, 1995), Thomas R. Mann and Norman J. Ornstein, eds., 53-78.

¹⁶ Peter Cohn, “Congress-The Paygo Blues,” *National Journal*, July 7, 2007.

¹⁷ Mark A. Peterson, “The Congressional Graveyard for Health Care Reform,” in James A. Morone and Lawrence R. Jacobs, eds., *Healthy, Wealthy, & Fair: Health Care and the Good Society* (New York: Oxford University Press, 2005), 205-233.

many institutional hurdles, the chances of taking an ideal financing plan developed by policy analysts and adopting it exactly as envisioned into law are indeed slim.

The Financing Menu

I now turn to a political analysis of the main options for funding comprehensive reform. Several caveats are in order. First, these options are not necessarily mutually exclusive, real-life health reform plans can and do combine various funding alternatives listed separately in this menu. In part that is because a distinction exists between where to get new money to subsidize the uninsured and how to finance coverage and ensure universality in a reformed system. Second, my focus is on the politics of funding universal coverage at the national level. States have a somewhat different set of choices, including the option of financing reform by drawing on federal revenues. Third, I am primarily concerned here with feasibility not desirability. It is common for health reformers of all stripes to believe that their preferred solution is also the most politically viable, but that doesn't make it so. Some funding schemes have compelling substantive virtues but glaring political vices, and vice versa. Finally, while this section makes preliminary judgments about the political feasibility of select financing options, ultimately feasibility is determined by much more than those options' internal political properties, a theme I return to in the paper's conclusion.

The Holy Grail

The first place many health reformers look for funds to cover the uninsured is the tax code. In particular, the tax exclusion for employer-sponsored health insurance

presents an inviting target. Advocates contend that reforming the tax exclusion could generate funds for expanded coverage, slow health spending, and make health financing more equitable. It is little wonder, then, that for at least two decades, policymakers and analysts have entertained the idea of capping or eliminating the tax subsidy for employer-sponsored insurance. Such proposals have been a staple of conservative health reforms since the Reagan administration, including President Bush's 2007 plan to create a standard deduction for health insurance,¹⁸ though they often have aimed less to cover the uninsured than to shift the insured away from employer-based insurance. Still, liberals might also support reducing the tax subsidy if savings are dedicated to financing universal coverage.

Limiting the exclusion for employer-sponsored insurance is an appealing funding source for health reform because the subsidy is expensive, regressive, and a convenient (if not altogether convincing) scapegoat for rising health care costs. The tax subsidy for employer-sponsored insurance, encompassing both income and payroll taxes, now costs state and federal governments over \$200 billion in foregone revenues a year (averaging \$2,778 per insured worker), making it the most expensive tax expenditure in the federal budget.¹⁹ Capping the tax exclusion for employer-sponsored insurance at about \$4000 for individuals and \$11000 for families (without indexation to inflation) would generate an estimated \$1 trillion in revenues over the next decade.²⁰

¹⁸ Len Burman, Jason Furman, Greg Leiserson, and Roberton Williams. *The President's Proposed Standard Deduction for Health Insurance: An Evaluation* (Washington: Urban Institute and Brookings Institution Tax Policy Center, 2007).

¹⁹ Thomas M. Selden and Bradley M. Gray, "Tax Subsidies for Employment-Related Health Insurance: Estimates for 2006," *Health Affairs* 25, no. 6 (2006): 1568-1579.

²⁰ The Congressional Budget Office, *Budget Options* (Washington: U.S.: GPO, 2007): 279.

The subsidy is also highly regressive, with its benefits disproportionately accruing to higher-income workers. In 2004, for example, the tax expenditure on health benefits averaged \$2,780 for families with incomes of \$100,000 or more, but only \$102 for families with incomes below \$10,000.²¹ The redistributive argument is compelling: why not redirect the money now spent on a regressive subsidy for private insurance towards the progressive cause of covering the uninsured? Finally, many analysts believe the subsidy encourages employers and workers to purchase overly generous, expensive insurance policies, leading to greater utilization of services and ultimately, higher health care spending.²²

The tax exclusion for employer-sponsored health insurance thus creates a seemingly irresistible pot of gold: its \$200 billion prize is more than enough to pay for universal coverage. To date, however, this has proven to be the political equivalent of fools' gold since actually extracting that money is no easy feat. The political reality is that middle- and upper-income Americans enjoy substantial financial benefits from the tax expenditure. Many of these tax subsidy beneficiaries probably don't understand how it works or even know that it exists, but proposals to tax health insurance would get their attention in a hurry. The same regressive character of the subsidy that offends standards of equity also offers political protection, since it gives a strong stake in preserving the status quo to the most politically active and connected segments of the population. And

²¹ John Sheils and Randall Haight, "The Cost of Tax-Exempt Health Benefits in 2004," *Health Affairs* 23 (2004): w109.

²² Report of the President's Advisory Panel on Tax Reform, *Simple, Fair and Pro-Growth: Proposals to Fix America's Tax System*, (Washington: U.S. GPO, 2005): 80.

unions that have fought long and hard to maintain health benefits can be expected to oppose any policy that imposes a health insurance tax on their membership.

Moreover, when middle-class, insured Americans think about health reform, what most of them have in mind is not a proposal to make their health insurance benefits subject to taxation, which largely explains why prior proposals to limit the tax exclusion have made little political progress. Similarly, the “Cadillac coverage”²³ that some health policy analysts rail against is likely not an insurance policy that many Americans would recognize as their own. There is not much of a popular constituency for reform that limits tax subsidies in order to induce less generous health insurance coverage.

In the end, the sizable revenues available from the tax subsidy for employer-sponsored insurance represent a grail that though not impossible to obtain, is not easily taken. Generating funds by limiting the tax exclusion makes health reform explicitly and visibly redistributive, triggering all the political controversy that entails. Financing coverage for the uninsured by forcing already insured Americans to pay more for their own insurance without offering them anything tangible in return for their troubles is hardly a recipe for political success. However, if appeals to equity or fiscal necessity fail to overcome these barriers, perhaps stealth redistribution could work: changes to the tax exclusion could conceivably be cloaked in enough technical detail or linked to a new benefit as part of a dense legislative package (preferably with immediate benefits and phased-in pain) so that voters wouldn’t appreciate the long-term consequences—a formula worked to full effect in the 2003 Medicare Modernization Act’s promotion of private plans, though of course obscuring a sizable tax hike requires rather sharper skills

²³ President’s Advisory Panel on Tax Reform, 81.

in political illusion.²⁴ Yet even if policymakers successfully alter the tax treatment of health insurance (reducing the subsidy is surely a more attainable goal than eliminating it, though this also limits potential savings), it still leaves open the question of what mechanisms a universal health system would use to ensure universality and pay for insurance.

The Zombie

There is a familiar litany of problems with employer-sponsored insurance: it is inequitable, with coverage varying by firm size, industry, and wages; it promotes “job lock” and when workers lose their jobs they lose insurance coverage; it does not effectively accommodate part-time, self-employed and other “new economy” workers; it places companies in the burdensome and intrusive position of making health care choices for their employees; as noted above, it is subsidized through a regressive tax subsidy that disproportionately benefits higher-income workers; it imposes regressive flat premiums that require low-income workers to pay a higher share of their incomes for health insurance than their better-off coworkers; it is administratively expensive; it obscures the costs of insurance and has never produced sustainable cost control.²⁵ A 2005 Wal-Mart

²⁴ Robert A. Berenson, “Doctoring Health Care, II: Yo Democrats, Medicare Is Privatizing,” *American Prospect*, December 17th 2006. Available at: http://www.prospect.org/cs/articles?article=doctoring_health_care_ii

²⁵ Sherry A. Glied and Phyllis C. Borzi, “The Current State of Employment-Based Health Coverage,” *The Journal of Law, Medicine & Ethics* 32, no. 3 (2004): 404-409; Uwe E. Reinhardt, “Employer-Based Health Insurance: R.I.P.,” in *The Future US Health Care System: Who Will Care for the Poor and Uninsured?*, eds. Stuart H. Altman, Uwe E. Reinhardt and Alexandra E. Shields (Chicago: Health Administration Press, 1998), 325-352; Clark C. Havighurst and Barak D. Richman, “Distributive Injustice(s) in American Health Care,” *Law and Contemporary Problems* 69, no. 4 (2006): 7-82; Alain C. Enthoven and Victor R. Fuchs, “Employment-Based Health Insurance: Past, Present, and Future,” *Health Affairs* 25, no. 6 (2006): 1538-1547.

memo that outlined a plan to control costs by requiring physical tasks for all jobs in order to avoid sick, expensive workers vividly illustrated the perverse incentives created by employer-sponsored health insurance.²⁶

It is all the more striking, then, that an employer mandate has repeatedly emerged as reformers' health financing strategy of choice. Richard Nixon's 1974 reform plan relied on an employer mandate, as did Jimmy Carter's 1979 national health plan, and Bill Clinton made the same choice in 1993. A modified employer mandate (the "play or pay" option discussed in a subsequent section) is the foundation for the health reform plans of 2008 Democratic presidential candidates John Edwards, Barack Obama and Hillary Clinton, as well as that of Republican Governor Arnold Schwarzenegger in California. Clearly, the employer mandate enjoys enduring appeal: like a zombie, it is a policy option that simply will not die.²⁷

There are substantive advantages to employer-sponsored insurance, including risk pooling. But the explanation for employer mandates' persistent centrality in health reform debates has much more to do with perceived political advantages. First, as Larry Brown explains, an employer mandate "can wear the halo of incrementalism."²⁸ Employer-sponsored health insurance has been the cornerstone of the U.S. health care system since the 1940s. Despite the erosion of employer-sponsored insurance, about 160 million Americans (61% of the non-elderly population) continue to obtain health

²⁶ Steven Greenhouse and Michael Barbaro, "Wal-Mart Memo Suggest Ways to Cut Benefit Costs," *New York Times*, October 26, 2005.

²⁷ I am borrowing the zombie analogy from Morris L. Barer, Robert G. Evans, Clyde Hertzman, and Mira Johri. *Lies, Damned Lies, and Health Care Zombies: Discredited Ideas That Will Not Die*. Health Policy Institute Discussion Paper #10: March 1998.

²⁸ Brown, "Who Shall Pay?," 178.

insurance through employers.²⁹ Mandating that employers provide insurance consequently extends a financing arrangement that is familiar and that builds both on the status quo and history. An employer mandate also maintains a preeminent place for private insurance in the health care system. That most uninsured Americans are in working families makes expansion of employer-sponsored insurance all the more attractive as a political strategy.

Second, an employer mandate privatizes health care financing and thereby makes universal coverage appear possible without resorting to new broad-based taxes, no small advantage in a country with strong anti-tax politics. The Clinton administration chose to anchor its health plan around an employer mandate largely for this reason. Rather than create a new direct tax that flows to the government, a mandate finances health insurance through premiums paid by (mostly) employers and employees. An employer mandate, in other words, is a popular financing strategy partly because of what it's not.

In economic terms there may be no difference between an employer-mandated premium contribution and a tax, especially given the axiom that employers' health care expenses are largely shifted to workers in the form of lower wages. But in political terms the gap can be huge since many workers undoubtedly believe that employers are paying for their health insurance when they pay the lion's share of premium costs. Since employers now pay on average 84% of premiums for single coverage and 73% for family coverage, introducing a mandate that requires employer contribution rates in that range

²⁹ Kaiser Family Foundation. *The Uninsured: A Primer*, p.31. <http://kff.org/uninsured/upload/7451-021.pdf>

maintains the status quo for insured Americans.³⁰ The perception that employer-sponsored insurance is paid for by employers is thus a large part of employer mandates' political appeal. That this perception, according to conventional economic wisdom, is wrong matters not for the politics of reform: economic facts are, in this instance, no match for political realities.

Third, an employer mandate could command broad public support. It embodies the idea that employers should help pay for their workers' health insurance, a practice that Americans are accustomed to. An employer mandate also taps into cultural notions that workers are deserving beneficiaries of social protections, so that extending insurance coverage can be portrayed as an issue of fairness. The concept that work should pay has conservative as well as liberal appeal. In a 2003 poll, 77% of respondents (including 72% of Republicans) favored requiring businesses to offer private insurance as a means to cover the uninsured.³¹ Well-insured Americans who now receive health insurance through their jobs might look favorably at reforms that reinforce rather than replace the employer-sponsored system. Companies that already pay for their own employees' health insurance and must not only compete with firms that do not insure but also pay for those firms' uninsured workers (through cost-shifting and dependent coverage) might also support a mandate, especially if there is a cap on the maximum employer contribution.

³⁰ Kaiser Family Foundation and Health Research and Educational Trust. *Employer Health Benefits: 2006 Annual Survey*. <http://kff.org/insurance/7527/upload/7527.pdf> at p.61.

³¹ Robert J. Blendon, John M. Benson, and Catherine M. DesRoches, "Americans' Views of the Uninsured: An Era for Hybrid Proposals," *Health Affairs* web exclusive w3 (August 27th, 2003): 405-414.

Whatever their advantages, employer mandates—as evidenced by the failure to adopt them into law—also carry substantial political liabilities. For starters, an employer mandate creates additional, compulsory financial obligations for businesses that do not currently provide insurance. Those obligations, as the Clinton administration discovered, can provoke fierce resistance, especially among small businesses, and since much of that resistance is ideological, no amount of subsidies may temper the opposition (moreover, subsidies require the raising of public funds that an employer mandate ostensibly avoids).³² Employer mandates, in other words, create visible losers in financing reform and those losers are likely to fight back. Language only gets you so far: political sponsors can insist that an employer mandate is not a tax, an assertion subject to dispute by the CBO among others,³³ but to those who it will be imposed on the compulsory mandate to pay for health insurance represents a clear and substantial expansion of government authority. Such an expansion will necessarily be controversial.

An employer mandate is also vulnerable to arguments that it will impair economic competitiveness and, through its impact on small businesses, hurt the economy (again, the reality could be different but political perception is what counts here). And while employers who presently provide insurance may prefer an employer mandate over other forms of universal health insurance, when push comes to shove they may prefer even more to keep the employer-sponsored insurance system voluntary and to maintain the time-tested option of cutting back on coverage and shifting costs to workers. Finally, the

³² Brown, “Who Shall Pay?,” 178.

³³ Congressional Budget Office, *An Analysis of the Administration’s Health Proposal* (U.S. GPO, 1994). CBO concluded that employer and employee premium payments to Health Alliances under the Clinton health plan should be considered as “government receipts” and included as part of the federal budget.

status quo that an employer mandate builds on is shaky and moving in the wrong direction. In 2007, only 60% of all firms offered health benefits, down from 69% in 2000.³⁴ As health care costs march upwards and the percentage of firms that provide insurance drops even further, the political distance that a mandate must cross to achieve universal coverage by compelling all firms to pay for health insurance grows.

The Social Insurance Special

Rather than relying on an employer mandate and the politically convenient (if economically dubious) proposition that it is not a tax, a universal coverage system could be funded directly through payroll taxes. After all, payroll taxes already occupy a prominent position in U.S. fiscal policy, comprising 35% of all federal revenues (second only to income taxes as a revenue source for the national government).³⁵ Two of the most popular social programs in the U.S., Medicare and Social Security, rely on payroll taxes.³⁶ The programs' popularity is arguably due in part to their financing arrangements. Payroll taxes mean that benefits are earned by workers, who as contributors finance current program obligations while establishing their own entitlement to future benefits,

³⁴ Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2007 Annual Survey*. <http://www.kff.org/insurance/7672/upload/EHBS-2007-Full-Report-PDF.pdf>

³⁵ <http://www.taxpolicycenter.org/taxtopics/Payroll-Taxes.cfm>

³⁶ The American form of social insurance, where payroll taxes are earmarked for federal trust funds, differs from the European model, where payroll contributions are made to multiple non-profit institutions like Germany's sickness funds that operate insurance. This arrangement, as Joe White notes, makes it "possible to argue that revenues and spending are not directly part of government." The European social insurance model has obvious political advantages but there is no direct American analogue and as the Clinton administration discovered with its much-maligned Health Alliances, it is a model that is not easy to establish here. See Joseph White, "Commentary on Social Insurance for Health Care: Economic, Legal, and Political Considerations," Paper Presented University of Toronto School of Public Policy & Governance, November 2006: 2, and Andrea Louise Campbell and Kimberly J. Morgan, "Financing the Welfare State: Elite Politics and the Decline of the Social Insurance Model in America," *Studies in American Political Development* 19 (Fall 2005): 175.

thereby distinguishing social insurance from welfare.³⁷ And since payroll taxes for Medicare and Social Security are earmarked for program trust funds that pay out visible benefits, workers sees a clear link between paying taxes and benefits, enhancing public support. Indeed, “Social Security taxes have always been among the most popular taxes even though their cost has risen tremendously over time.”³⁸ The political advantages of earned benefits and earmarked revenues could extend to a payroll tax-financed national health insurance plan (payroll taxes are one— though hardly the only—way to finance a single-payer system). Moreover, if a universal system is funded, like Social Security and Medicare, through matching employer and employee payroll taxes, it can appeal to notions of joint responsibility for funding health insurance, while benefiting from the perception that employers pay their share of the taxes rather than pass the costs onto workers. Finally, payroll taxes may be less visible than income taxes since they do not require an annual filing process, diluting public understanding of their total cost and thereby reducing taxpayer hostility.³⁹

In sum, payroll taxes are familiar, associated with popular social programs, and have an established history of funding health insurance. Unfortunately for their political fortunes, payroll taxes are also sure to galvanize substantial opposition. Unlike employer mandates, payroll taxes do not try to hide the fact that health reform means raising taxes, yet there is little credit to be earned for political honesty. Funding universal coverage via

³⁷ Theodore R. Marmor and Jerry L. Mashaw, “The Case for Social Insurance,” in Stanley B. Greenberg and Theda Skocpol, eds., *The New Majority: Toward a Popular Progressive Politics* (New Haven: Yale University Press, 1997): 78-103.

³⁸ Andrea Campbell, *How Americans Think About Taxes: Public Opinion and the American Fiscal State* (unpublished book manuscript): 14

³⁹ Ibid.

payroll taxes risks turning the debate over health reform into a conflict over tax reform and consequently taking head-on the powerful anti-tax strain in American politics.⁴⁰ Judging by recent decades, that is at best an uphill struggle. Public support for Social Security and Medicare remains high, but support in Congress and in the White House for payroll tax funding has clearly eroded since the 1970s.⁴¹ Medicare and Social Security payroll tax rates have not been raised since 1990, and tellingly, neither the 1988 nor the 2003 Medicare benefit expansions were funded by payroll taxes. The contemporary politics of payroll taxes do not provide a promising foundation for health reform: Republicans are ideologically opposed to raising such taxes, and Democrats, scarred by the stigma of being labeled a tax and spend party, are reluctant to sponsor payroll tax increases.⁴² There is arguably more public support for raising payroll taxes than policymakers believe but as long as the aforementioned political dynamics hold it will be difficult to fund universal coverage by enacting a substantial new payroll tax.

Payroll tax financing would also create visible losers, among them companies that do not currently provide health insurance, and employees whose premiums are now entirely covered by their employers.⁴³ If the payroll tax is, like Social Security and Medicare, funded jointly through equal employer and employee payments, it will represent a tax increase for many employees, and it could substantially raise costs for

⁴⁰ Walter A. Zelman, "The Rationale Behind the Clinton Health Care Reform Plan," *Health Affairs* 13, no. 1 (1994): 9-29.

⁴¹ Campbell and Morgan, "Financing the Welfare State," 173-195.

⁴² Some Democrats also worry about the regressive implications of further payroll tax increases. See Campbell and Morgan, "Financing the Welfare State," 183.

⁴³ Zelman, "Rationale Behind the Clinton Plan."

well-insured, middle- and high-income earners.⁴⁴ On the other hand, if the payroll tax rate is set so that employers are paying a greater share than employees (say an 80%/20% split)⁴⁵ it will only intensify employer opposition. In other words, there is no politically painless way to create a new payroll tax. And unless the payroll tax rate is set at very high rates, additional revenues will probably be needed to pay for universal coverage and those who are outside of the workforce. Finally, payroll taxes are politically vulnerable to charges that they would raise labor costs, reduce employment, and hurt the economy.

Reformers could respond that employers and employees are already paying exorbitant health insurance premiums, and that a payroll tax-financed, single-payer system would spend less money on health care than we do now by creating monopsony purchasing power and reducing administrative costs. There is much substantive merit to that argument. However, it does not diminish the political costs of switching from employer-paid premiums to a payroll tax system that would transfer private health care spending to the public budget. Even if spending on health care is less than it would be otherwise, more of that spending would be funded from taxes. A payroll tax ultimately cannot avoid the political liabilities that inevitably come with explicitly raising taxes.

The Combo

Play or pay financing for health reform, a modified employer mandate whereby employers provide for coverage or pay a quit tax (usually as a percentage of payroll) to

⁴⁴ Paul Starr, Review of *Boomerang: Health Care Reform and the Turn Against Government*, *Contemporary Sociology* March-April 1997: 150-153.

⁴⁵ Kevin Grumbach et al., "Liberal Benefits, Conservative Spending: The Physicians for a National Health Program Proposal," *JAMA* 265, no. 19 (1991): 2549-2554. For instance, this plan proposed a payroll tax of 9% on employers and 2% on employees.

the government, has re-emerged as a popular financing strategy for both state and national reformers. Its political appeal presumably lies in the *or*; rather than a direct employer mandate, it gives employers a choice. That could soften employer opposition to a mandate, especially if the quit tax level is set at a relatively low level so that the tax on not offering health insurance doesn't seem like such a bad option. It also enables sponsors of play or pay plans to argue that they are not simply mandating businesses provide health insurance but instead are offering them a reasonable choice of how they want to contribute to their employees' medical care costs. And if the tax for not offering insurance is paid entirely by employers, it could attract more public support than a matching employer/employee payroll tax. Like a conventional employer mandate, play or pay schemes seek to score political points by building on the status quo, drawing on notions of employer responsibility for funding insurance, and preserving a prominent role for private insurance.

Yet the political virtue of choice that lies at the core of play or pay also can be a political vice. By establishing a system that calls for creating an employer mandate *and* a payroll tax, play or pay financing potentially takes on the political liabilities of both financing options: opponents can argue that play or pay simultaneously means a big new tax and a big new mandate on employers. Either argument can be politically lethal on its own, overcoming both of them could prove extraordinarily difficult. Moreover, because workers whose companies pay the quit tax as well as other uninsured persons are enrolled in or given access to government insurance programs, play or pay plans are also subject to the charge that they open a backdoor path to national health insurance by expanding the scope of public programs. Indeed, if the tax option is set low enough so that it's a

financially more attractive option for many employers to pay the tax rather than provide insurance themselves, a substantial shift in enrollment towards public insurance could in fact occur (a shift that could be hastened by rising health care costs). Advocates of public insurance will find this outcome to their liking and view this feature as a crucial virtue of play or pay; opponents will just as certainly see it as a critical vice. Finally, the more that play or pay schemes hold down the payroll tax level and increase subsidies to win business support (especially among small businesses), the more they require additional funds from sources other than the quit tax to pay for universal coverage.

The Foreigner

One alternative to financing universal health insurance through employers—either through mandates or payroll taxes—is to turn to a value-added tax (VAT).⁴⁶ VATs have much to recommend. They are broad-based, enforceable, and can generate substantial revenues. They are compatible with a range of different comprehensive reform plans, from vouchers to national health insurance, and enable an end to employer-based insurance and all its failings. They have relatively low administrative costs and cause relatively few economic distortions. And they can be implemented so that the total tax is not a visible part of sales receipts, reducing public hostility.⁴⁷ Finally, broad-based

⁴⁶ Ezekiel J. Emmanuel and Victor R. Fuchs, “Health Care Vouchers—A Proposal for Universal Coverage,” *The New England Journal of Medicine* 352, no. 12 (2005): 1255-1260.

⁴⁷ James R. Hines, Jr., “Taxing Consumption and Other Sins,” *Journal of Economic Perspectives* 21, no. 1 (2007): 49-68; James M. Bickley, *Value-Added Tax: A New U.S. Revenue Source?* (Washington: Congressional Research Service, 2006); James M. Bickley, *A Value-Added Tax Contrasted with a National Sales Tax* (Washington: Congressional Research Service, 2000); Gilbert Metcalf, “Value-Added Taxation: A Tax Whose Time Has Come?” *Journal of Economic Perspectives* 9, no.1 (1993): 121-140.

consumption taxes are widely used in other industrialized countries, with the U.S. presently the only OECD nation without a VAT.

Funding the health care system exclusively through an earmarked VAT could promote cost control since any increase in health care funding that exceeded general economic growth would require explicitly raising the VAT level. In other words, Americans' traditional resistance to tax increases would help rein in health care spending and a VAT would provide a clear and transparent instrument that reflected the public's willingness to pay more for medical care.⁴⁸ And since a VAT-funded health care system would replace employer financing, it could attract support from businesses who, buffeted by rising costs, want to get out of the business of providing and paying for their workers' (and for some companies, their retirees') health insurance.⁴⁹

Yet a VAT faces formidable political barriers. As advocates of the metric system can attest to, widespread use abroad does not necessarily make a foreign innovation—even a sensible one—any easier to import here.⁵⁰ The same anti-tax strain that might keep a VAT from rising too fast also might keep it from being enacted in the first place. Introducing a major new tax to the United States would, to say the least, not be easy: will members of Congress who are reluctant to raise existing taxes step up to sponsor a significant new tax that is unfamiliar to the public and whose benefits and

⁴⁸ Ezekiel J. Emanuel and Victor R. Fuchs, *A Comprehensive Cure: Universal Health Care Vouchers, Hamilton Project Discussion Paper 2007-11* (Washington: Brookings Institution, 2007); James A. Morone, "Medicare for All," 63-74, in Jack A. Meyer and Elliot K. Wicks, eds., *Covering America: Real Remedies for the Uninsured* (Washington: Economic and Social Research Institute, 2002).

⁴⁹ Micheline Maynard, "Retirees' Health Costs Loom Over U.A.W. Talks," *New York Times*, July 19, 2007. The United Automobile Workers union now has "more retirees than active workers in its ranks." GM and UAW recently agreed to create an independently administered health care trust that would shift retiree health care costs off of GM's books. It remains to be seen what impact that agreement, and similar agreements if other companies follow suit, will have on business support for health reform. See Micheline Maynard, "With U.A.W. Accord, G.M. Looks to a New Detroit," September 27, 2007.

⁵⁰ Felicity Barringer, "Brave New World of Metrics a Mile Away," *Washington Post*, November 19, 1981.

economic logic few voters are likely to understand? The record to date is not encouraging. Congressman Al Ullman (Dem-Or.), chair of the House Ways and Means committee, called for establishing a VAT in 1978 and promptly lost his next election; the VAT subsequently became known in Congress as the “Al Ullman Memorial Tax.”⁵¹ The Clinton administration contemplated using a VAT to finance its universal coverage plan, but after having inauspiciously floated the idea around April 15th, rejected the option, in part because of polling that showed public resistance to the idea.⁵²

Enough time has passed that VAT proposals can probably safely escape the shadow of Al Ullman. But the VAT is still politically vulnerable. Opponents surely would have a field day drawing on anti-tax sentiment and attacking the VAT’s economic and administrative impact. It doesn’t take much imagination to envision attack ads that warn of escalating consumer prices and excessive tax burdens that could derail the economy or of a newly empowered Internal Revenue Service set to impose burdensome administrative requirements on businesses.⁵³ And while the VAT has a potential bipartisan constituency, it also faces bipartisan opposition: some conservative Republicans fear its potential as a revenue raising machine to fund expanded government, while some liberal Democrats worry about its distributional impact on lower-income Americans.

⁵¹ Charles P. Alexander, “Pay Up, Big Spenders,” *Time*, July 18, 1983.

⁵² Thomas L. Friedman, “New Tax on Goods is Weighed to Pay for Health Care,” *New York Times*, April 15th, 1993; Richard L. Berke, “Clinton Aide Said Polls Had Role in Health Plan,” *New York Times*, December 9, 1993. However, in a 1993 Time/CNN/Yankelovich Partners Poll, while 66% of those surveyed opposed enacting a federal VAT, if the VAT was adopted specifically to pay for health insurance for the uninsured, 60% favored it. Similarly, 51% favored a VAT to pay for a national health care system in a 1993 NBC News/Wall Street Journal poll (polling data from Roper Center).

⁵³ Howard Gleckman, “Three Roads to Reform: A Bush Panel Hines in On Ways to Make Taxes Fairer and Simpler,” *Business Week*, August 1, 2005.

Finally, though a VAT is broad-based, it may not be broad enough to serve as the sole financing source for health care. A VAT would raise net revenues equivalent to .4% of GDP for each percentage point of the tax; in 2005, a VAT of 5% would have raised an estimated \$250 billion in revenues.⁵⁴ Given that U.S. health care costs now consume 16% of GDP and over \$2 trillion, it quickly becomes apparent that it would take a very high VAT, so high as to be politically untenable, to finance all U.S. medical care spending. Excluding, at least in the short-run, the Medicare and Medicaid populations would lower the tab but such a financing system would still require a double-digit VAT,⁵⁵ a reality few politicians will be eager to embrace.

As the retirement of the baby boomers and escalating health care costs put more pressure on the federal budget, the VAT could re-emerge as an option for generating needed revenues. But in health reform, any VAT plan that seeks to displace employer-based financing invites political sticker-shock at the visible revenues that must be raised to replace the largely invisible financing system that now exists. That sticker-shock could be moderated by lowering the tax rate and instead using a VAT to pay for a modest part of the nation's health care bill, rather than establishing it as the sole or primary financing source of a universal system. But even an incremental VAT is likely to ignite considerable political controversy.

⁵⁴ William G. Gale and C. Eugene Steuerle, "Tax Policy Solutions," in *Restoring Fiscal Sanity 2005: Meeting the Long Run Challenges* (Washington: Brookings Institution Press, 2005), Alice M. Rivlin and Isabel Sawhill, eds., 113; Bickley, "Value-Added Tax," 2-7.

⁵⁵ Emanuel and Fuchs, *A Comprehensive Cure*.

The Vegas

Another option to pay for health reform is via sin taxes. There are three political advantages. First, there is seemingly no shortage of sinful activities that can be targeted, including smoking, drinking, eating, and driving. Tobacco taxes have proven especially popular in health reform; the federal share of the State Children's Health Insurance Program was paid for in 1997 by increasing the federal excise tax on cigarettes from .24 to .39 cents per pack, and current plans to reauthorize and extend SCHIP rely on further increases in federal tobacco taxes. Individual states like Oregon have also generated funds to expand coverage for the uninsured by raising tobacco taxes.

Second, such taxes draw on arguments that risky or irresponsible behavior damages individual as well as public (or environmental) health and consequently is costly to society. Sin taxes can be justified both on the grounds that individuals engaging in such behavior should have to pay for generating externalities and that they deter individuals from consuming the offending products, thereby lowering associated long-term health costs. Sin taxes thus can claim to do double-duty by reducing consumption while simultaneously raising revenues. Perhaps for that reason, they can attract support from liberals as well as conservatives who find them more palatable than other taxes.

Finally, as opposed to broad-based revenues, sin taxes on activities like smoking target a subset of the population; non-smokers, who represent a majority of Americans, may be all too happy to tax their smoking compatriots. Although sin taxes mean concentrating the financing burden on often well-heeled and politically connected industries and their consumers, politicians looking for funds in fiscally tight

environments are not, given some of the unpalatable alternatives, averse to taxing unpopular industries to pay for popular programs.

Alas, sin doesn't pay like it used to. The proportion of American adults who are smokers dropped from 37% in 1974 to 21% in 2004.⁵⁶ There simply aren't enough smokers around to fund universal coverage. Increasing the federal excise tax on cigarettes by .50 cents a pack would generate only a total of \$53 billion over the next decade, which can pay for SCHIP expansion but not much beyond that.⁵⁷ Similarly, alcohol taxes don't provide much bang for the bottle either; over that same decade, raising federal excise taxes to \$16 per proof gallon would produce about \$60 billion in revenues. Taxing driving, on the other hand, does yield substantial funds; a .50 cents increase in the federal excise tax on motor fuels would raise \$685 billion from 2008-2017. The problem, of course, is trying to find politicians willing to run for (re)election on the basis of substantially raising gasoline taxes, which impact many more Americans than cigarette taxes do, in a country whose gasoline taxes rank third lowest in the OECD.⁵⁸ Regardless of the environmental benefits, judging by public reaction to recent gasoline price increases there are few political rewards to be had for taking this issue on. And if a gasoline taxes can be raised, health reformers would have to compete for the ensuing revenues (after all this is a tax not directly linked to health care) against a range of other pressing interests, from rebuilding infrastructure and investing in environmental-friendly technologies to reducing the deficit.

⁵⁶ http://www.cdc.gov/tobacco/data_statistics/tables/adult/table_2.htm

⁵⁷ The revenue estimates for tobacco, alcohol, and gasoline taxes come from CBO, *Budget Options*, 320-323.

⁵⁸ Hines Jr., "Taxing Consumption and Other Sins," 55-56.

Finally, health care reform could be funded through a so-called “fat tax” (think “Big Macs for the Uninsured”). That would mobilize public health advocates looking to alter eating habits and capitalize on growing public policy concern over the consequences of rising obesity rates.⁵⁹ It also could, given the rate at which Americans consume unhealthy foods, potentially raise substantial funds; targets could include everything from snack foods and soft drinks to foods high in saturated fat, salt, and sugar.⁶⁰ However, since a broad-based obesity tax would impact many Americans, as well as the companies whose profits depend on selling fat, it could face significant opposition. Public opinion data currently show substantially less support for taxing snack foods than for other public health interventions, such as taxing cigarettes.⁶¹ Moreover, estimated revenues from taxing obesity are not as large as one might think; politically palatable small taxes on snack foods and other items generate only modest revenues.⁶² In order for an obesity tax to pay for a significant share of the universal coverage bill, much higher food taxes would be required, and such taxes would in turn generate much stronger opposition.⁶³

⁵⁹ Obesity prevalence among U.S. adults (aged 20-74) increased from 15% during 1976-80 to 31% in 1999-2000. Katherine M. Flegal et al., “Prevalence and Trends in Obesity Among US Adults, 1999-2000,” *Journal of the American Medical Association* 288 (2002): 1723-1727.

⁶⁰ Michael F. Jacobson and Kelly D. Brownell, “Small Taxes on Soft Drinks and Snack Foods to Promote Health,” *American Journal of Public Health* 90, no.6 (2000): 854-857.

⁶¹ J. Eric Oliver and Taeku Lee, “Public Opinion and the Politics of Obesity in America,” *Journal of Health Politics, Policy, and Law* 30, no. 5 (2005): 923-954.

⁶² For instance, in 2000 (856) Jacobson and Brownell estimated that a 1 cent tax on 12-oz. soft drinks would generate \$1.5 billion annually in revenues, with taxes of 1-cent per pound on candy, chips, and other snack foods generating a total of \$314 million.

⁶³ A 10% tax on all dairy products would raise an estimated \$4.45 billion annually, though poor families would be disproportionately impacted. Hailey H. Chouinard et al., “Fat Taxes: Big Money for Small Change,” *Forum for Health Economics & Policy* 10, no.2 (2007): 1-28.

In sum, the sin taxes most likely to be used successfully in health reform are precisely those least likely to generate substantial revenues. Sin taxes can play a role as part of a broader financing package for universal coverage, but that role is likely to be limited.

The All-American

Universal coverage could also be funded without any new revenues at all. That is, it could simply be added to the federal budget and to the federal deficit, with the costs of a universal system paid for through general revenues. Before dismissing that proposition as fiscally irresponsible, it is worth noting that we have financed a number of recent public policies through deficit financing, including the wars in Afghanistan and Iraq, the Medicare prescription drug benefit, and tax cuts. Apparently, these activities were deemed sufficiently socially (or politically) desirable that they required no dedicated funding or offsetting savings and simply could be added to the federal ledger. It tells you all you need to know about the uninsured that this option evidently is not viable for health reform. We ultimately find ways to fund policies and activities that are national priorities. Since the uninsured are evidently not a priority, affordability concerns block their claim on the federal budget while those same concerns are suspended for more valued programs and populations. The notion that universal coverage is unaffordable remains, as Uwe Reinhardt argues, a political fiction, since even when the United States had a projected surplus of \$5.6 trillion in 2001 policymakers were not moved to use those funds to

finance expanded coverage and instead approved a major tax cut that disproportionately benefited wealthier Americans.⁶⁴

Of course, there are ways to responsibly pay for health reform through general revenues (which finance such All-American programs as education and defense) without adding to the deficit. One is simply to raise more general revenues.⁶⁵ And here we find liberals' health reform holy grail: paying for universal coverage by rolling back the Bush tax cuts. That option, popular among 2008 Democratic presidential candidates, makes health reform explicitly redistributive. Health insurance coverage is funded for mostly low-income Americans by raising taxes on higher-income Americans so that the health care and tax systems are both made fairer in one fell swoop.

There are three political advantages to this financing strategy. First, there is ample money to be had from the Bush tax cuts—for instance, Hillary Clinton's health plan estimates that about \$50 billion could be raised just from eliminating tax cuts for households making over \$250,000.⁶⁶ Consequently, a large share of the universal coverage bill can be paid for without imposing any new broad-based taxes or raising existing taxes on most Americans.

Second, there is reason to believe a majority of the public would support using revenues from rolling back the Bush tax cuts to fund universal coverage. In a February 2007 CBS News/New York Times poll, 76% of those surveyed said that making sure all Americans have access to health care was more important than maintaining recent tax

⁶⁴ Reinhardt, "Is There Hope for the Uninsured?," 383-4.

⁶⁵ Raising all federal tax rates by 1% would produce an estimated \$445 billion in revenues during 2008-2017. See CBO, *Budget Options*, 255.

⁶⁶ *American Health Choices Plan*. Available at: <http://www.hillaryclinton.com/feature/healthcareplan/americanhealthchoicesplan.pdf>

cuts, and 61% were willing to pay higher taxes “so that all Americans have health insurance they can’t lose no matter what.”⁶⁷ To be sure, financial sacrifices are easy to make in the abstract; saying “yes” to a pollster doesn’t come with any cost. But even if insured Americans cringe at the reality of paying higher taxes to cover the uninsured, they might not oppose their wealthier compatriots having to do so, especially given public opinion data showing that a majority of respondents believe rich people pay less in taxes than they should.⁶⁸ Moreover, there is precedent (e.g., the 1993 Omnibus Budget Reconciliation Act) for adopting tax changes that increase federal revenues by “zap[ping] the rich”⁶⁹ and focusing tax hikes on higher-income Americans.

Third, if policymakers wait for 2010, they don’t have to pass new tax increases for the wealthy but can instead just let provisions of the 2001 and 2003 tax cuts expire.

However, this financing strategy carries the same political vulnerabilities as previously discussed options that are explicitly redistributive and visibly raise taxes. It invites charges of “class warfare” and allegations that if Washington is allowed to raise taxes on your rich neighbor, you’re next. Anti-tax groups will argue that any tax increase harms the economy and there is no assurance that advocates will be able to convince the public that only tax cuts for the wealthy are being rolled back. Indeed, depending on how middle class and wealthy is defined, such a tax hike could affect more Americans than

⁶⁷ *The New York Times/CBS News Poll*, February 23-27. Available at: http://graphics8.nytimes.com/packages/pdf/national/03022007_poll.pdf

⁶⁸ Larry M. Bartels, “Homer Gets a Tax Cut: Inequality and Public Policy in the American Mind,” *Perspectives in Politics* Vol.3, no. 1 (2005): 19. In a 2002 National Election Study survey, 51.6% of respondents said rich people are paying less than they should in taxes, 32.8% said they were paying about the right amount, and 12.8% said they were more than they should.

⁶⁹ Steuerle, *Contemporary Tax Policy*, 174.

the tax the rich rhetoric suggests. Moreover, the 2001 Bush tax cuts received broad public support even though they were regressive and large public majorities favored repeal of the estate tax.⁷⁰ Paying for health reform by raising taxes on upper-income taxpayers also imposes the financial burden of covering the uninsured on a group that already has insurance and believes it has little to gain from universal coverage. Finally, it does the one thing that health reformers have tried so hard since the 1980s to avoid: explicitly raise taxes.

Another option for financing health reform through general revenues is the Medicaid model, with the federal government providing matching funds to states. This approach has the fiscal advantage of minimizing federal costs since a significant portion of the universal coverage bill would be shifted away from Washington, and the political advantage of capitalizing on enthusiasm for federalism and states' growing role in health reform.⁷¹ However, fiscal federalism would simply shift the financing dilemma to the state level without providing any solutions, and the federal government would still have to pay the lion's share of costs, again raising the issue of where those additional revenues are going to come from.

A third way to fund universal coverage through general revenues without worsening the deficit is to find offsetting savings in current programs, namely Medicare and Medicaid. This was in fact a major component of the Clinton administration's financing plan for the Health Security Act. With big, expensive health insurance

⁷⁰ Bartels, "Homer Gets a Tax Cut." In large part, that is because public opinion on tax policy is "ill informed, insensitive to some of the most important implications of the tax cuts, and oddly disconnected from (or misconnected to) a variety of relevant values and material interests" (21). On public support for the estate tax, see Larry Bartels, "Unenlightened Self-Interest: The Strange Appeal of the Estate-Tax Repeal," *American Prospect* May 17, 2004.

⁷¹ White, "Budgeting and Health Policymaking," 70.

programs comes the opportunity for big savings, from lower payments to medical providers and health plans, higher premium payments from beneficiaries (in Medicare), and reductions in utilization of high-priced services. The federal government has previously shown the capacity (in 1983, 1989, and 1997) to impose Medicare reforms on providers that generate significant budgetary savings.⁷² This is, in other words, a familiar budgetary option that has a proven track-record of attracting bipartisan Congressional and Presidential support.

But there are downsides. If the health care status quo is left relatively intact, how much money can be squeezed out of Medicare and Medicaid without jeopardizing patients' access to medical care? Targeting Medicare for savings could cost reformers the support of consumer organizations and elderly advocacy groups like AARP. While raising costs for higher-income Medicare beneficiaries enjoys broad support, there are not enough high income beneficiaries to make much of a financial dent in the bill for universal coverage. Reducing payments to Medicare Advantage plans would generate savings, albeit modest in scope, yet the more beneficiaries become accustomed to the extra benefits plans provide, the more difficult it becomes to eliminate excess payments. And targeting Medicaid (robbing the poor to pay for the non-categorically eligible poor) will raise the ire of states that depend on federal dollars.

In sum, redirecting existing health insurance payments and finding budgetary savings in projected spending on current programs is an attractive alternative to raising new revenues in a tax-phobic environment. However, various constituencies are invested

⁷² Rick Mayes and Robert A. Berenson, *Medicare Prospective Payment and the Shaping of U.S. Health Care* (Baltimore: Johns Hopkins University Press, 2006).

in existing programs, so redirecting spending has its own political costs.⁷³ In addition, it is not clear that there is enough revenue available from incrementally trimming Medicare and Medicaid to fund universal coverage either in the short or long-run, so although savings from those programs could potentially play a role in funding health reform, they can't do it alone.

The Do-It-Yourselfer

A final financing option is to stipulate that Americans must purchase their own insurance through an individual mandate. Both Massachusetts' health reform plan and California Governor Arnold Schwarzenegger's proposed reforms rely on an individual mandate, which also is a component of John Edwards' and Hillary Clinton's health plans. The political attraction is that health care, often described in the language of rights and government obligations, is made into a personal responsibility, enabling reformers to potentially appeal to conservative as well as liberal audiences. It forces free riders to "pay their fair share"⁷⁴ and individuals to take responsibility for their health, thereby invoking the rhetoric of responsibility popularized in recent years by the advance of health care consumerism. It also builds on the precedent of other individual mandates such as auto insurance while ensuring that everyone joins the risk pool, potentially reducing adverse selection concerns and thus the need for underwriting in insurance markets.⁷⁵

⁷³ Jeffrey Young, "Hospitals Balk at Bush Health Plan," *The Hill.com*, January 24, 2007. For instance, hospital lobbyists "expressed displeasure" that a Bush administration proposal to encourage state-based insurance expansions might be funded partly by reducing DHS payments.

⁷⁴ Len M. Nichols, "Where's Obama's Mandate?," *The American Prospect*, June 4, 2007. Available at: http://www.prospect.org/cs/articles?article=wheres_obamas_mandate

⁷⁵ Ibid.

Furthermore, to the extent that health insurance is self-financed, the need for additional revenues is reduced and health reform financing is privatized. Employers would certainly prefer that mandates be targeted toward employees rather than on businesses, so individual mandate plans could win their support. Some individual mandate proposals would end employer-sponsored insurance, which could attract even more business support. And individual mandate systems maintain a prominent role for private insurance, thereby minimizing insurance industry opposition.

Yet any prospect of self-financing universal coverage is illusory. Quite simply, most of the uninsured are uninsured because they cannot afford to purchase coverage, so mandating them to do so is meaningless (except to be punitive) without substantial subsidies. Serious individual mandate proposals that seek to move towards universal coverage must contain serious subsidies and those subsidies can add up: a recent individual mandate proposal estimates that subsidies for purchasing a basic plan would cost \$200 billion annually.⁷⁶ And that then begs the question of where the money for the subsidies is going to come from. Furthermore, if an individual mandate is not paired with an employer mandate or a play or pay option, currently insured workers will worry about employers dropping coverage and shifting health care costs to them. Even with subsidies there is likely to be a group that makes too much money to qualify for government help but whose incomes are modest enough that purchasing health insurance is a financial burden. Currently well-insured members of this group might ask why they should finance subsidies for the uninsured while actually getting less security themselves out of

⁷⁶ Nichols estimates that about \$100 billion could be raised from the higher income tax revenues that would follow plans to “cash out” employer-paid health insurance premiums and convert them into wages. Len M. Nichols, *A Sustainable Health System for All Americans* (Washington: New America Foundation, 2007). Available at: http://www.newamerica.net/publications/policy/sustainable_health_system_all_americans

health reform. An individual mandate thus creates explicit subsidies that are politically vulnerable to opposition from those (especially workers whose health insurance is currently subsidized by employers) who don't want to pay for them.⁷⁷ Finally, while an individual mandate has long attracted some bipartisan support, it is also the case that many liberals and conservatives would oppose it as, respectively, too little and too much.

In the end, an individual mandate does not offer a means for financing universal coverage as much as it imposes a requirement that then requires its own financing. The rhetoric of responsibility is no substitute for real money. The significant subsidies required by any truly comprehensive individual mandate plan mean that it must look to other sources (general revenues, sin taxes, and so on) to fund a universal system.

A Final Note on Financing Options and Cost Control

The preceding discussion focused on the political feasibility of different financing arrangements and the obstacles and opportunities each option for funding universal coverage faces. Yet funding options may also have important political consequences for a health care system. In particular, how much is a nation's capacity to control costs affected by whether its health care system is funded by dedicated revenues (such as earmarked VAT or payroll taxes) rather than general revenues?

There is a compelling theoretical case that earmarked financing should produce more robust cost control. A program funded solely through earmarked financing has, in effect, a budget that is equal to collected revenues; increases in health care spending thus

⁷⁷ Brown, "Who Shall Pay?," 177.

require increases in the earmarked tax or offsetting savings from cost control.⁷⁸ Explicitly increasing a separate tax is a highly visible and potentially unpopular activity. The public and politicians alike could recoil at the prospect of endless increases in a health care tax, which could strengthen political resolve to pursue cost containment measures as an alternative. In this situation, elected officials may well decide that it is less risky to go after providers and other health care stakeholders than to go after voters with higher taxes. Public aversion to paying taxes, in other words, becomes an instrument of cost control. In contrast, paying for rising health care costs out of general revenues requires no explicit change in a dedicated tax and instead relies on politicians' willingness to take funds from the government treasury. In this case, taking a greater share of general revenues to pay for rising health care spending might seem like an easier (and less visible) option than imposing controversial cost control measures.

Are these theoretical assumptions about earmarked and general revenue financing borne out in practice? The U.S., of course, has ample experience with earmarked financing for health care through Medicare. Medicare Part A is funded through payroll taxes that are dedicated to the Hospitalization Insurance trust fund. In part, this financing arrangement was created because Wilbur Mills, chair of the House Ways and Means Committee during Medicare's enactment, believed it would produce fiscal restraint.⁷⁹ How much restraint earmarked funding has actually generated in Medicare is, however, subject to interpretation. Certainly, intermittent trust fund shortfalls (which trigger fears of program bankruptcy) have led policymakers to adopt new cost containment measures,

⁷⁸ Emmanuel and Fuchs, *A Comprehensive Cure*, 21.

⁷⁹ Eric M. Patahsnik, *Putting Trust in the US Budget: Federal Trust Funds and the Politics of Commitment* (Cambridge: Cambridge University Press, 2000): 100.

such as the Medicare prospective payment system for hospitals, and tighten up existing regulatory controls on providers.⁸⁰ Raising the payroll tax to pay for growing Medicare spending has been harder to do politically in the past two decades than it was in the program's early years; anti-tax sentiment has thus helped fuel the federal government's drive to control costs. Furthermore, changes in provider payment policies have substantially reduced the rate of growth in Medicare spending, and Medicare's cost control performance has generally exceeded that of private health insurers over the past 25 years.⁸¹

On the other hand, while Medicare's cost control performance has been good relative to private insurance, many analysts might not regard its absolute performance as stellar. Moreover, Medicare is only partially funded by earmarked revenues and provider payments have been reduced as well in Medicare Part B, financed through general revenues and beneficiary premiums. And Medicaid is not funded by earmarked revenues yet that program has also adopted cost controls. In fact, during 2000-2003 Medicaid spending per enrollee grew at a slower rate than per enrollee spending in Medicare.⁸² The Medicaid and Medicare Part B experiences suggest that general revenue financing systems can also generate forces for fiscal restraint; even if no specific tax has to be raised to pay for rising costs in a general revenue system, more spending on health care takes money away from other budgetary priorities, and that can trigger cost control.

⁸⁰ Jonathan Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003), 74-106.

⁸¹ Chapin White, *The Slowdown in Medicare Spending Growth* (Washington: U.S. CBO, 2006).

⁸² Kaiser Family Foundation, *Medicaid Enrollment and Spending Trends* (June 2005).

Figure 2: Funding Sources for Selected OECD Health Systems

Country	% GDP on healthcare	% Publicly Funded	Financing Sources for Government Health Care Spending
Australia	9.2%	67.5%	<ul style="list-style-type: none"> • General Revenues (Federal government funds 46% of health care spending, States fund 22%) • Payroll Tax: 1.5-2.5% Medicare Levy on taxable income
Canada	9.9%	69.8%	<ul style="list-style-type: none"> • General Revenues • Plans administered by provinces, partially funded by federal government • 3 provinces have their own tax, such as the Ontario Health Premium
France	10.5%	78.4%	<ul style="list-style-type: none"> • 51.1% funded by employer payroll contributions • 34.6% funded by 7.5% levy on all earnings, including investment income • 3.3% from specific taxes on cars, tobacco, and alcohol
Germany	10.9%	78.2%	<ul style="list-style-type: none"> • 56.9% of funding comes from payroll contributions to statutory health insurance (Sickness Funds) • 14.2% of wages paid equally by employer and employee into sickness funds • 7.8% of expenditures comes from general revenues
Japan	8.0%	81.5%	<ul style="list-style-type: none"> • 30% of health care spending from general revenues • 55% of health care spending from health insurance premiums • 8.5% health insurance premium for employed, paid by employers and employees • Income-based premium for the self-employed
United Kingdom	8.3%	85.5%	<ul style="list-style-type: none"> • 81.5% of NHS spending from general revenues • 12.2% from health specific income tax (National Insurance Contributions)

Sources: Jonathan Cylus and Gerard F. Anderson. *Multinational Comparisons of Health Systems Data, 2006*; Commonwealth Fund; Health Canada; Victor G. Rodwin, The Health Care System under French National Health Insurance. *Am J Public Health* 2003;93:31–7; European Observatory on Health Systems, *Health Care Systems in Transition*; Masanori Ito; “Health Insurance Systems in Japan: a Neurosurgeon's View,” *Neurologia medico-chirurgica*, Vol. 44, pp.617-628 (2004).

Looking outside the United States, the evidence of the impact of differential financing arrangements on cost control is mixed. As Figure 2 shows, OECD countries use a range of funding sources to finance their health care systems. Some countries, like Canada and Great Britain, rely heavily on general revenues, while nations such as France and Germany have social insurance systems that draw on earmarked payroll taxes. It is standard for OECD health systems to have multiple funding sources; health care is not financed entirely by a single earmarked funding source in any of the nations examined here. Private funding sources (private insurance, user charges, out-of-pocket costs) also play a varying role in financing medical care across the OECD.

While the OECD nations provide a range of different financing mixes, their experiences do not support any clear conclusion about how those mixes impact cost control. After performing an empirical analysis of the effects of financing arrangements on health care spending, Sherry Glied explains that “The main finding...is that there is no persistent and regular relationship between the structure of system financing and the rate of growth in per capita health expenditures in a health system.”⁸³ Depending on the time period measured, different countries perform better in cost control. Joe White argues that this suggests that the impact of financing systems varies with economic conditions: in tough times and periods of budgetary constraint, it is easier to make substantial cuts in a general revenue-funded system (such as Canadian Medicare) than in a social insurance system, while in good times, earmarked financing provides more restraint against spending increases (since increasing revenues requires a visible decision

⁸³ Sherry Glied, “Health Care Financing, Efficiency, and Equity,” Paper Presented at the University of Toronto School of Public Policy & Governance, November 2006: 10.

to raise taxes, as opposed to automatic increases in general revenues).⁸⁴ Yet the correlation between financing arrangements and structure of health systems (tax-financed systems also are more centralized than multi-payer social insurance systems, which abets cost control) and the limits in available data make any definitive conclusions impossible.

Finally, it is worth noting that some political scientists argue that tax revolts and welfare state backlashes are more likely in countries with high (and highly visible) income and property taxes, and less likely in countries that alternatively rely more on consumption and social insurance taxes.⁸⁵ Health system financing thus could impact overall public support for taxation and government activity, which could in turn affect the ability of public health insurance programs to raise revenues.

In sum, the theoretical expectation that earmarked financing will produce decisively superior cost control than general revenues confronts a much more complicated reality. Ultimately, the absence of a clear and consistent relationship between financing structure and cost control makes sense: after all, cost control has much to do with how providers are paid, how coordinated the payment system is, how the diffusion of medical technology is limited, how competition and markets are structured, and a host of other factors that have nothing to do with the structure of health system financing.⁸⁶ By itself, a financing arrangement cannot assure cost control. If health care spending consistently outpaces earmarked finances, the chances are good, given public

⁸⁴ See Joseph White, "Commentary on Social Insurance for Health Care: Economic, Legal, and Political Considerations," Paper Presented at the University of Toronto School of Public Policy & Governance, November 2006: 8-10.

⁸⁵ Harold L. Wilensky, *Rich Democracies: Political Economy, Public Policy and Performance* (Berkeley: University of California Press); Junko Kato, *Regressive Taxation and The Welfare State* (Cambridge: Cambridge University Press, 2003).

⁸⁶ White, "Commentary," and Glied, "Health Care."

support for health care, that other financing sources will be added. Indeed, funding diversification is common, as Tim Jost notes: “Both tax-financed and social insurance programs...are looking for alternative approaches to funding their health care programs.”⁸⁷

There may still be grounds for preferring earmarked funding in the United States, since it would make health care spending and tax tradeoffs more visible in a country that previously has shown little spending restraint and perhaps would also lessen the temptation for deficit financing. But if the U.S. does not adopt the cost control instruments common in the OECD, it will not control costs regardless of its financing arrangements.

Conclusion

Is there a politically plausible financing strategy for comprehensive health reform? As this paper has shown, there are no obvious answers to that question. It is easy in hindsight to bash the Clinton administration for the 1993-94 health care reform debacle, but in fact there were no easy choices then about financing universal coverage and there aren't any easy choices today. All the major financing options have serious political liabilities of one kind or another; either they risk arousing public opposition and anti-tax sentiment or they risk arousing stakeholder opposition, or both. And the less controversial options generally don't raise enough money to cover all the uninsured.

Yet it would be a mistake to evaluate the feasibility of different health reform financing options solely on the basis of their respective political strengths and

⁸⁷ Timothy Jost, “Funding Health Care Services: The Optimal Balance,” Paper Presented at the University of Toronto School of Public Policy & Governance, November 2006: 22. Diversification is not the only alternative; Jost relates that in France, health insurance funds were allowed to run deficits.

weaknesses. The reality is that political feasibility is a relative concept that changes over time, and is profoundly impacted by elections, the economy, the public mood, and other crucial socioeconomic and political factors. What is happening within the health care system—the rate of growth in insurance premiums and the uninsured population, Medicare and Medicaid costs pressures, the erosion of employer-sponsored insurance—is only part of the much broader political world that health reform operates in. To take one example, the feasibility of funding alternatives for health reform under a House Ways and Means Committee chaired by Bill Thomas is very different than under a Ways and Means Committee chaired by Charlie Rangel.

We should be careful then not to simply extrapolate from present political circumstances to paint an unchanging portrait of what's possible and what's not possible in health reform. After all, the history of health policy is full of surprises and of mistaken feasibility judgments that defied many analysts' predictions: the Clinton health plan, the Medicare catastrophic health insurance debacle, the list could go on and on. While we can make reasonable assumptions about what's likely to happen in health financing politics right now, we simply don't know what the political environment will look like in 2009 and beyond.

The answer, then, to the question of how politically feasible is any given health reform financing strategy must be it depends: it depends on who is in power in Congress and the White House, what the economy is like, how much of our attention (and revenues) is devoted to international conflicts, and so on. It depends crucially on political leadership: two presidents with differing powers of persuasion and legislative skill might fare very differently in their ability to win approval for the same reform. And it depends

on political strategy and the ability of reformers to market their ideas, build coalitions, and capitalize on political circumstances, as evidenced by the successful drive to repeal the estate tax.⁸⁸ It also depends on what a broader health care reform package looks like. Isolating the financing provisions of comprehensive reform is a useful exercise, but it is artificial. In the real world those provisions would be considered as part of a larger set of reforms. Certainly, the wrong financing strategy can sink health reform (as it did with Medicare's catastrophic health insurance program in 1989), but strategies that seem controversial or infeasible when judged separately may have a better than expected chance if they are part of a reform plan that has other politically attractive elements. How health reform is financed is a crucial issue, but if the prevailing political majority and public don't like the health care system proposed by reformers then having a politically sound financing strategy will not be enough.

Despite these cautions, a few tentative conclusions about the politics of financing health reform are possible. First, it seems highly unlikely that the U.S. will replace its patchwork, mixed financing system with a single-source public financing system. Most other OECD countries use multiple financing sources and given the strength of the status quo and how high U.S. spending is, it is likely we will retain a mixed system.

Second, in the short to medium-term, politically viable proposals for financing universal coverage probably have to build on employer-sponsored insurance. Employer-sponsored insurance may rest on the economic illusion that employers pay their workers' health insurance premiums, but the political price for ending that illusion is high. And any health reform that builds away from rather than on employer-sponsored insurance

⁸⁸ Michael J. Graetz and Ian Shapiro, *Death by a Thousand Cuts: The Fight Overtaxing Inherited Wealth* (Princeton: Princeton University Press, 2005).

must confront the monumental challenge of replacing an established and rather large financing source.

Third, the difficult politics of paying for universal coverage (and the even more difficult politics of controlling costs) encourages reform-minded politicians to put their faith in savings from increasing prevention, improving quality, moving to electronic medical records, reducing waste, and other reforms whose fiscal impact is at a minimum uncertain, and in reality, is probably often overstated. These faith-based financing strategies might work well on the campaign trail, but they are unlikely to pass muster in a budget process that demands real funding. Moreover, the less you control costs, the more pressure a financing system will feel to keep pace with the rising price-tag for health care.

Finally, the political fortunes of universal coverage depend on redistribution. In the end, someone—employers, taxpayers, the insured, the wealthy—is going to have to pay more (or pay differently) for health reform. Until a politics emerges that imposes those costs on the relevant stakeholders or persuades them to accept the tab, universal coverage is simply not possible.