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Abstract

This paper describes a way to finance universal coverage that preserves much of the current financing system and replaces funds obtained from regressive sources with revenue from more progressive ones. New funding would be needed for 24% of health expenditures. These replacement funds would be raised through an increase in the federal personal income taxes. Premiums would be eliminated since their cost is the same to everyone regardless of income. Cost sharing and out-of-pocket spending for medically-necessary services are also abolished.

In a more equitably-financed system, employers' would pay a new payroll tax that raised the same amount of money they currently spend for employee health insurance premiums; this would require a payroll tax of about 7%. Revenue from an increase in the federal personal income tax would replace household out-of-pocket expenditures for medically-necessary services and payments for insurance premiums. For the average, middle-income family, the tax increase would total \$73.1 in 1998. In exchange for the tax increase, no American or American employer would need to buy health insurance or face out-of-pocket charges for any medically-indicated health care.

¹ While universal insurance coverage has been the goal of health care reformers for many years, the specifics of how to equitably finance such a system are less well understood. This paper outlines a way to finance universal coverage that preserves much of the current financing system and replaces funds obtained from regressive sources with revenue from more progressive ones. One way to more equitably finance health care would be to replace current out-of-pocket spending and households' purchases of health insurance premiums with revenues from an increase in the federal personal income tax. For the average, middle-income household, this would mean a tax increase of \$731 in 1998. In exchange for the tax increase, no one would need to buy health insurance or face any out-of-pocket charges.

The financing system described here is designed to function within a health care system that provides universal coverage for all medically-necessary services for either all or part of the population.⁷ The health care system would also include the following cost containment components: a global budget with enforcement mechanisms, capital planning and budgeting, a single payer, and negotiated reimbursement rates. In addition, the link between employment and health insurance coverage would be severed.²

Money that pays for health care flows from a variety of sources. Income and payroll taxes, purchases of premiums, and out-of-pocket expenditures are the most common. Within each of these funding streams, it is possible to determine the share of income paid for health care by households at various income levels. When higher-income households pay a larger share of income than lower-income households, the funding stream is progressive. When the reverse is true and lower-income households pay a higher share of income than do upper-income ones, then the funding sources is regressive. Progressive financing is considered more equitable than degressive.

The following principles shape the financing system: progressive sources of revenue; no financial penalty for being ill or using services, that is, no cost sharing; and minimized transition costs -- the new financing system should build on the current one where that is possible and compatible with the other goals of financing.

How Much Will It Cost?

Before deciding how to fund a new system, it is necessary to know how much it will cost, and in particular, whether it will cost more than the old. This is especially important since the universal plan described here differs from the current system in ways that have large cost implications. First, the currently uninsured and underinsured will gain full insurance coverage, increasing their access to and use of services. Second, reductions in cost sharing could lead to increased utilization by the already insured. Third, administrative costs will fall due to the single payer.³ Fourth, new cost containment features will provide a better constraint on cost growth in the years after the plan is implemented.⁴

There have been just a few estimates of how national expenditures would change if a universal, single payer system were instituted. However, there is general agreement in the findings: the effect on spending would be minimal and within a very few years, expenditures

under the new system would be lower than under the old. The General Accounting Office (1991a) estimated that a shift to a single payer, universal system could occur with essentially no change in total expenditures. The Congressional Budget Office (1993) estimated that S. 491 (Senator Paul Wellstone's American Health Security Act) would raise national expenditures above baseline (the level of spending that would have occurred if no changes in the system had been made) by 4.8% in the first year after implementation.' However, in subsequent years, improved cost containment and the slower growth in spending associated with the new system would reduce the gap between expenditures in the new system and the baseline. By year five (and in subsequent years), the new system would cost less than baseline.⁶

In the model presented in this paper, it is assumed that in the first year after implementing a universal, single-payer plan, total national health expenditures would be unchanged from baseline. If expenditures were higher than baseline in the first few years, then additional revenues above those described here would be needed. However, these higher costs would be more than offset by savings that would accrue within the first decade of the program.

NEW Ways to Fund a Health Care System

In thinking about ways to fund health care, it is necessary to consider funding separately from payers and services received. Under a new system, consumers would continue to seek and receive health care services possibly from the same providers they used in the old (current) system. Service delivery could continue unchanged. However, some health care payers (the people who pay the bills -- for example, private insurance companies, Medicare, and Medicaid) and some of the funding sources would be different. Progressive sources of funds would be retained and payers that obtain their funds through progressive sources would continue to pay for health care. Regressive sources of financing, however, would be discontinued and replaced with more progressive sources. Payers who obtain their funds from regressive sources would no longer pay for health care. Ending regressive financing would primarily impact private health insurance companies. Insurance firms obtain their funds from premiums paid by the people they insure. Even when people obtain health insurance through an employer who pays some or all of the cost, wages are reduced to offset this expense, so employees actually bear most or all of the cost of their premiums. Since the price of a particular insurance policy is the same regardless of a household's income, this means that a low-income household (that has insurance) pays a larger share of its income for a premium than does an high-income household. This regressive source of financing would need to be replaced.

As a rule, progressive income taxes are the most equitable way to pay for health care. Premiums should be avoided since, even under a community-rated system, the cost is the same to everyone regardless of income and, therefore, is regressive. Cost sharing and out-of-pocket spending should be avoided since these expenses fall disproportionately on people who use the most services (the less healthy members of the community) and the costs are not assessed in relation to income.

The Current Financing System

In 1995 (the last year for which these data are available), federal, state, and local governments were the largest purchasers of health care services, responsible for 44% of the national total: 33% by the federal government and 11% by states and localities. (Including Workers Compensation spending and payments made by the public sector in its role as an employer purchasing health insurance for employees raises the total to 52%.) Employers' spending for health care (primarily for insurance for employees) was approximately 28% of all health expenditures. Households accounted for 26% of the total. Non-patient revenues, for example, charitable donations and net revenues from sales in hospital gift shops, were 3% of funds. See Table 1. The sources of this money is now examined to determine whether the funding stream should be eliminated and/or changed in a new system.

Households: Households' direct purchases of private health insurance premiums (not through an employer) and employees' payroll deductions for health insurance premiums constitute 7% of all money flowing into the health care system. Since premiums are an inequitable way to fund health care, this funding stream would need to be replaced.

Households' out-of-pocket expenditures account for 19% of all health care dollars. Table 2 shows the services currently purchased out of pocket. Some of these services are not medically necessary and would not be covered under the new system, for example, cosmetic surgery and nonprescription drugs. But all medically-indicated services would be covered.

Data that would allow the calculation of the exact share of out-of-pocket spending should be paid for through the new system are not available. However, it is possible to roughly estimate the medically-necessary component of out-of-pocket spending as 80% of current expenditures, or about 15% ($19\% \times 0.80$) of all health expenditures.⁷ Some 4% of national health expenditures would continue to be financed out of pocket.

Businesses: In their purchases of health care for employees, businesses currently are responsible for 28% of all health care spending. There are a number of reasons why reforms are needed in the way businesses pay for health care. First, as mentioned, although employers often pay some or all of the cost of employee health insurance and health care, wages are reduced to offset at least part of this expense. So employees actually bear most or all of the cost of premiums. To end the reliance on premiums requires a change in the way employers pay for health care. Second, some of the cost of employee health care may ultimately be borne by firms, not workers, resulting in lower profits for the firm or higher prices for the firm's products. This places a firm that is "doing the right thing" by providing health insurance for its workers at a competitive disadvantage compared with a firm that does not provide health coverage. To level the playing field among firms and remove the incentives to avoid providing employee health insurance, all employers must share in the responsibility for paying for health care.

Although wages are reduced to offset most or all of the cost of an insurance policy, if employers were suddenly relieved of the responsibility for employee health insurance coverage and dropped their health insurance policies — for example, because a universal health care system funded entirely through taxes on employees were instituted — it is unlikely that all the savings would be returned to employees as higher wages. Some of the savings would likely be

retained by employers. So, the employees would pay higher taxes to support the tax-financed health care system, but would not have the additional income to be able to afford this. At the same time, employers would receive windfall profits. This squeeze on workers must be avoided while ensuring that the money currently spent for employer-sponsored health insurance continues to flow into the system.

A more equitable way for this money to be raised would be through a payroll tax that brought in the same amount of money as was paid for premiums under the current system.⁸ Employers currently pay about \$307 billion for health care while wages and salaries total about \$4,500 billion. Therefore, a payroll tax on all employers of slightly less than 7% would also raise about \$300 billion. Some employers who currently pay a large amount of money for employees' health care would see their costs fall. (These savings should be passed on to workers as wage increases.) Other employers that currently spend little for health care would see their costs rise. Workers, who ultimately pay these taxes through lower wages, would face costs equal to 7% of their earnings. This system would also level the playing field among employers and remove the competitive advantage currently enjoyed by those who provide no health care coverage to employees. Since this payroll tax could be collected as part of the existing payroll tax system, it would be quite simple and inexpensive to administer.

Federal Government: As with other premiums, Medicare premiums paid by those seniors choosing to participate in Medicare coverage for doctors visits (2% of all health expenditures) should be replaced. Current Medicare payroll taxes, 1.45% of all wages and salaries paid by both employers and employees, would continue to flow unchanged into the system although the Medicare program would no longer exist as a separate system. Other federal payments (for Medicaid, the balance of the Medicare system, and other federal health programs) are paid out of general revenues raised through personal and corporate income taxes, excise taxes, and other taxes and fees. Under the new system, these revenue streams would continue to provide the same level of resources for health care.

State government: These funds, in the same amount as under the current system, would continue to flow into the new health care system.

Non-patient revenues: These funds would continue in the new health care system.

Replacements for Regressive Funding

Three funding streams have been identified that would need to be replaced:

- * households' purchases of private health insurance premiums, 7% of total health care spending, or \$80 billion in 1998;
- * 80% of household out-of-pocket spending, 15% of total spending, or \$171 billion in 1998;
- * expenditures on Medicare Part B premiums, 2% of spending, or \$23 billion in 1998.

In 1998, \$274 billion in health care funding would need to be replaced out of an estimated \$1,138 billion spent for health care (CBO 1998). Of all the money currently paying for health care, fully 76% would continue to be raised as is currently done with changes within the employer funding stream as described. Since total expenditures would be unchanged, the changes in financing simply shift costs among payers.

The scenario presented in this paper assumes that these funds would be replaced with revenue from the federal personal income tax, the most progressive source of funding. However, if funding was reduced for other federal programs, for example, the military, then the amount of replacement funding needed would be reduced. In addition, if a higher level of cost sharing were retained or if more money were raised from employers, it would be possible to fund a universal system with a smaller increase in taxes.

In 1998, the average, middle-income household will have an income of about \$37,290 and pay about \$2,088 (5.6% of income) in federal personal income taxes. (If this number seems small, it is because it omits payroll taxes; nearly three-quarters of households pay more in payroll taxes than federal income taxes). To fully replace the needed health care funding would require this household to pay an additional 2% of income in federal personal income taxes, or an additional \$731, raising its total to \$2,819. The increase for households with incomes below this level would be less than 2% of income, and the increase would be larger for upper-income households. Table 3 shows the necessary tax increase for households in five different income categories. Because a system exists to collect personal income taxes, the administrative costs of this change are trivial. In exchange for the tax increase, no American (or American employer) would have to buy health insurance or face any out-of-pocket charges. Everyone would have access to all needed health care services and their insurance could never be lost or taken away. We would also gain a much more efficient system.

Conclusion

A publicly-funded, universal health care system is possible. However, to improve equity, new funding would be needed for the 24% of health expenditures that are current paid by funds from regressive sources. These replacement funds could be raised through an increase in the federal personal income tax, the most progressive way to fund health care. For the average, middle-income household, taxes would rise by \$731. In other words, for fully 60% of households, the increase would average less than \$731. For another 20%, the increase would average about \$1,600. Only the 20% of households with the highest incomes would face a larger tax increase. In exchange for the tax increase, premiums and out-of-pocket spending would be eliminated. Costs would be redistributed from the sick to the healthy, from low- and middle-income households to those with higher-incomes, and from businesses currently providing health care benefits to those that do not. Just as important, greater efficiency and improved cost containment would become possible, leading to sizable savings in the future. The impediment to fundamental reform in health care financing is not economic, but political. Political will, not economic expertise, is what will bring about this important advance.

Table 1
Sources of Health Care Funds, 1995

Total Government	44%
Federal Government	33
Payroll taxes for Medicare	11
Medicaid, balance of Medicare, and other fed programs	20
Medicare Part B premium	2
State and Local Government	11
Households	7.6
Premiums	7
Out of pocket	19
Business	28
Employee health insurance	25
Workers' compensation ins.	2
Non-Patient Revenues	3
Total	100%

Note: These numbers may differ slightly from those in other sources. These data show expenditures by federal, state and local governments for employees' health care as spending by businesses, not as public sector spending. Also Workers' Compensation is shown as a business expenditure, not spending by the public sector.

Source: Cathy Cowan and Bradley Braden. Business, Households, and Government: Health Care Spending, 1995. *Health Care Financing Review* 18(3): 195-210; 1997.

Table 2
Out-of-Pocket Spending: What It Currently Buys

29%	nondurable medical goods such as bandages and prescription and nonprescription drugs (just less than half -- 42% is prescription drugs).
17%	physician services.
14%	nursing homes.
13%	other professional services (optometrists, chiropractors, podiatrists, and other licensed medical personnel, and specialty outpatient facilities for mental health and substance abuse)
13%	dental services.
5%	hospital services.
4%	durable medical goods such as eyeglasses, hearing aids, and medical equipment.
3%	home health.
100%	

Source: Health Care Financing Administration web page (www.hcfa.gov/stats), March 23, 1998.

Table 3
Change in Personal Income Taxes
Needed to Fund Universal Health Plan, 1998

Households by Income Level ^a	Average Income	<u>Currently</u>		<u>Progressively-Financed Universal Health Plan</u>		
		Effective Tax Rate	Taxes Paid	Effective Tax Rate	Taxes Paid	Increase
Lowest 20%	\$ 8,860	- 6.9%	- \$611	no change	no change	\$ 0
Second 20%	22,530	1.4	315	1.9%	426	110
Middle 20%	37,290	5.6	2,088	7.6	2,819	731
Fourth 20%	56,170	8.1	4,550	10.9	6,142	1,592
Top 20%	130,577	15.6	20,351	21.0	27,473	7,123

^a Households are ranked by share of poverty-level income.

Note: Effective tax rates show the share of income actually paid in taxes, after deductions, exemptions, and other adjustments are made. Negative taxes indicate net credit received, for example, from the Earned Income Tax Credit.

Sources: Bob McIntyre, Citizens for Tax Justice, 1998, unpublished tables, based on data from the Congressional Budget Office for effective tax rates; and author's calculations.

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Endnotes

1. A system that covered only part of the country would be possible but it would be administratively more complex and more expensive than a truly universal system. Coverage within the partial system could be defined geographically, for example, to cover particular states or regions, or demographically for certain demographic groups based on age or income. However, for the “partial” universal system to operate with adequate cost containment, it would need to function completely autonomously and in isolation from any other health care system (including the currently existing one). To prevent selection bias, consumers would need to be somewhat randomly selected in a system and prohibited from switching between them. Providers would need to participate in, or fully opt out of, the universal plan, similar to the current situation for Medicare. In accordance with capital planning and budgeting policies, the universal system would pay for only those services performed in facilities and using equipment previously approved by the capital planning process.

2. See Himmelstein, Woolhandler et al., 1989 for a more detailed description of such a system.

3. See U.S. General Accounting Office 1991 a and Woolhandler and Himmelstein 1991 .

4, See U.S. General Accounting Office, 1991b and Rogal, Gauthier, and Barrand, 1993.

5, CBO (1993, p.9) assumes that cost containment is just 75% effective with base costs expected to rise at the rate of population plus GDP growth.

6, By the fourth year, spending under the new system would be equivalent to baseline spending. Over the following three years (years five through seven), total savings (compared to baseline) would exceed the increased (above baseline) expenditures of the first four years. In sum, over the first seven years, expenditures would be roughly the same under either system, although the new system would have provided universal coverage. In subsequent years, however, savings (compared to baseline) would accrue. In year five (that is, in 2002 if the plan were implemented in 1998), savings would approximate 1.7% of national health expenditures, or \$24 billion in a \$1.4 trillion system (author’s calculations based on CBO 1993, p. 9 and CBO 1998, p. 144). Savings would total 3.5% of health expenditures in year six and 5.4% in year seven.

7. This includes all prescription drugs and 25% of nondurable medical goods, 90% of physician services, all nursing home stays, 90% of other professional services, 85% of dental services, 99% of all hospital services, 75% of durable medical goods, and all home health. The 80% total is in accordance with CBO’s (1993) assessment of S. 491 (American Health Security Act of 1993). CBO analysts estimated that out-of-pocket spending would fall by 80% when medically-necessary services were covered by the new plan.

8. Alternatively, either more or less money than is currently paid could be collected from employers. Like the current payroll tax for Medicare, the payroll tax proposed here would apply to all earnings; there would be no cap on earnings subject to the tax.