

## Health Care Policy

### AN EQUITABLE WAY TO PAY FOR UNIVERSAL COVERAGE

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This article describes a way to finance universal health care 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 percent of health expenditures and would be raised through an increase in the federal personal income tax. Premiums are 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 percent. Revenue from an increase in federal personal income taxes 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 \$731 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.

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 article 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. As described here, one way to more equitably finance health care is 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 for medically necessary services.

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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.<sup>1</sup> 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 (1).

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 source is regressive. Progressive financing is considered more equitable than regressive financing.

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 (2, 3). Fourth, new cost-containment features will provide a better constraint on cost growth in the years after the plan is implemented (4, 5).

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 immediate 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 (2) estimated in 1991 that a shift to a single-payer, universal system could occur with essentially no

<sup>1</sup>

A system that covered only part of the country (defined either geographically or demographically) would be possible but it would be administratively more complex and more expensive than a truly universal system.

change in total expenditures. The Congressional Budget Office (CBO) (6) estimated that S. 491 (Senator Paul Wellstone's American Health Security Act of 1993) 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 percent in the first year after implementation.<sup>2</sup> 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 5 (and in subsequent years), the new system would cost less than baseline.<sup>3</sup>

In the model presented in this article 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, we need 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 (the sources of the money that is spent by the payers) would be different. Progressive sources of funding 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.<sup>4</sup> Payers who obtain their funds from regressive sources would no longer pay for health care. Ending regressive financing would primarily affect private health insurance companies. Insurance firms

<sup>2</sup> The CBO (6, p. 9) assumes that cost containment is just 75 percent effective with base costs expected to rise at the rate of population plus GDP growth.

<sup>3</sup> By the fourth year, spending under the new system would be equivalent to baseline spending. Over the following three years (years 5 through 7), total savings (compared with 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 5 (i.e., 2002 if the plan were implemented in 1998), savings would approximate 1.7 percent of national health expenditures, or \$24 billion in a \$1.4 trillion system (calculations based on 6, p. 9; 7, p. 144). Savings would total 3.5 percent of health expenditures in year 6 and 5.4 percent in year 7.

<sup>4</sup> Most states have regressive revenue systems. This plan continues to use money from states, however, and this should be addressed in the future.

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 a 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 percent of the national total: 33 percent by the federal government and 11 percent by states and localities (8). (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 percent.) Employers' spending for health care (primarily for insurance for employees) was approximately 28 percent of all health expenditures. Households accounted for 26 percent of the total. Non-patient revenues—for example, charitable donations and net revenues from sales in hospital gift shops—were 3 percent of funds (Table 1). The sources of this money are now examined to determine whether the funding stream should be eliminated and/or changed in a new system.

1. *Households.* Households' direct purchases of private health insurance premiums (not through an employer) and employees' payroll deductions for health insurance premiums constitute 7 percent 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 percent 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 that 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 percent of current expenditures, or about 15 percent

Table 1

Sources of health care funds, 1995<sup>a,b</sup>

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Total government	44%
Federal government	33
Payroll taxes for Medicare	11
Medicaid, balance of Medicare, and other federal programs	20
Medicare Part B premium	2
State and local government	11
Households	26
Premiums	7
Out-of-pocket	19
Business	28
Employee health insurance	25
Workers' compensation insurance	2
Non-patient revenues	3
Total	100%

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<sup>a</sup>Source: reference 8.

<sup>b</sup>These numbers may differ slightly from those in other sources. The 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.

(0.8 × 19 percent) of all health expenditures.<sup>5</sup> Some 4 percent of national health expenditures would continue to be financed out of pocket.

2. *Businesses.* In their purchases of health care for employees, businesses currently are responsible for 28 percent 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

<sup>5</sup>

This includes all prescription drugs and 25 percent of nondurable medical goods, 90 percent of physician services, all nursing home stays, 90 percent of other professional services, 85 percent of dental services, 99 percent of all hospital services, 75 percent of durable medical goods, and all home health. The 80 percent total is in accordance with the CBO's (6) assessment of S. 491. CBO analysts estimated that out-of-pocket spending would fall by 80 percent when medically necessary services were covered by the new plan.

Table 2

Out-of-pocket spending: What it currently buys<sup>a</sup>

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
<u>3</u>	Home health
100%	

<sup>a</sup>Source: Health Care Financing Administration web page ([www.hcfa.gov/stats](http://www.hcfa.gov/stats)), March 23, 1998.

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 insurance policies—for example, because a universal health care system funded entirely through taxes on households 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 that was paid for premiums under the current system.<sup>6</sup> 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 percent 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 percent 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.

3. *Federal Government.* As with other premiums, Medicare premiums (2 percent of all health expenditures) paid by those seniors choosing to participate in Medicare coverage for doctors' visits should be replaced. Current Medicare payroll taxes, 1.45 percent of all wages and salaries paid by both employers and employees, would continue to flow unchanged into the health care system, although Medicare would no longer exist as a separate program. 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.

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

5. *Non-Patient Revenues.* These funds would continue in the new health care system.

#### Replacements for Regressive Funding

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

- households' purchases of private health insurance premiums: 7 percent of total health care spending, or \$80 billion in 1998;

<sup>6</sup>

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.

- 80 percent of household out-of-pocket spending: 15 percent of total spending, or \$171 billion in 1998;
- expenditures on Medicare Part B premiums: 2 percent 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 on health care (7). Of all the money currently paying for health care, fully 76 percent 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 most equitable way to replace these funds is with revenue from an increase in the federal personal income tax, the most progressive source of funding. However, if funding were reduced for other federal programs (e.g., 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, a universal system could be funded 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 percent 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 in federal income taxes.) To fully replace the needed health care funding would require this household to pay an additional 2 percent 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 percent 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 percent of health expenditures that are currently 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, annual taxes would rise by \$731. In other words, for fully 60 percent of households the increase would average less than \$731; for another

Table 3

Changes in personal income taxes needed to fund universal health plan, 1998<sup>a</sup>

Household by income level <sup>b</sup>	Average income	Currently		Progressively financed universal health plan		Increase
		Effective tax rate <sup>c</sup>	Taxes paid	Effective tax rate <sup>c</sup>	Taxes paid	
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

<sup>a</sup>Sources: McIntyre, R., Citizens for Tax Justice, 1998, unpublished tables based on CBO data for effective tax rates; and author's calculations.

<sup>b</sup>Households are ranked by share of poverty-level income.

<sup>c</sup>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.

20 percent the increase would average about \$1,600. Only the 20 percent 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.

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