RAISING THE MONEY FOR HEALTH CARE FOR ALL: Traditional Single Payor Financing versus Pooled Financing

The traditional single payor approach to financing universal health care would raise taxes to replace all private insurance and out-of-pocket payments.

In 1997, private health spending nationwide was estimated at $585 billion or 53.6% of total health spending, which was $1.092 trillion.[1] The estimated figure for 1999 private health spending is $654 billion.[2]

Fully 92% of the private payments are made by individuals or businesses—32% out-of-pocket and 60% through private insurance. (Philanthropy accounted for 6%.)

Traditional single payor plans would replace all this private spending with public tax dollars, requiring a tax increase of $654 billion in calendar 1999, or roughly $644 billion in fiscal 1999.[3] (The sum needed is actually somewhat lower. The private spending figure includes public spending for government workers' health insurance, but for simplicity here we use that figure.)

Raising some $644 billion in fiscal 1999 to replace all private spending would have meant an *89% rise in federal income tax receipts*. Or using a broader approach to revenue generation, it would have meant a *39% rise in all federal revenues,* including personal and corporate income tax; Social Security, Medicare, inheritance, and excise taxes; customs duties; and the rest.[4] (Jerry Brown, running for president in 1992, said something like, "they're out of their minds if they can even *think* about a tax increase as large as that. It's the craziest thing I ever heard.")

We suggest an alternative. That would be to start health care financing reform by raising federal taxes only to cover today's out-of-pocket costs. The resulting tax increase would still be substantial—some $206 billion. But that is less than one-third of the $644 billion that would be needed to replace all private health spending with public funds.

The figure on the next page shows the effects of a $644 billion federal tax increase or a $206 billion tax increase on top of current federal revenue.

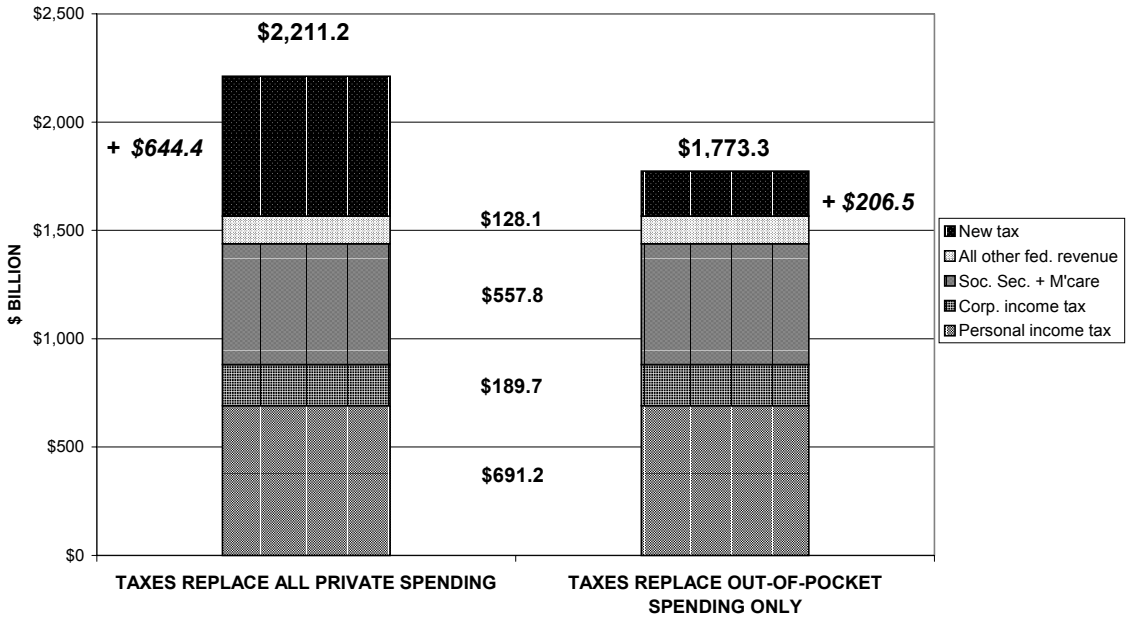
Private employers would be required to maintain their effort in paying for coverage.[5] But they would pay into a single payor fund, not to an insuror. Maintenance of effort would be defined by 1999 health insurance cost per worker, in 1999 dollars. The burden, and purchasing power, of these payments would gradually shrink over time. Just as gradually, taxes would be raised to replace the lost purchasing power. (One path might be a payroll tax against which employers' payments would be credited.) This avoids the political grief of a $644 billion tax increase. Had this approach been taken in 1974, when Kennedy and Nixon debated the way to cover all Americans, over 80% of health spending would be financed publicly today.

How would all the money be assembled in one place, to win the benefits of a single payor plan? Today's private insurance funds would be pooled with Medicare, Medicaid, other persisting public revenues, and the new federal tax in a single trust fund. Several streams of money would flow into the trust fund, but only one stream would flow out. (This parallels what individual Canadian provinces have long done. There, federal taxes, provincial taxes, and—sometimes—private insurance premiums are combined to finance universal coverage.)

Now, some would say that we should not worry about a giant tax increase—even one that would almost double the income tax— since private spending would be cut by a greater amount. The problem here is that the winners are not the same as the losers.

The losers would fiercely fight a sudden huge tax hike, even if it were offset—for the state as a whole—by larger savings elsewhere. And losers are always louder than winners. A pooled multi-payor approach to financing health care for all could win single payor's benefits without the outcry and political problems that would inevitably accompany a huge increase in taxes.

FEDERAL FINANCING OF PRIVATE HEALTH SPENDING: EFFECTS ON FEDERAL SPENDING, FY 1998



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Notes

[1] Office of the Actuary, Health Care Financing Administration, "1997 National Health Expenditures," www.hcfa.gov/stats/nhe-oact/nhe.htm.

[2] Sheila Smith, Mark Freeland, Stephen Heffler, and others, "The Next Ten Years of Health Spending: What Does the Future Hold?" *Health Affairs*, Vol. 17, No. 5 (September-October 1998), pp. 128-140, exhibit 1. We calculated the 1999 estimate by taking the 1998 figure and adding 6.5% (the authors' projected average annual rate of increase from 1998 to 2001).

[3] This figure is one-quarter of the calendar year 1998 private spending and three-quarters of the calendar year 1999 private spending.

[4] Federal income tax revenues in FY 1999 were estimated at $721.6 billion and total federal revenue at $1643.3 billion. See Office of Management and Budget, "Federal Receipts," Analytical Perspectives, Budget of the United States, FY 1998, p. 39 (www.access.gpo.gov/su_docs/ budget98).

[5] Employers would have to maintain their effort, measured in nominal, 1999, dollars per employee.