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Perspective

Why Paying for Health Care Reform Is Difficult and Essential — Numbers and Rules

Henry J. Aaron, Ph.D.

No health care reform bill can succeed unless Congress finds the money to pay for it. The challenge is brutally simple. The up-front costs of extending coverage are certain and immediate.

The savings from delivery-system reform are speculative and slow. U.S. budget projections indicate explosive increases in government borrowing and rapid increases in debt-service costs, which could cause lenders to lose faith in the nation's repayment capacity. Prospects are so bleak that not even the achievement of the worthy goals of health care reform justify increasing already perilous budget deficits.[1]

Reform must therefore be paid for — with tax increases, spending cuts, or both. Congressional rules and the disciplined budget scoring of the Congressional Budget Office (CBO) make the challenge even more daunting.

The draft House bill (HR 3200) exemplifies the problem. The CBO estimates the bill's net cost at $1.042 trillion over 10 years — a gross cost of $1.182 trillion, less $140 billion net from taxes on and transfers to businesses to encourage private coverage (see table). Final estimates of the cost of this bill and others will vary in amount and detail. But any bill that reduces the number of uninsured people as much as HR 3200 does will have a similar cost.

Little money will be spent immediately. The CBO estimates that only 17% of the 10-year outlays would be spent in the first 5 years, less than would be spent in the 10th year alone. The reason? Setting up health insurance exchanges and the administrative framework to pay subsidies to tens of millions of households is hard and time-consuming. A rough rule of thumb is that annual spending in the 10th year after enactment will run about one fifth of the total cost for the first decade — $202 billion, in the case of HR 3200.

As is well known, a minority of 41 senators can filibuster to block ordinary legislative action. But the reconciliation authority in the congressional budget process offers a way around this hurdle. Congress can include in its annual budget resolution "reconciliation instructions" directing specified committees to report designated spending or tax legislation. If those committees do not act or a filibuster blocks action, the leadership can propose its own "reconciliation" bill that will be open to only limited debate and that can be passed by a simple majority of senators. The

The Cost of Extending Coverage and Various Ways of Paying for It.*

Cost or Revenue Source	2019	2010–2019
	billions of dollars	
HR 3200		
Spending increases to boost coverage	+230	+1,182
Net from taxes on and transfers to businesses to encourage private coverage	–28	–140
Outlay reductions (roughly half from cuts in annual updates in Medicare payments to providers)	–50	–219
Tax increases (mostly income surtax on high-income filers)	–86	–583
Total net increase in the deficit	65	239
Administration proposals ("reserve for health care reform")		
Medicare and Medicaid savings	–88	–619
Capping value of itemized deductions	–39	–269
Other tax-increase options		
Capping exclusion of employer-financed health insurance premiums		
From income and payroll tax at 50th percentile, unindexed	–232	–1,142
From income tax only at 75th percentile, indexed according to the consumer price index	–101	–456
From income tax only at 75th percentile, indexed according to medical prices	–9	–62
Increasing alcohol taxes to $16 per proof gallon	–6	–61
Taxing sweetened beverages 3 cents per 12-oz can	–5	–50
Collecting a 1% value-added tax†	–97	–1,001

* Positive values indicate increases in spending or reductions in taxes; negative values indicate reductions in spending or increases in taxes. Values may not sum to the stated totals because of rounding. Data are from the Urban Brookings Tax Policy Center, the Center on Budget and Policy Priorities, the Office of Management and Budget, and the Congressional Budget Office.

† Value added is the difference between the value of a business's sales and its purchases from other companies. This estimate is based on the assumption that setting up the administration of a new tax on value added would take 2 years.

2009 budget resolution called for sweeping health care reform legislation. It also stipulated that such legislation could not increase the deficit through 2019. If this legislation is blocked by filibuster, it can be passed through reconciliation.

But reconciliation is not without obstacles. The most formidable is the "Byrd rule," which authorizes any senator to raise a point of order against "extraneous" provisions, which include those that boost deficits during the period of the budget resolution — 5 years for most elements of the 2009 resolution — or in any year thereafter. Any provision that does not affect revenues or mandatory spending is also extraneous. To overcome such points of order requires 60 votes, the same number needed to end a filibuster. Thus, any bill will require 60 votes to pass the Senate unless it does not boost the deficit in the first 5 years after passage or in any single year thereafter. Furthermore, President Obama has pledged to veto any legislation that is not paid for.

In scoring a bill, the CBO counts effects only on federal revenues and expenditures. Effects of private-sector initiatives do not count, nor do changes in spending in the private sector or by state or local governments. Only reductions in federal outlays that are fairly certain to be realized count. Claimed savings from a new public insurance plan would count only if statutory language specifies how the money would be saved.

Given Senate voting rules and the current fiscal mess, paying for HR 3200 means that Congress must find spending reductions or revenue increases totaling approximately $1 trillion over 10 years and $200 billion in the 10th year alone. Filling the gap in the 10th year is perhaps the largest challenge.

The administration has proposed reductions in health care spending totaling $619 billion over 10 years and tax increases totaling $269 billion. The CBO estimates that net spending cuts in HR 3200 total only $219 billion over 10 years and just $50 billion in the 10th year. The tax increase proposed by the admin-

istration — capping the value of itemized deductions at 28% for people in the 33% and 35% tax brackets — drew withering fire from both Republicans and Democrats and is probably dead. HR 3200 would raise far more revenue — $583 billion over 10 years and $86 billion in the 10th year. Nearly all would come from an individual income-tax hike for filers with taxable incomes above $350,000 (on joint returns). Even if HR 3200 passed, the CBO estimates that it would boost the deficit by $239 billion over 10 years and by $65 billion in the 10th year.

Some analysts have proposed using a new value-added tax (VAT), earmarked to pay for reform.[2-4] All other developed countries rely heavily on VAT revenues. Even at modest rates, an earmarked VAT could easily pay for health care reform. But no president, including Barack Obama, has embraced this revenue source, and few members of Congress have shown interest in using it.

Other options for raising revenue are either politically unattractive or yield so little revenue that they are hardly worth the trouble. Virtually all analysts agree that the current exclusion of employer-financed health insurance premiums from personal income and payroll taxes is an expensive, inefficient, and unfair way to provide coverage. Many favor capping the exclusion. Unfortunately, mild caps yield little revenue, and stringent caps have serious flaws. Subjecting only the portion of employer-financed premiums above the 75th percentile in generosity (above $5,642 for individuals, $11,011 for couples, and $13,806 for families in 2009) to personal income tax and adjusting the cap for the growth of medical expenses would yield only $62 billion over 10 years and just $9 billion in 2019. Much more revenue would be generated in 2019 — $101 billion — if the cap were adjusted only for the increase in consumer prices, and still more — $212 billion — if the excess were subject to both income and payroll taxes and the cap was not adjusted for inflation. But adjusting a cap only for changes in consumer prices would mean a tax increase by 2019 for most taxpayers with employer-sponsored health insurance that, as a percentage of income, would be larger for low-income than for high-income filers.[5] In addition, the burden would fall unevenly and (it could be argued) unfairly — hitting hardest those Americans who live in areas where insurance is particularly expensive or who work for employers with high average premiums, such as small businesses or those employing older or relatively unhealthy workers. Increased taxes on alcoholic beverages or new taxes on sweetened beverages, though desirable on health grounds, would yield little revenue.

The challenge of finding acceptable ways of paying for near-universal coverage is formidable and may prove insurmountable. For reasons that President Obama has forcefully stated, health care system reform is vital. But the full reform agenda may be beyond immediate political reach. It is therefore essential to identify elements of the full plan that would set the stage for later reforms and that can be financed at a politically digestible price — and find a way to ensure their passage.

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