DESIGNING UNIVERSAL CARE FUNDING FOR OREGON THROUGH THE LENS OF ECONOMIC TRANSFER PRINCIPLES

By Warren George 4/10/21

INTRODUCTION:

Designing a funding package for universal care requires some basic knowledge of how the current system affects individuals according to health, age, income, employment status, and other factors, and then estimating how the specific attributes of new health care funding proposal might alter those effects. Every change from the current system is, in effect, a transfer of cost distribution compared to the option of leaving things the way they are.

This report advocates for designing a universal care system, not in terms of ideological arguments over how to design a taxation system from scratch, but in looking at the current funding system as it is and then planning the realistic alterations which would enable universal care.

Some recommendations are made at the end of the report with suggestions for immediate action.

DEFINITIONS OF TERMS USED IN THIS REPORT

CMS: Centers for Medicare and Medicaid Services

Cost-sharing: Nearly all private insurance policies (and some government programs) have a cost-sharing arrangement which requires the covered individual to pay a portion of the cost of medical services up through some deductictible limit. Forms of cost sharing include copays, co-insurance, and charges incurred before the deductible limit is met. It is very possible that a universal care system will not require cost-sharing.

Distribution of payments by income: There are three common distributions which describe how the cost of health care is distributed among those who pay for health care. All three are used in the current U.S. funding system. See Figure 1 for graphical schematics of each.

a. **Flat-per-person** – This is how most things are purchased in daily life. An ice-cream cone, or an automobile insurance policy is about the same price no matter who buys it. As will be shown later, about 50% of the cost of U.S. health care is currently financed on a flat-per-person basis. .
b. **Proportional** – Under a proportional distribution, the amount paid is proportional to income. If you make twice as much as someone else, you pay twice as much. The Medicare tax on wages and income from self-employment is an example of a proportional distribution. As will be shown later, about 8% of the cost of U.S. health care is currently financed using this distribution method.
c. **Progressive** – Under a progressive distribution, the amount paid *escalates* with higher income. If you make twice as much as someone else, you pay MORE than twice as much. Oregonians pay progressive income taxes both at the state and federal level. As will be shown later, about 42% of the cost of U.S. health care is currently financed using this distribution method.

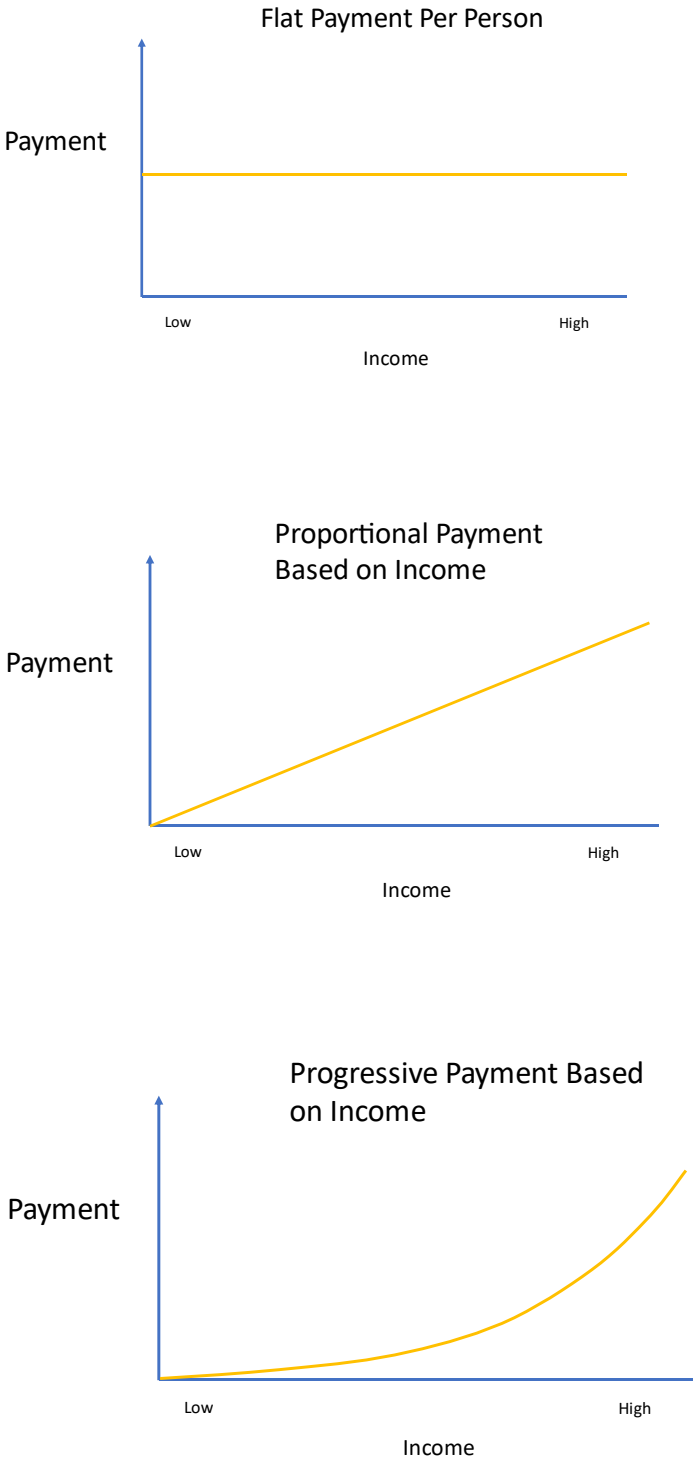

Figure 1. Flat-per-person, proportional, and progressive distributions of cost affect individuals differently by income. (Schematic Illustrations by w.george)

Distribution of services - Most people require few health services but a few require a lot. Each year, a few patients will require services into the millions of dollars.

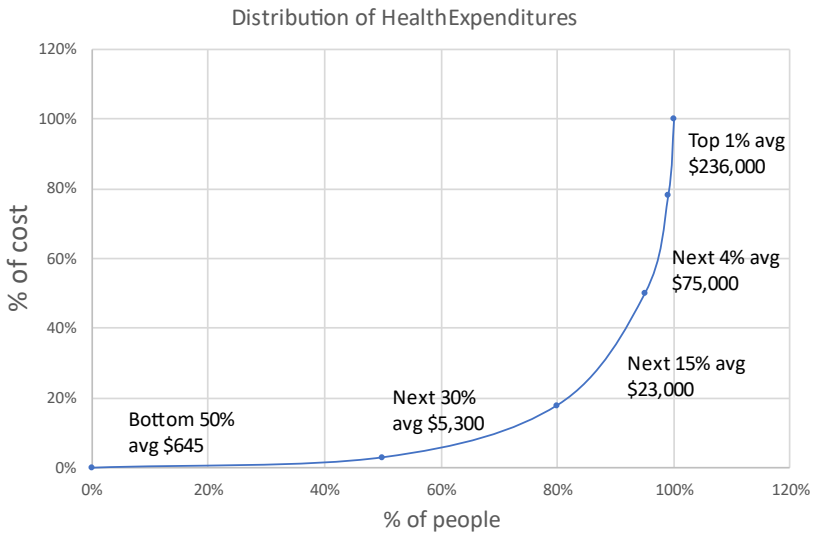

Figure 2. Distribution of Health Services. Five percent of people use half the services. Of the people in the higher-cost group, some have a bad year and recover; some have significant chronic conditions, and many are elderly people in their last year of life. (Graph by w.george, Data source Kaiser Family Foundation, 2017)

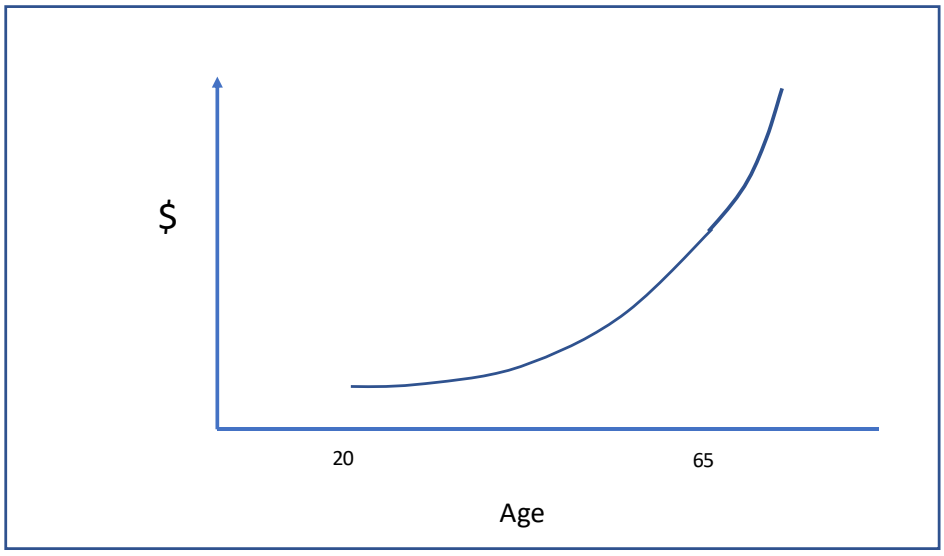

Figure 3. Graph illustrating how the need for health services increases with age. (Schematic Illustration by w.george, data source CMS tables)

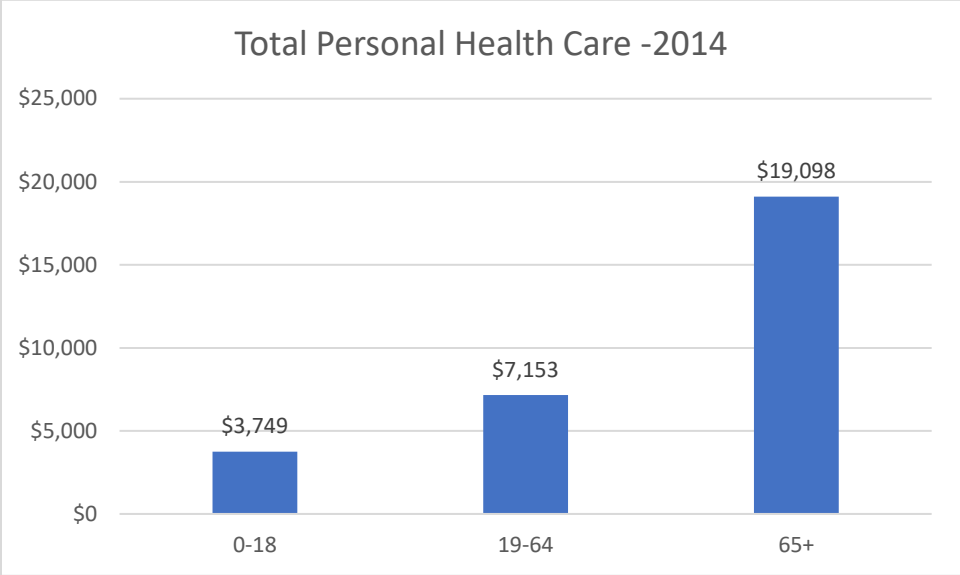

Figure 4. Average cost by age grouping (Graph by w.george, Data source CMS, 2014)

ODOR – Oregon Department of Revenue

OOP – Out-of-Pocket expenditures paid directly to a provider or supplier.

QUINTILES – A way of dividing people into five equally sized groups for comparison. Quintiles of income can be explained as follows if people were placed in a single line according to their income:

1st Quintile: From 0 to 20% of all earners. This is the group with the lowest income.
2nd Quintile: From 20% to 40% of all earners.
3rd Quintile: From 40% to 60% of all earners. This is the middle group.
4th Quintile: From 60% to 80% of all earners.
5th Quintile: From 80% to 100% of all earners. This is the group with the highest incomes.

As of 2018, the ODOR calculated the tax filer quintiles for full year residents at the following income levels:

1st Quintile: From 0 to $16,100
2nd Quintile: From $16,100 to $32,900
3rd Quintile: From $32,900 to $57,100
4th Quintile: From $57,100 to $100,100
5th Quintile: Over $100,100

Income between the quintiles is, of course, not equal. Figure 5 shows the distribution as of 2013. A gradual trend started about three decades ago with the bottom 40% of earners losing about one third of their income distribution to such trends as out-sourcing and automation. At the same time, income of those in the 70th percentile and above have held steady or increased as a percentage of total income.

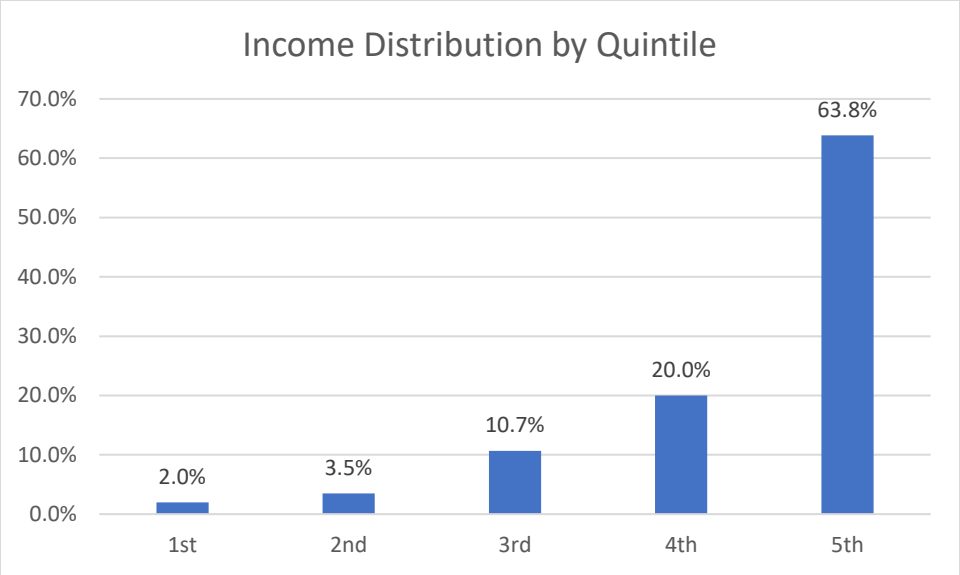

Figure 5. Distribution of income by quintile. The bottom two quintiles, which now sum to about 5.5%, received over 9% as recently as the 1990's. (Graph by w.george, Data source ODOR, IRS, 2013)

Subsidization – Subsidization occurs when one group pays part or all of the cost for another group. Subsidization can happen in two ways:

> **External Subsidization** – Money is collected from one group and used to pay for services provided to a different group.
> **Internal Subsidization** – A provider accepts a lower rate of reimbursement from one group but charges another group more to make up the difference.
>
> The Medicaid system can be used as an example of both internal and external subsidies. Money in the form of taxes is collected from one group to pay for services provided to low-income patients, and providers are required to charge less for those services than they charge other patients. Unless otherwise noted, this paper deals only with external subsidies.

ASSUMPTIONS USED IN THIS REPORT

1. **Amounts paid by employers are part of the employee compensation package.**

2. **The most significant savings of a universal care system will depend on simplified billing, such as replacing hospitals and major clinic fee-for-service billing with global budgets. This may be a controversial assumption to people who believe that this is not necessary.**

3. This report should be regarded as an educational aid to help direct fiduciary planning, not as a substitute for fiduciary planning.

4. Much of the data for this report comes from the National Health Expenditure Accounts as published by CMS. Oregon expenditures may vary from the national data but until the specific Oregon data is available, national data is assumed to be a reasonable estimator of state data.

SECTION 1: CURRENT FUNDING

Health Care in the United States is funded through six different revenue collection programs, listed in Table 1 from largest to smallest.

Table 1. The Six Sources of Health Care Funding (2017)		
1	43%	PRIVATE INSURANCE POLICY PREMIUMS AND COST-SHARING
2	35%	GENERAL FUND TAXES
3	8%	MEDICARE TAXES ON PAYROLL AND SELF-EMPLOYMENT
4	7%	CASH TRANSACTIONS (Estimated portion of 11% OOP)
5	4%	DONATIONS
6	3%	MEDICARE PREMIUMS

Each of these categories can be classified as either care purchased for one's self and family for care now or for in the future, or care provided to someone else through what could be regarded as a humanitarian payment or tax. As of 2017, about 39% of all health care expenditures in the United States depended on humanitarian taxes and donations with the beneficiaries being lower-income persons and people on Medicare.

Table 2. Payments for Self and Family vs. Humanitarian Aid to Others		
	Self	Humanitarian
Private Insurance Premiums and Cost-Sharing	43%	
General Fund Taxes		35%
Medicare Taxes on Payroll and Self-Employment	8%	
Cash Transactions	7%	
Donations		4%
Medicare Premiums	3%	
TOTAL	**61%**	**39%**

DESCRIPTION OF THE SIX SOURCES OF HEALTH CARE FUNDING:

1. **PRIVATE INSURANCE POLICY PREMIUMS AND COST SHARING: - 43%:** This category includes premiums paid to private insurance companies (and to self-insured entities) plus co-pays, co-insurance, and deductibles paid for services covered by those arrangements. The cost of co-pays, co-insurance, and deductibles is included in the same category as premiums because they are significantly interchangeable. Customers can choose between the convenience of a higher but predictably steady monthly payment, or having a plan which is more economical overall for most people but where total monthly cost can fluctuate according to use of medical services. Higher deductible plans are only appropriate for purchasers who can absorb some degree of fluctuation in cost.

   The majority of the funding for private policy premiums comes from employer related plans.

Although almost all of this category is in the form of insurance sold specifically for medical services, this category also includes the medical portion of workers compensation insurance and the medical liability portion of other insurance policies such as; automobile insurance, homeowners' insurance, and other business and individual liability insurance coverage.

As shown in the schematic below, premiums and policy cost-sharing expenses are generally distributed on a flat per-person basis for those who have regular insurance. Lower-income people eligible for Medicare do not generally have regular insurance.

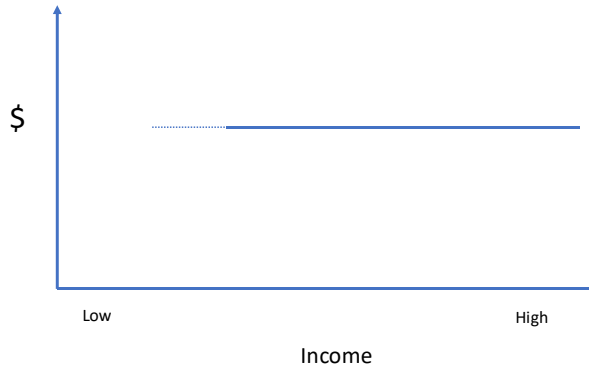

Figure 6. (above) Disregarding subsidies, the cost of private insurance is about the same for all individuals who have the same policy.

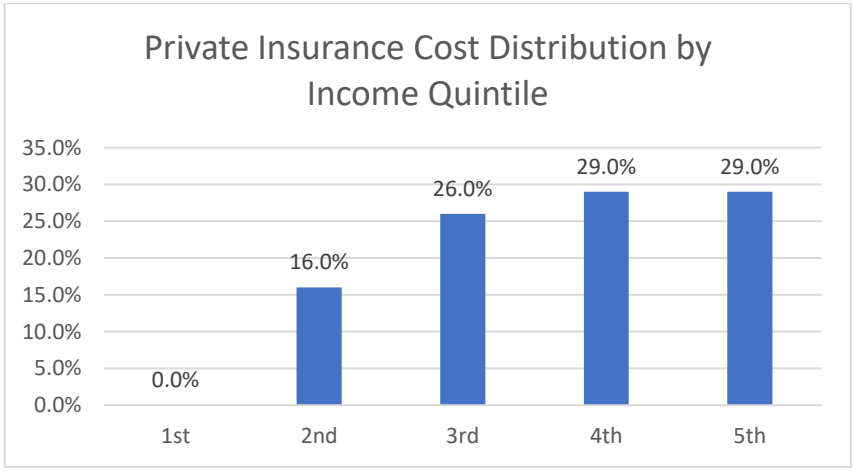

Figure 7. Private insurance cost distribution. Almost all persons in the 1st quintile qualify for Medicaid. Some people in the 2nd and 3rd quintiles qualify for Medicaid, or for ACA subsidies depending on their number of dependents. (Graph by w.george, Estimates by w.george)

2. **GENERAL FUND TAXES - 35%** General fund taxation accounts for over one third of all health care spending and provides external humanitarian subsidy for seniors and for persons with lower incomes. A breakdown of these programs is given in Table 3. Income taxes provide about 80% of federal general fund revenue and about 86% of Oregon general fund revenue. For convenience, the approximation is made in this report that general fund revenue is predominately all from income tax, or from sources which behave like income tax. (Deficit spending at the federal level is significant but for simplification is not considered in this report.) Medicare is the only program which is partially funded by its participants.

Table 3. Government General Fund Component of Medical Care (2017)

Program	%of Total HC Expenditures	Medicare Premiums	FICA Tx	Paid from General Fund
Medicare	21.8%	3.0%	8.0%	10.7%
Medicaid	18.0%			18.0%
CHIP	0.5%			0.5%
Other Gvt Programs	1.2%			1.2%
Other State and Local	1.1%			1.1%
Indian Health Services	0.1%			0.1%
Veterans Affairs	2.3%			2.3%
Department of Defense	1.2%			1.2%
			TOTAL	**35.1%**

Income taxes in the United States, and in Oregon, are very progressive such that the cost burden falls significantly onto those with higher incomes. The top 3% of earners pay about 50% of the income tax revenue. Since general fund revenue pays about 35% of the total health care expenditures, the top 3% of all earners pay perhaps 15% of all health care cost in America even when other general fund revenue sources and deficit spending are taken into account.

This category of humanitarian transfer does not include the cost of providing health care benefits to government employees, except for specific programs where the government provides direct care such as the VA. Government employees are typically covered by private insurance programs.

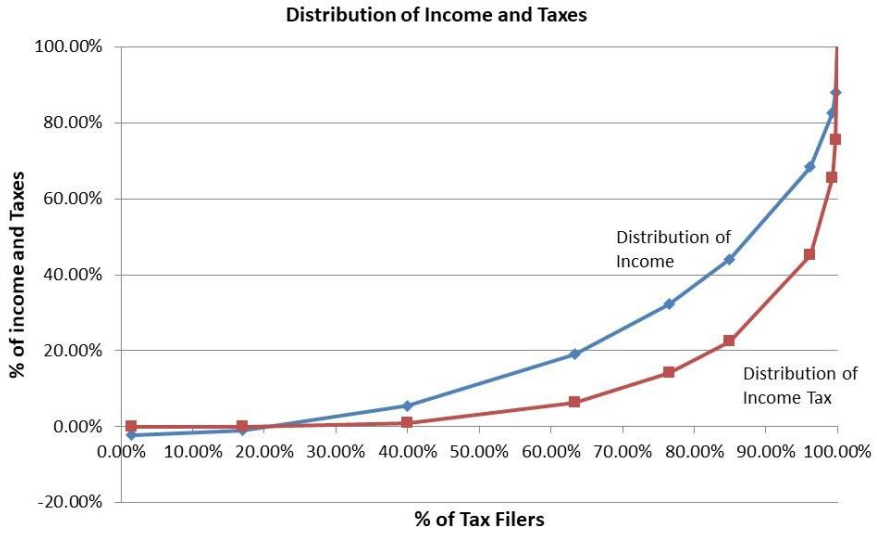

Figure 8. Distribution of income and income taxes for U.S. tax filers. (Graph by w.george, Data source: IRS.gov, 2013)

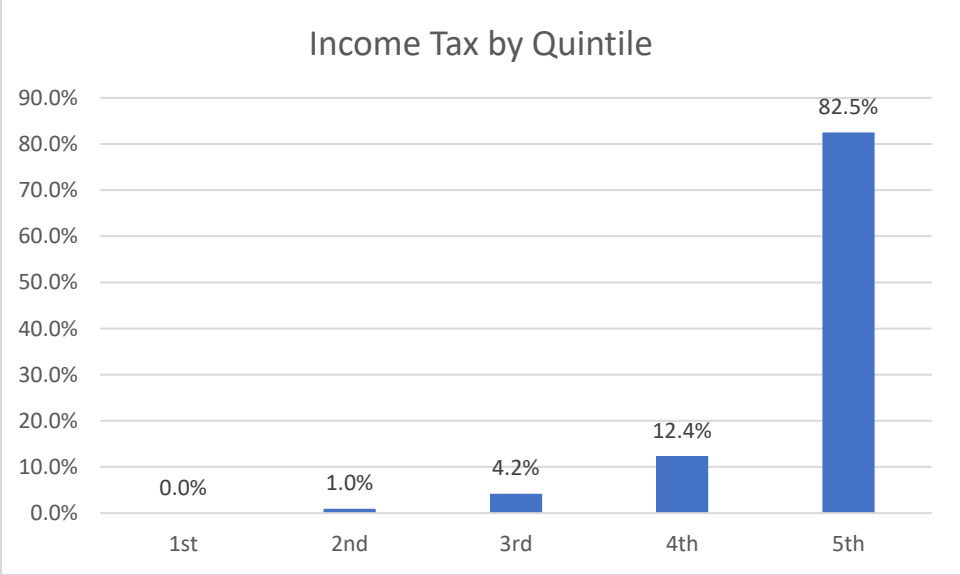

Figure 9. When divided into income quintiles, most of the U.S. income tax is paid by the top 20% of earners. (Graph by w.george, Data source: IRS.gov, 2013)

3. **MEDICARE TAXES ON PAYROLL AND SELF-EMPLOYMENT - 8%** Popularly believed to pay for most all of Medicare, these taxes fund about 37% of Medicare expenditures. A tax of 2.9% (nominally split between the employer and employee) is collected on wages, salaries, and income from self-employment. Beginning in 2013 an additional 0.9% tax is charged on employees whose earnings from wages, salaries, and self-employment exceed $200,000 for singles or $250,000 for joint filers. With the exception of the surtax begun in 2013, this is a proportional tax rather than a flat-per-person tax or a progressive tax. (See Figure 10).

   Medicare taxes are not collected on other sources such as income from pensions, investments, or rents and royalties. As opposed to federal and state income taxes which are not collected below some threshold, Medicare taxes start with the first dollar. Some people regard the Medicare tax as unfair because compared to people who receive wages, people who have income from self-employment may be able to avoid part of their Medicare tax by characterizing their income as being from rent or royalties not subject to the tax.

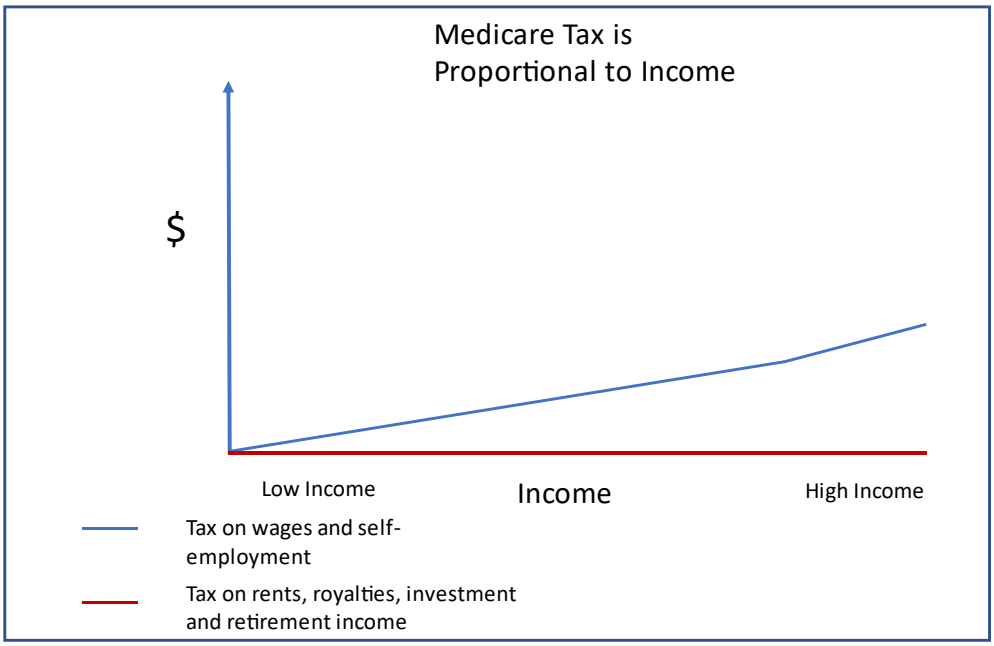

Figure 10. The Medicare tax is generally proportional to wages. Taxes on self-employment income are a small portion of the tax collected. Income for rents, royalties, investment, and retirement sources is not taxed for Medicare. (Schematic Illustration by w.george)

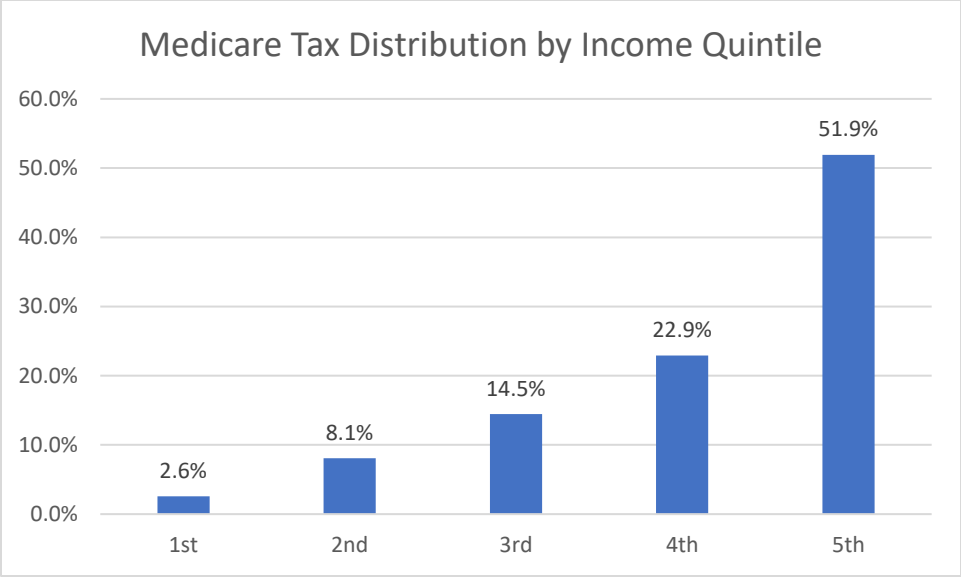

Figure 11. This breakdown of Medicare Tax distribution is based on the assumption that most of the income subject to the tax is wages, salaries, and tips. The 5th Quintile is affected by two opposing effects. Their tax rate is higher than the other quintiles, but a lower percentage of their income is subject to the tax on wages and self-employment. (Graph by w.george, Data from ODOR Table D 2018)

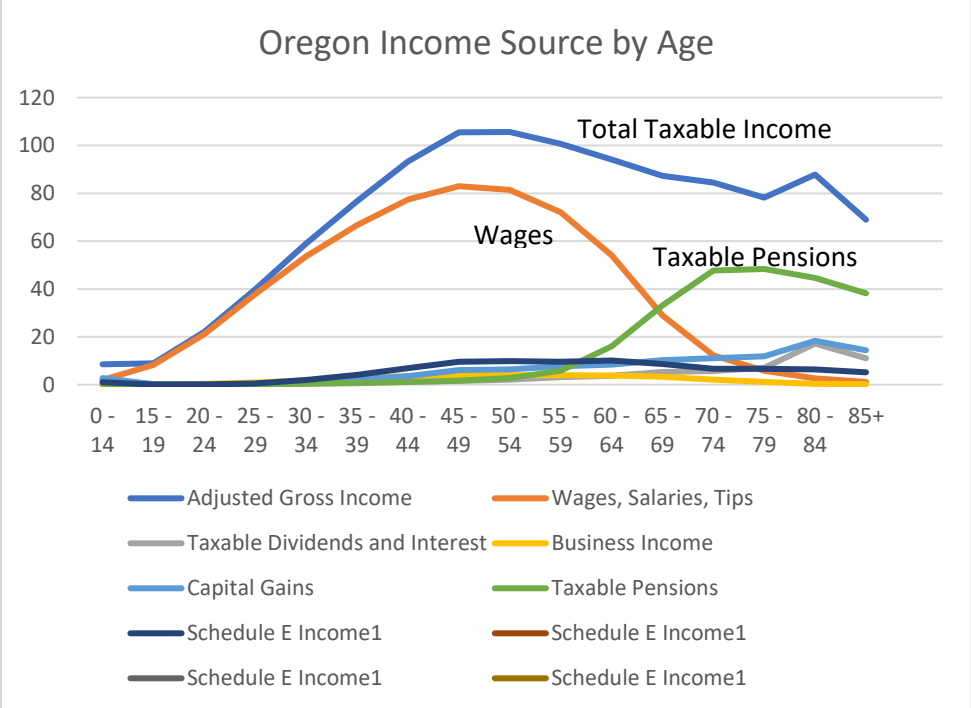

Figure 12. Most Medicare Tax is collected between ages 30 and 60. Seniors pay little Medicare Tax because they have little income from wages. Retirement income is not subject to the Medicare Tax. (Graph by w.george, Data from ODOR,2018)

4. **CASH TRANSACTIONS – 7%:** These are cash payments made to providers and suppliers where no insurance arrangement exists. The amount shown here has been estimated as a portion of the 11% total out-of-pocket cost reported in the National Health Expenditure Accounts. Close to half of all payments for dental services are paid in cash without any insurance involvement. This would be similar for other professional services such as optical care. Many people also purchase prescription drugs directly without insurance. Durable and non-durable medical supplies are purchased almost entirely on a cash basis.

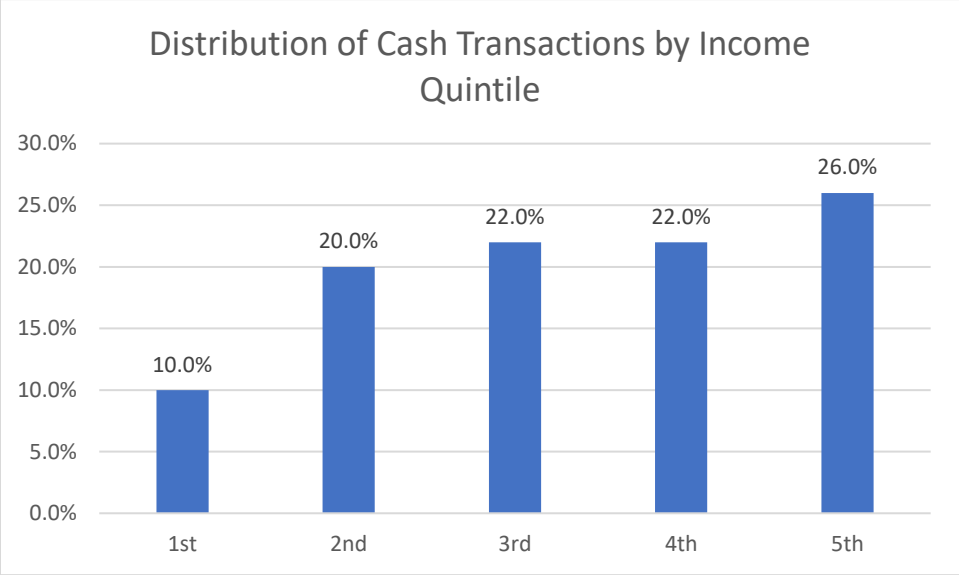

Figure 13. Cash transactions are generally on a flat-per-person distribution. Cash transactions are lower for the first two quintiles of income because those who qualify for Medicaid have dental and similar services covered, whereas the higher quintiles are more likely to pay cash for these and other services. (Graph by w.george, estimates by w.george)

5. **DONATIONS - 4%** : These are private charitable donations from individuals and foundations which are used to help provide direct care to patients. About 80% of these donations go to hospitals and major clinics. In assigning the demographics of those who fund these donations, it is assumed that donations are mostly from older and higher net worth individuals.

   A concern of health care funding planners is that donations have been declining over the last few decades as public funding for health care has increased. If a system is created which is 100% publicly financed, the current level of donations will probably cease altogether and need to be replaced with additional public revenue.

   Other estimates put donations at a higher percentage of total cost, closer to 6%.

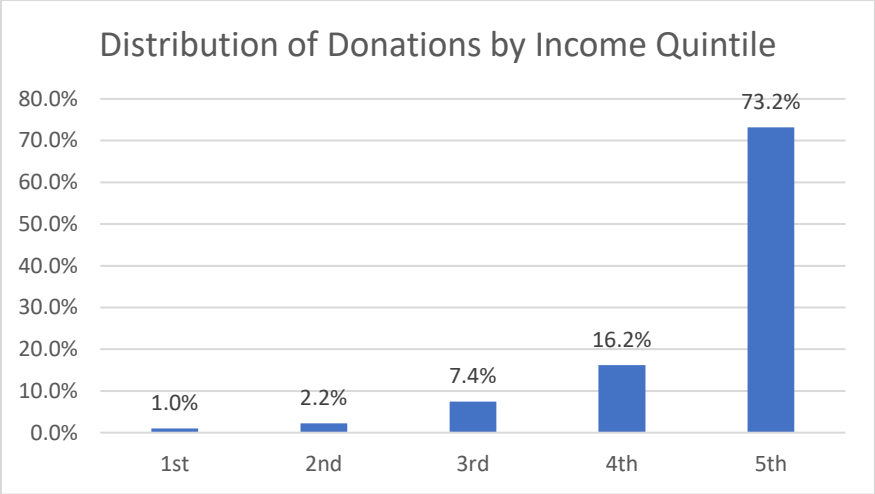

Figure 14. Assumed distribution of donations by quintile. (Graph by w.george, estimates by w.george)

6. **MEDICARE PREMIUMS – 3%** These are premiums paid directly to Medicare in the form of Part B and Part D premiums. This does not include premiums paid for private supplemental policies. Medicare Part B and D premiums are means-tested and begin increasing for those in the 4th and 5th Quintiles.

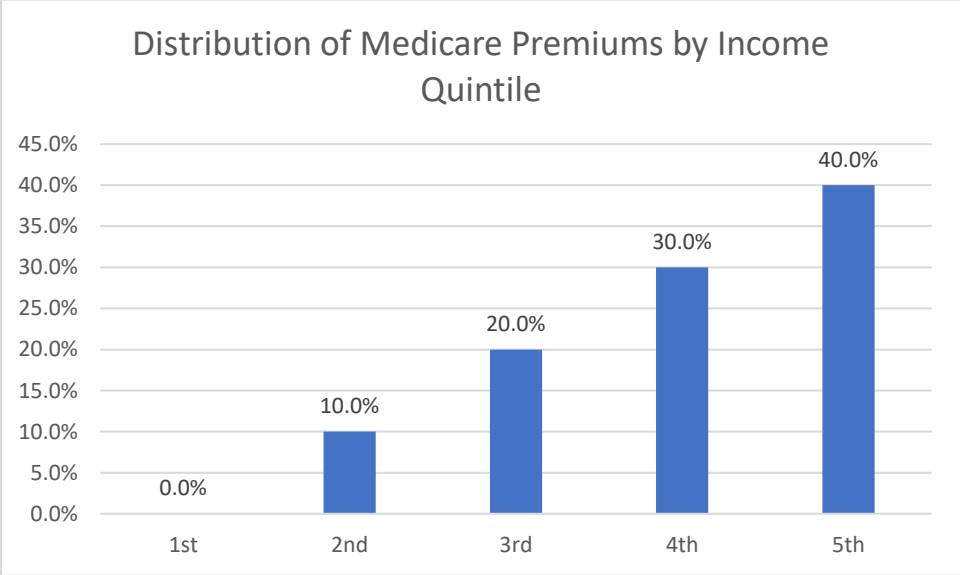

Figure 15. Medicare premiums are means tested with higher income persons paying higher premiums. Medicaid pays the premiums for low income participants. (Graph by w.george, estimates by w.george based on CMS Tables)

CURRENT TOTAL SPENDING BY INCOME QUINTILE

By summing the six individual components of health care funding, the total distribution of health care funding from each income quintile can be estimated as shown in Figure 16.

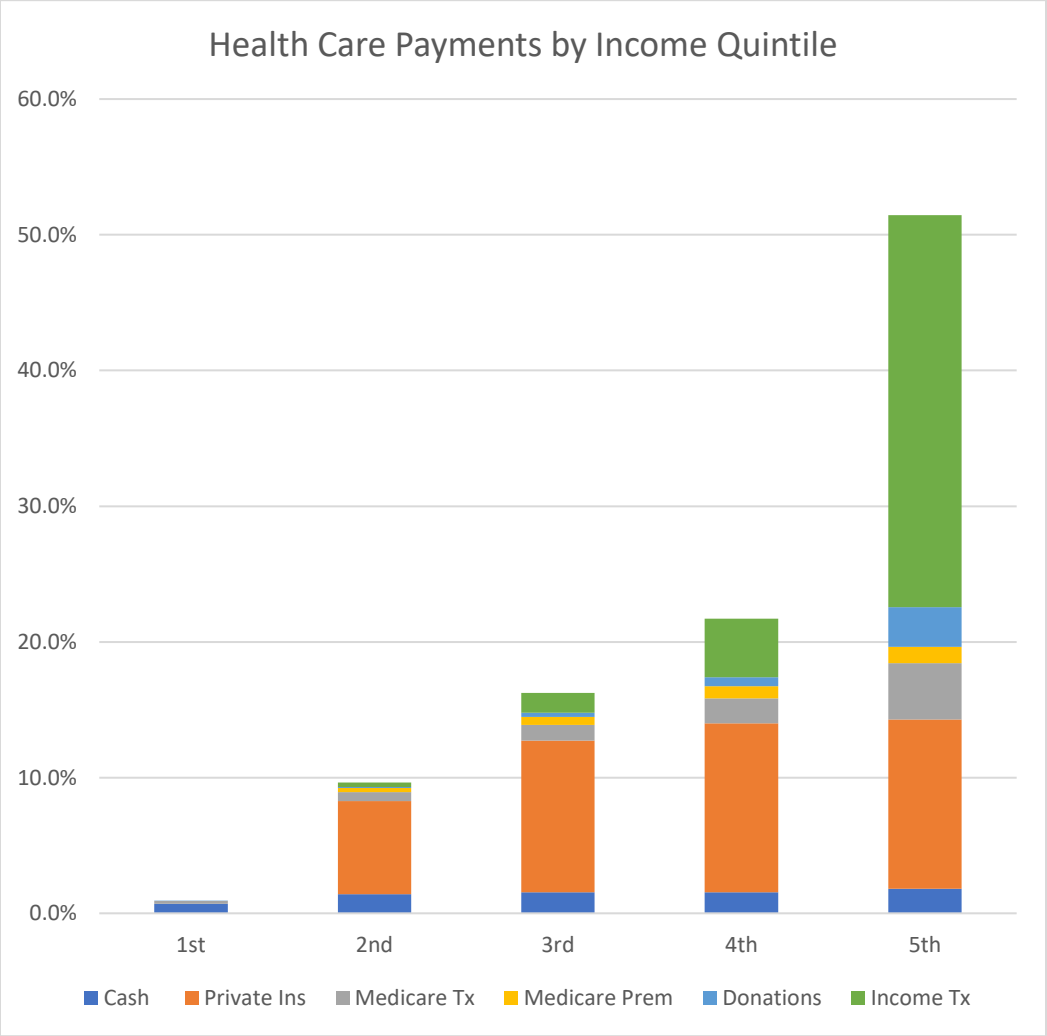

Figure 16. Over half of health care funding in the U.S. is currently coming from the top quintile primarily in the form of general fund income taxes which support low income (Medicaid) and Medicare programs. (Graph by w.george, data from IRS, CMS, and other sources)

SECTION 2: DESIGNING FUNDING FOR A NEW UNIVERSAL CARE SYSTEM

For any discussion of universal care funding, an assumption must be made about which services will be included and which revenue sources will be used for financing.

For purposes of this report, the following assumptions are made:

1. The universal care system will obtain permission to use existing funding for Medicare, Medicaid, and other government programs. This will require that funding for those programs must remain intact.

2. Services such as dental, optical, and purchases of medical supplies, that are currently paid for by cash transactions for non-Medicaid populations will continue to be paid by cash just as they are now. This may be a controversial assumption. The rationale behind the assumption in this report is that for the non-Medicaid population, these services are financially manageable and that converting them to a universal care system would increase the overall cost of these services vs the preferred convenience of paying cash. For low-income individuals, the universal care system would continue to pay for the same services which are now provided to Medicaid beneficiaries.

3. It is assumed that private donations would cease and that these funds would need to be replaced with public funding.

4. A conservative assumption is made that the increased costs of covering the existing uninsured population will be less than the anticipated savings of the universal care system, so there will be a net savings.

5. For services now typically provided by private medical insurance, all co-pays and deductibles will be eliminated in order to achieve substantial billing simplification.

Table 4 shows the funding sources which are assumed to be retained as is, and which are expected to be converted to public funding to create a publicly funded universal care system as required by SB 770.

Table 4. The Six Sources of Health Care Funding (2017)			Universal Care Funding	
			Retain Current Funding	Convert to Public
1	43%	PRIVATE INSURANCE POLICY PREMIUMS AND COST-SHARING		43%
2	35%	GENERAL FUND TAXES	35%	
3	8%	MEDICARE TAXES ON PAYROLL AND SELF-EMPLOYMENT	8%	
4	7%	CASH TRANSACTIONS (Estimated portion of 11% OOP)	7%	
5	4%	DONATIONS		4%
6	3%	MEDICARE PREMIUMS	3%	
		TOTAL	**53%**	**47%**

The major characteristics of the funds to be converted are as follows:

a. The major component, private insurance premiums and cost-sharing, follows the flat-per-person pattern of distribution.
b. The significant majority of these funds are currently tied to the employer-employee relationship, with a smaller amount coming from individual policies.
c. The employer-employee relationship has been an historically voluntary contributor to the cost of health care.
d. Because private health insurance reimburses providers at a higher rate relative to Medicare or Medicaid, it must be acknowledged that this revenue source is already involved in significant internal subsidization of Medicare and Medicaid, in addition to the external subsidization discussed in Section 1.
e. No assumption is made about the portion if any which is deducted from the employee's wage, since it is all part of the employee's compensation regardless.
f. A desire has been expressed to make health care less dependent on the employer-employee relationship.

TAXING OPTIONS

Three types of taxes have been suggested for converting private insurance premiums and their cost sharing payments to public funding.

a. An increase in Oregon's current income tax
b. A new payroll tax
c. A new sales tax

In considering which of these taxes to recommend, a natural question is how would each of these taxes affect various societal groups. Who gets to pay less and who will need to pay more? This is addressed further in the next section.

SECTION 3: DISCUSSION OF POTENTIAL ECONOMIC TRANSFERS

If the savings of universal care could be shared equally among all payers, there would be no relative winners or losers to discuss and no need to calculate who pays less and who pays more. Everyone could pay less. But the tax options suggested so far in the Finance and Revenue TAG meetings are almost all focused on transferring the cost rather than lowering the cost through savings.

If costs are lowered to any group of individuals in excess of the net savings of universal care, costs must be increased to other groups. This constitutes an economic transfer with one group benefiting from the transfer and other groups experiencing a loss relative to the current status quo. One step in evaluating each suggestion for funding universal care is to consider it in terms of the resulting economic transfers. Who pays less and who pays more?

Major potential transfers to be considered include the following:

1. Transfers based on individual health
2. Transfers based on elimination of multiple risk pools
3. Transfers based on income
    - Transfers based on employment status and type of income
    - Transfers based on existing employer benefits
4. Transfers based on age
5. Transfers based on insured vs. uninsured status
6. Transfers based on number of dependents

The first two of these types of transfers probably cannot be avoided, assuming that part of the savings of a universal care system comes from significantly simplifying the billing system in a way that makes it hard to track an individual's cost to the system, or to tell one group from another.

The above potential transfers are each discussed further on the following pages.

1. POTENTIAL TRANSFERS BASED ON INDIVIDUAL HEALTH

To consider how universal care could affect people based on funding mechanisms, it is important to first consider how the current system distributes cost according to health.

As discussed earlier, current premiums for private insurance policies are flat-per-person. In the current system, people with the same policy pay the same insurance premium regardless of their health. (ACA subsidies are temporarily disregarded for this discussion since they are based on income and not on health.)

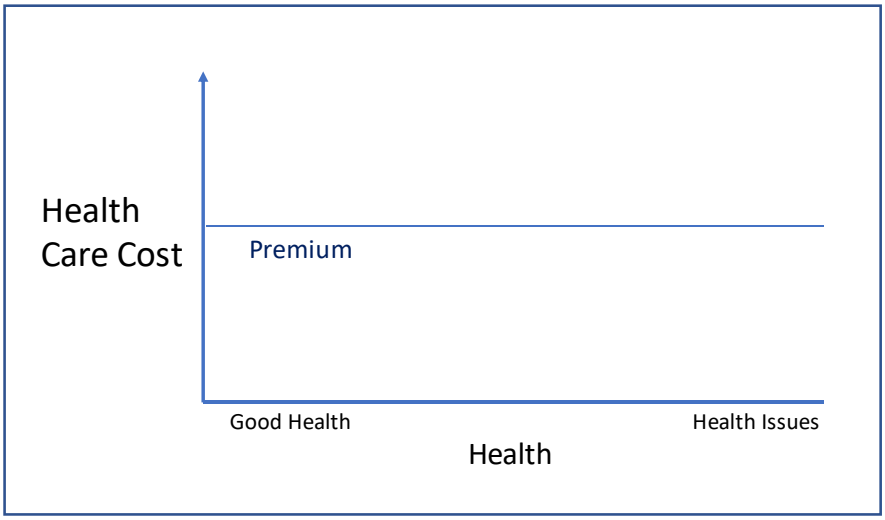

Figure 17. Premiums for the same policy do not vary by health. (Graph Schematic by w.george)

Onto the premium cost is added the cost of out-of-pocket expenses such as co-pays and other cost sharing up to the deductible amount. People who are well and only go for a physical every few years pay almost no co-pays and never come close to hitting the deductible. But a few people max out their deductible. As shown in Figure 18, the total cost including premiums and out-of-pocket cost are higher for people with significant health needs.

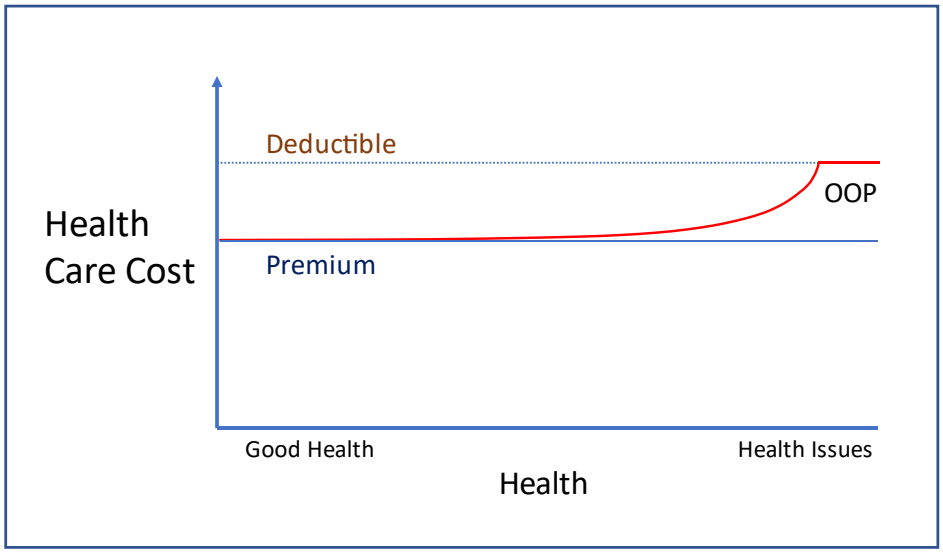

Figure 18. (above) People with health issues pay more OOP. (Schematic Illustration by w.george)

If a universal care system eliminates all co-pays and deductibles, the cost which was being paid in those formats will need to be spread out evenly. This will conceptually result in most people paying more to absorb the extra cost that sicker people previously had to bear. This effect is shown in Figure 19. Though most people will pay more, they may not mind because they will have less stress that they will be financially impacted by an unexpected illness or injury.

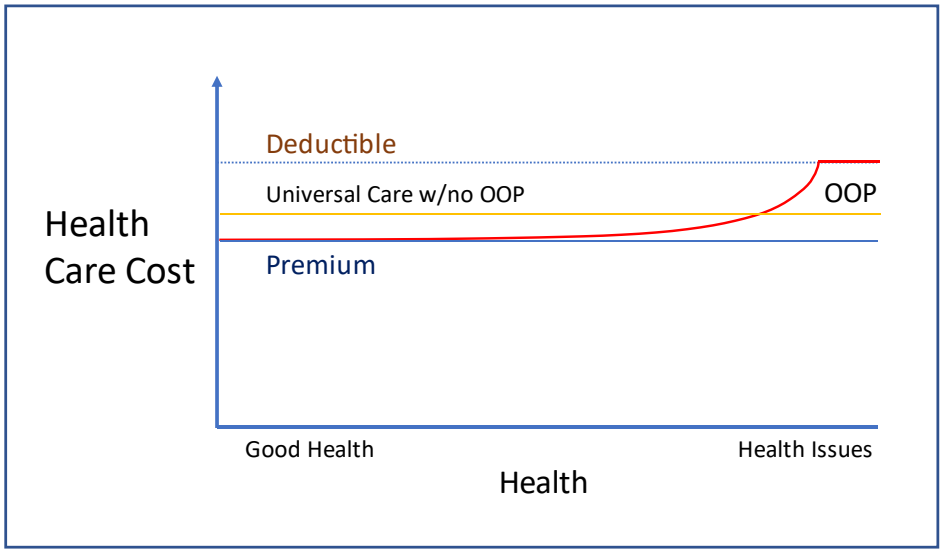

Figure 19. (above) Universal care evens out most of the cost. (Schematic Illustration by w.george)

The effect of health status on individual cost is more dramatic for high deductible plans. These plans have lower premiums but higher deductibles and other out-of-pocket costs so current difference between healthy and unhealthy people is greater. Therefore, the transfer will be larger in a switching from high deductible plans to a system of universal care where cost is spread out evenly. Healthy people with high deductible plans may see their cost rise more significantly than other groups.

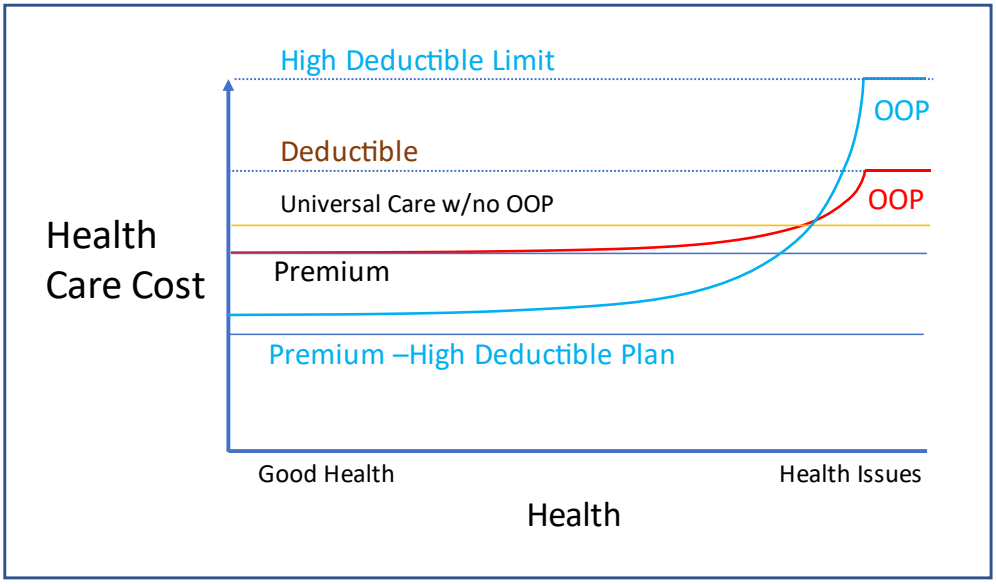

Figure 20. The effect of high deductible plans on distributing payments based on health. (Schematic Illustration by w.george)

This transfer for well people to pick up more of the cost from those with health issues is not solely a humanitarian issue, it is a necessary part of any system which reduces the overall cost of health care by eliminating billing on a Fee for Service basis. By eliminating billing, there is no longer a method to distribute cost based on who is sicker.

2. POTENTIAL TRANSFERS BASED ON COMBINING RISK POOLS

This is another transfer that presumably can't be easily avoided if the potential savings of universal care is to be realized.

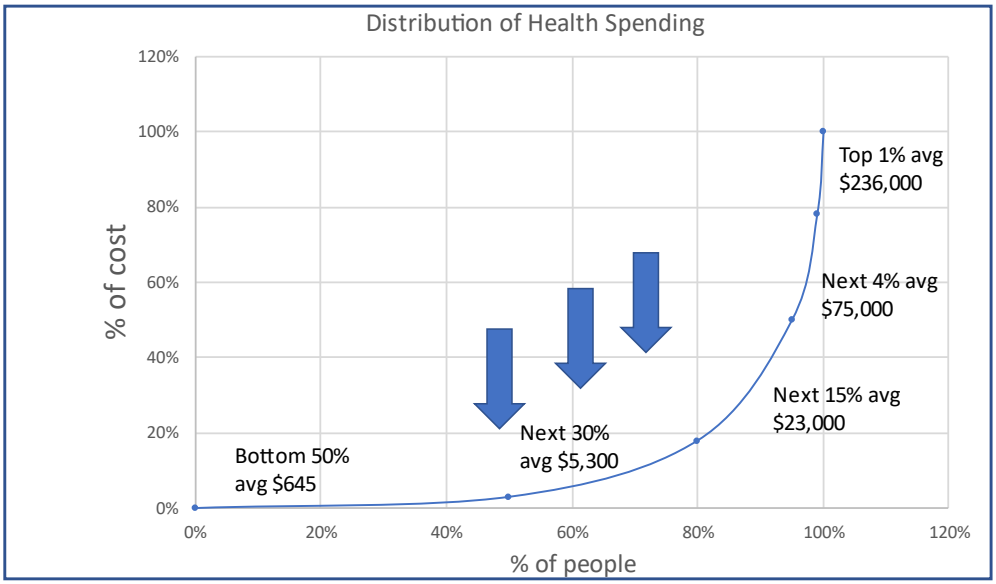

Figure 21. Different policy groups can currently vary their cost according to the average health of individuals in their risk pool. (Schematic arrows by w.george)

The premiums paid for health insurance currently can vary significantly according to the policy risk pool. People who are employed, for example, are generally healthier and so premiums for employer-based groups are generally lower. People with health issues are significantly less likely to be hired, and are less likely to be promoted and retained. This contributes to the higher cost for individual policies.

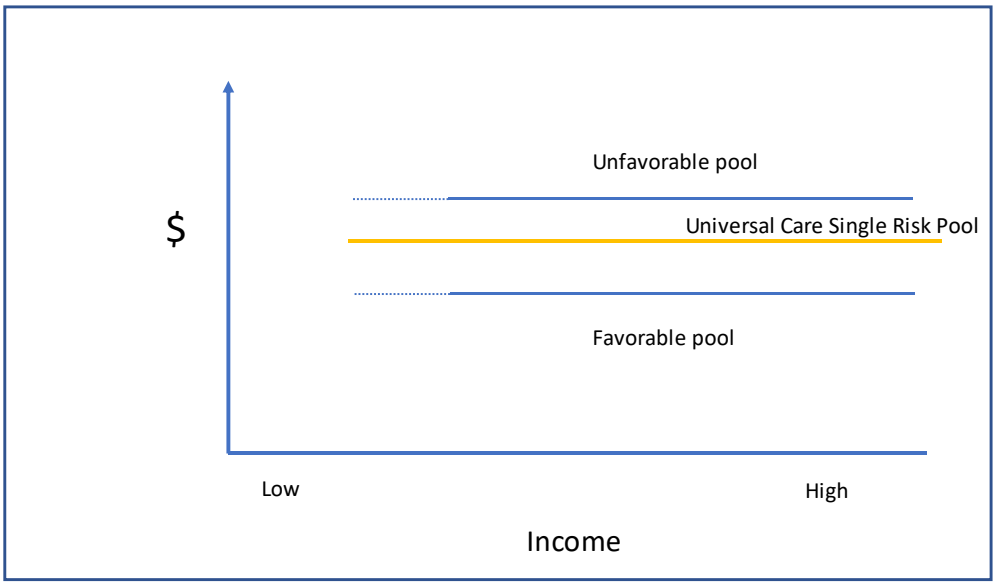

Figure 22. (above) Moving to universal care, and combining all risk pools into one, will result in savings for people currently in unfavorable pools, with higher cost for people currently in more favorable pools. (Schematic Illustration by w.george)

Since eliminating multiple risk pools is critical to achieving significant savings, the relative cost increase to people currently in favorable risk pools will need to be accepted, or at least tolerated by them based on the other benefits of the system such as reduced complexity and providing health security for all.

Calculating the amount of this transfer will require actuarial expertise but it is reasonable to conclude that some healthy people will see their costs double. The argument can be made that if society has an interest in the health of all, the groups which have financially segregated themselves into favorable pools are currently avoiding their "fair share."

The most favorable risk pools currently are self-insured employer pools for employers which recruit younger, healthier workers who by nature have lower medical costs.

When savings are taken into account, the healthier people and those from currently favorable risk pools may find that their individual cost increase to cover these transfers will be less than expected and they may even end up paying less than they do now, even though they are picking up a greater portion of the cost. Accurately estimating the savings of a universal care system is a critical part of planning.

3. POTENTIAL TRANSFERS BASED ON INCOME

In the United States, as opposed to other countries, almost no effort has gone into controlling cost. Instead, virtually every attempt to address cost has resulted in transferring more cost onto younger people as will be discussed later, and onto wealthier people. The transfer of more cost onto wealthier people has resulted in the 5th Quintile paying more than half of the cost of all health care.

It is assumed by many that the purpose of universal care discussion is just to continue the trend toward placing more of the cost onto people with higher incomes. But a reasonable question is how much of the cost can realistically be transferred based on income. A responsible answer may be "a little for sure but definitely not all." As mentioned before, transferring more cost onto those with higher incomes is not a necessary part of enacting universal care, but given the specific wording in SB 770 that funding will be progressive, it may be a required consideration of the Legislative Task Force on Universal Health Care.

The following discussion is intended to help illustrate how various funding proposals could affect individuals and households based on their income.

Currently, for people above the Medicaid eligibility level, the provisions of the ACA treat people differently based on whether they receive benefits from their employer. Persons who purchase individual policies are eligible to receive federal subsidies based on income and number of dependents. Persons who purchase medical benefits through an employer are not offered these same subsidies.

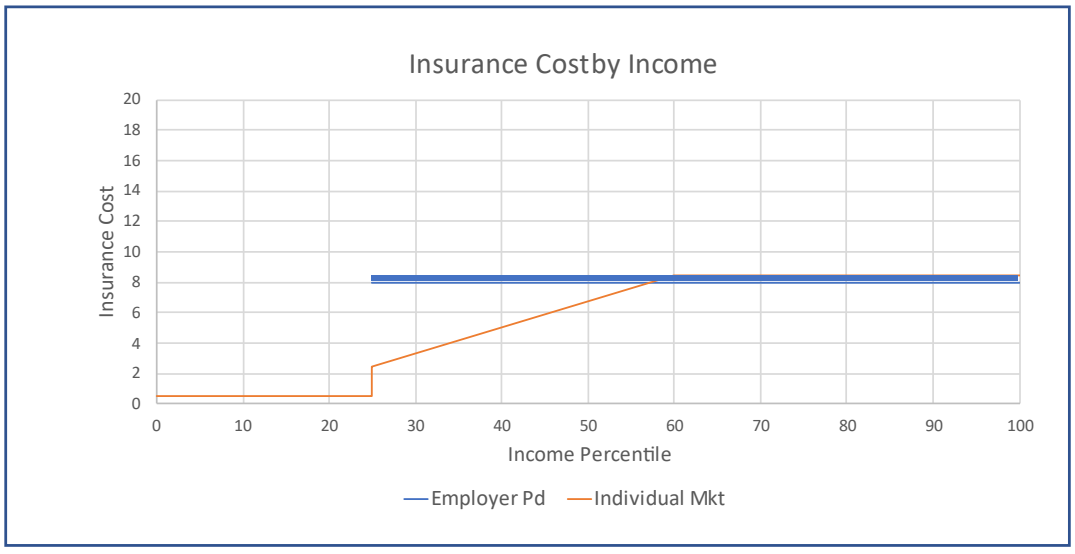

Figure 23. People on private insurance are treated differently based on whether that coverage was purchased through an employer.

The disparity between these two treatments has contributed to a trend where employees have actually voted for their employer to drop medical coverage, thereby allowing the employees to get government subsidized care at a fraction of the cost, but driving up the cost to the government. The differential treatment has also contributed to the trend of turning wage jobs into contract jobs.

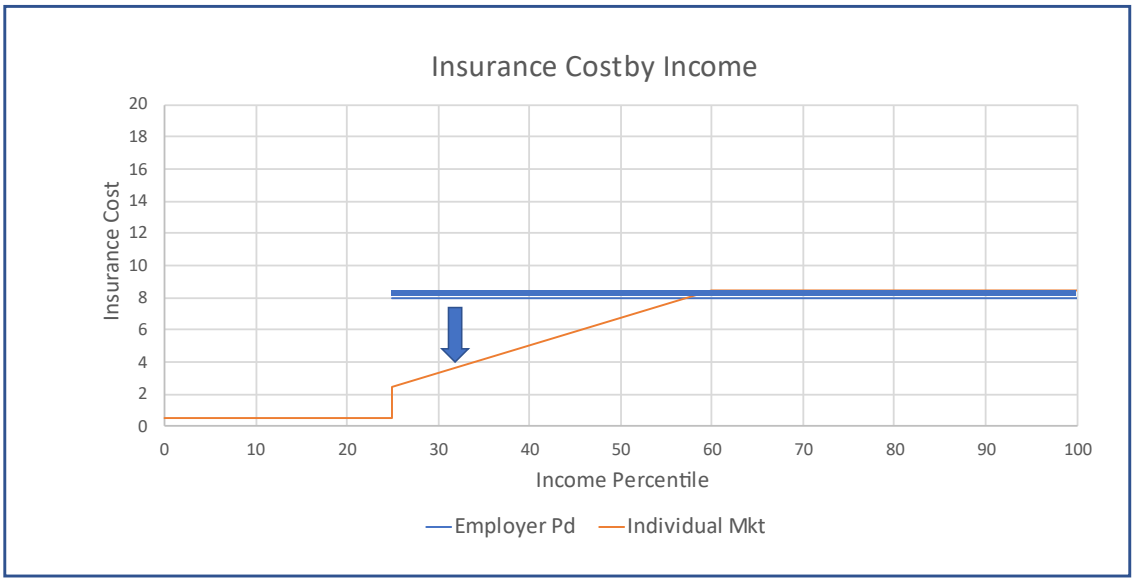

Figure 24. The unequal treatment of people with employer-based insurance has led to a decline in the number of employers who offer health benefits, and a decline in overall employment of low to medium wage jobs. (Graph by w.george, Data from ACA tables.)

Not all employers provide health insurance as part of their compensation package. In general, less profitable employers pay at lower wage rates and are less likely to provide benefits. More profitable employers pay higher wage rates and are more likely to provide the best benefits. Government employers generally behave the same as if they were a high profit employer.

Because private insurance pays providers at a higher reimbursement rate than Medicare or Medicaid, private insurance is part of an internal subsidy system providing a humanitarian benefit to participants in those programs.

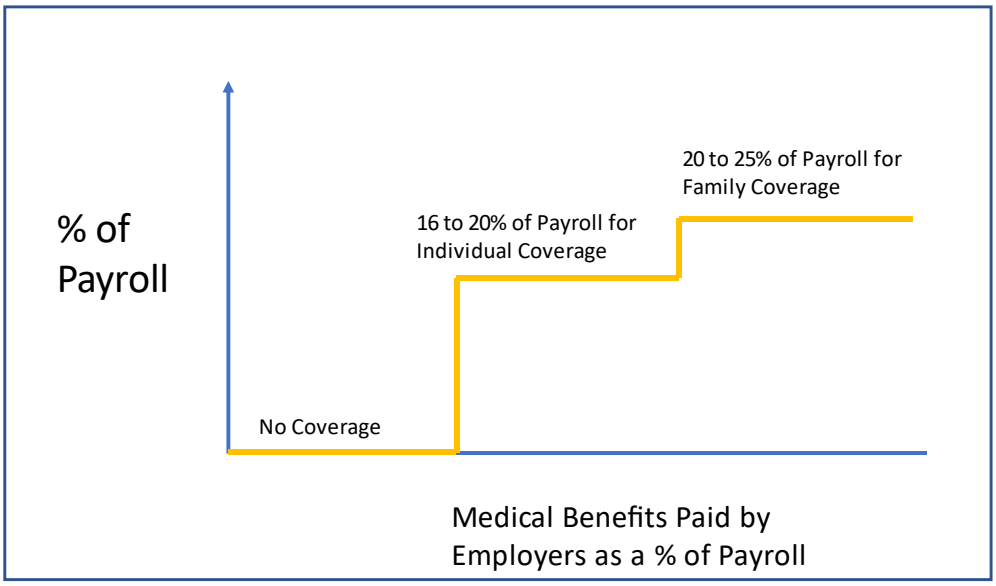

Figure 25. Some employers include no health benefits in their compensation package. Some include coverage for the worker only. Some provide family coverage. Individual coverage only may average about 16-20% of payroll cost. Family coverage may average about 20-25% of payroll cost. (Schematic Illustration by w.george)

The following graphs provide a schematic of how each of the common proposals for funding universal care would affect individuals according to their income.

For this discussion, ACA subsidies are disregarded in order to show the major effects of taxation. Figure 26 illustrates the current flat-per-person nature of the private insurance payments which need to be converted to public funding in order to achieve a fully funded public universal care system.

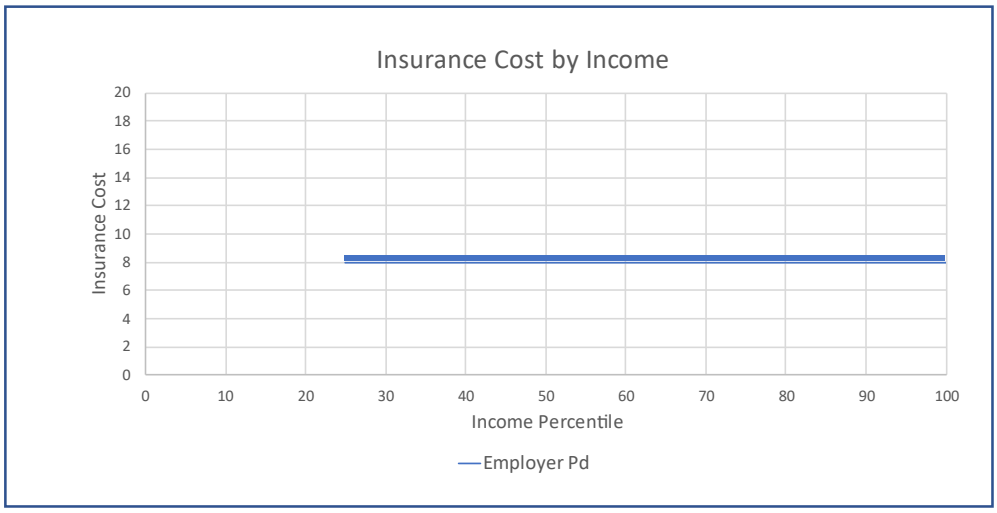

Figure 26. Payments for private insurance, including cost-sharing, are generally on a flat-per-person basis not related to income. (Schematic Illustration by w.george)

As illustrated below in Figure 27, converting the flat-per-person private insurance payments into a new tax on income would create a dramatic change in the payment distribution. Some people would save up to $10,000 per year or more while others would see their costs double or triple.

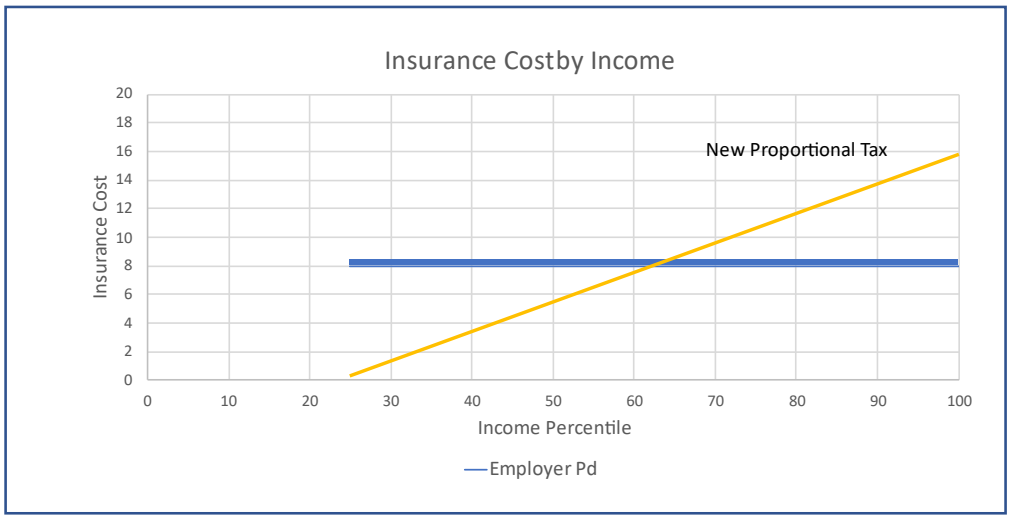

Figure 27. A new proportional tax on income above the Medicaid limit would be a significant change in how costs are distributed with almost everyone paying much more, or much less than they do now. (Schematic Illustration by w.george)

As illustrated in Figure 28, a new progressive income tax based on the same structure as existing progressive income taxes would result transferring almost all of the cost onto the top earners

who are already paying more than half of the health care cost. Under such a tax transfer, the top quintile would be paying over 80% of all health care cost and the necessary tax rates could be surprisingly high.

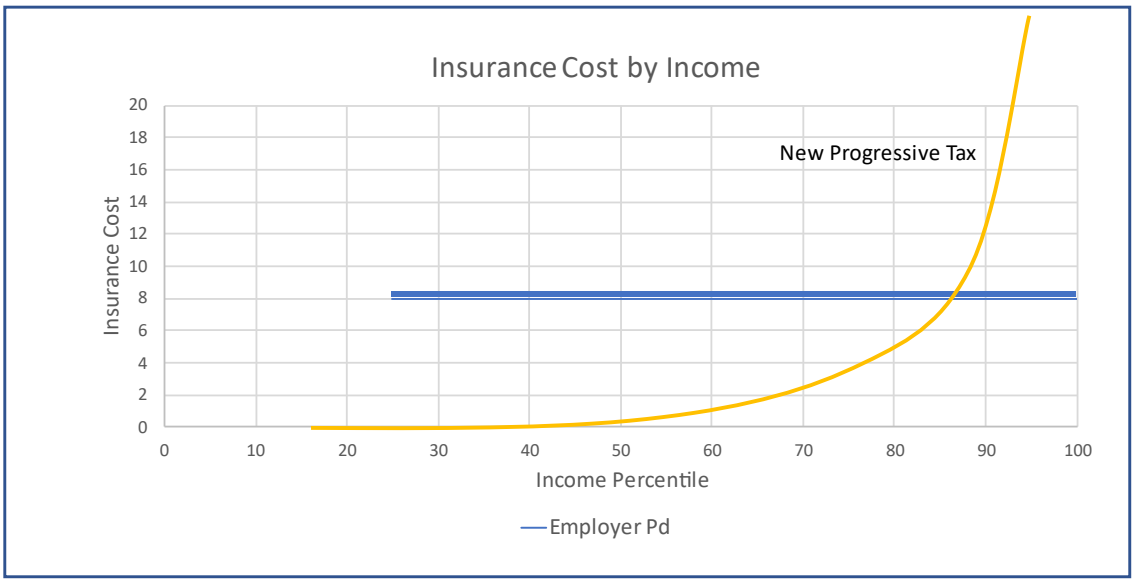

Figure 28. A new progressive tax to replace flat-per-person premiums would substantially transfer nearly all cost of health care onto the top earners. (Schematic Illustration by w.george)

Many people argue that sales taxes are inherently regressive, but depending on how they are designed and how well that the items most likely to be purchased by low income people are excluded, they can conceivably be proportional, or even progressive. The illustration given in Figure 29 is based on little data or knowledge but offers one idea of how a sales tax might affect people based on income. **Much research in this area would be required in order to replace argument and conjecture with solid evidence.**

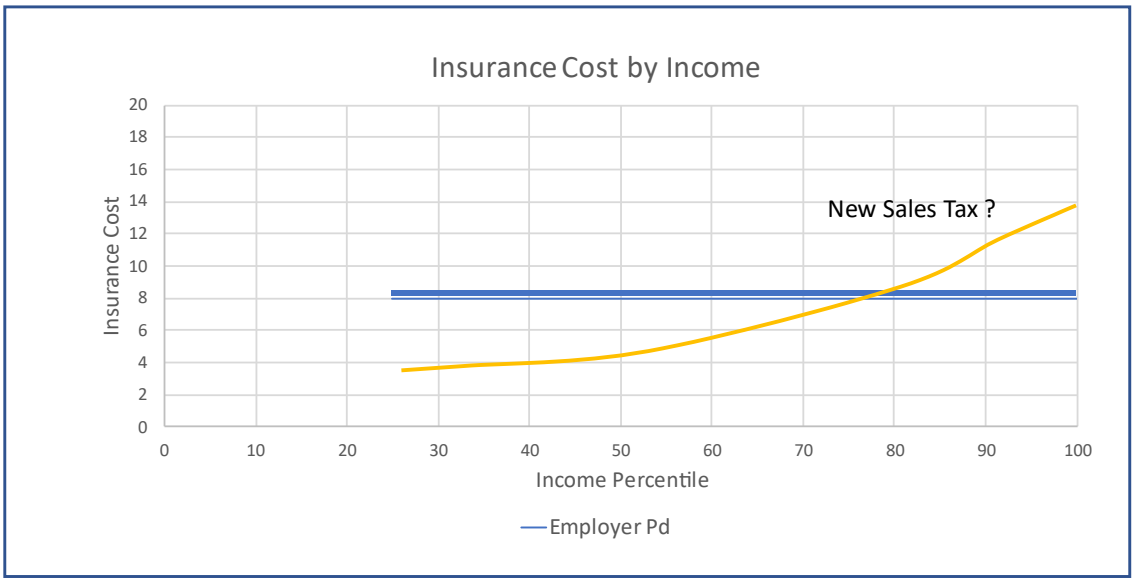

Figure 29. A possible depiction of how converting flat-per-person into a sales tax could affect persons of different income levels. (Schematic Illustration by w.george, estimates are conjectural.)

OTHER POTENTIAL TRANSFERS RELATED TO COST DISTRIBUTION BY INCOME.

a. Effect of Payroll Taxes

Almost every proposal for converting revenue from private premiums into public funding includes a proposed tax on payroll. Payroll taxes are inherently a tax on income, but not on all income, only on income from wages.

Any tax based on a percentage of payroll would result in a proportional distribution by income, similar to the Medicare payroll tax.

RAND proposes a 6.5% payroll tax which it claims would raise the same amount of money that employers in total now pay in premiums. While RAND's estimate seems too low, others propose the same methodology of evening out the cost across all employers.

Because the level of benefits provided in employer compensation packages is highly correlated with employer profitability and employee wages, such a payroll tax could be highly regressive in its effect. Figure 30 illustrates the problem.

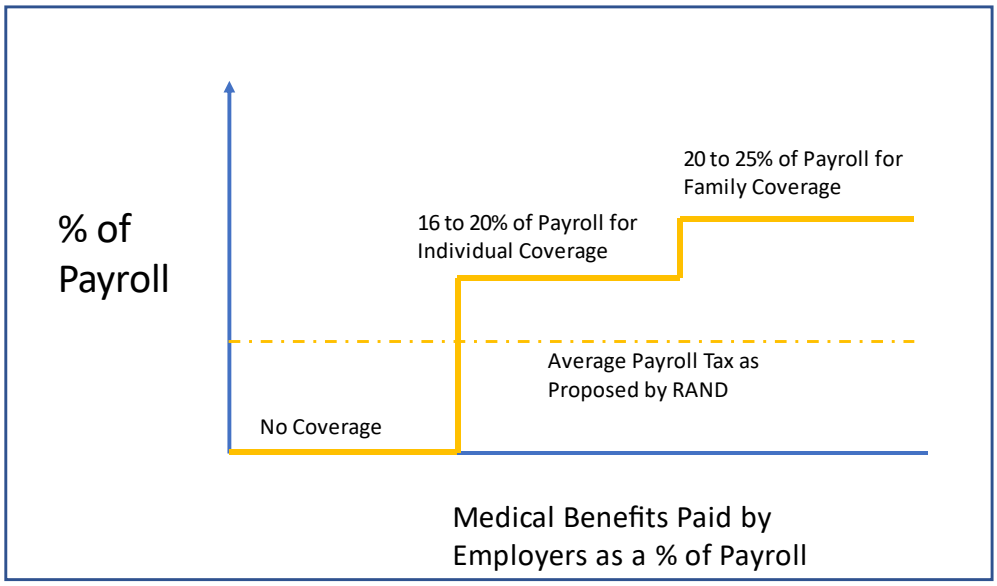

Figure 30. Charging all employers the same payroll tax percentage could result in a windfall to high profit companies and high wage employees, at the expense of low profit companies and low wage employees.

RAND proposes eliminating part of the regressive effect of this transfer by charging no payroll tax on employers with less than 20 employees but this seems unrealistic in practice. A firm with 19 engineers would suddenly get free health care. Any firm with 55 employees would suddenly divide into three separate companies which pay no payroll tax. Some people who have given this problem a lot of thought have considered a payroll tax based on a formula of profitability per employee and median income per employee.

But their effect, payroll taxes are in clear violation of SB 770 which requires that affordability be one of the criteria for selecting payment methods. The act of employing someone else is not a measure of wealth or income.

IMPORTANT NOTE: Employees who receive health care from their employer get a significant tax advantage from the federal and state governments because they do not currently pay income, social security, or Medicare tax on this portion of their compensation. While this tax benefit, often acknowledged to be the largest loophole in current tax law, may be truly unfair, the economic turmoil of losing this benefit is too large to realistically contemplate. To avoid this turmoil, payments which currently come from employers should be retained as nominally coming from employers, even if economically paid by the individual. A better solution might be to receive a waiver from the federal government which would ensure that payments to a state single-payer agency would retain the existing tax benefit regardless of whether the funding is paid directly by individuals, or whether the payment continues to be passed through employers.

b. Effect of Employment vs Self-Employment

Without further study it is unclear how various proposals might affect employed persons compared to self-employed persons including contract workers It would seem preferable that any new system charge the same rate for both payroll (wage) income and contract worker income in order not to accelerate the trend away from employment and toward contract work.

c. Effect on People with Income from Rents, Royalties, Investments, and Retirement Distributions.

Any system which converts private insurance payments into income based tax may have a disproportionate effect on people with income from rents, royalties, investments, and retirement income. These income sources are currently exempt from paying Medicare taxes and certain other kinds of general taxes for health care.

4. POTENTIAL TRANSFERS BASED ON AGE

There has been very little discussion of how the current cost of premiums varies by age. Prior to the ACA, insurance companies applied age-rating to each policy resulting in premiums about six times higher for a 64 year old than for a 20 year old. Under the ACA, insurance companies cannot charge more the 3 times higher for a 64 year old. But this artificial restriction which benefits older people at the expense of younger ones does not apply to self-insured employer plans whose expenses are the actual expenses incurred and therefore very dependent on the average age of the workforce.

Medicare participants pay token premiums which amount to a relatively small proportion of the cost of the services provided to them.

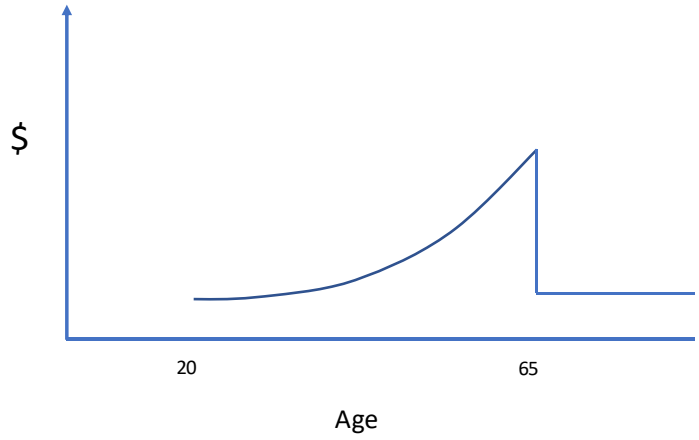

Figure 31. Approximate current distribution of health care cost by age of the individual. (Schematic Illustration by w.george)

Unless age-credits or other adjustments are specifically provided within a universal care funding plan, the result will be to lower the cost of middle-aged individuals at the expense of younger people and senior citizens. These will be significant issues to work out as both young and older individuals may fight this transfer. The issue will be a particularly hard sell to senior citizens due to their lack of full understanding that their existing premiums and previous Medicare Taxes only account for about half of the cost of their own care, let alone any humanitarian responsibility to help cover the cost of low-income individuals.

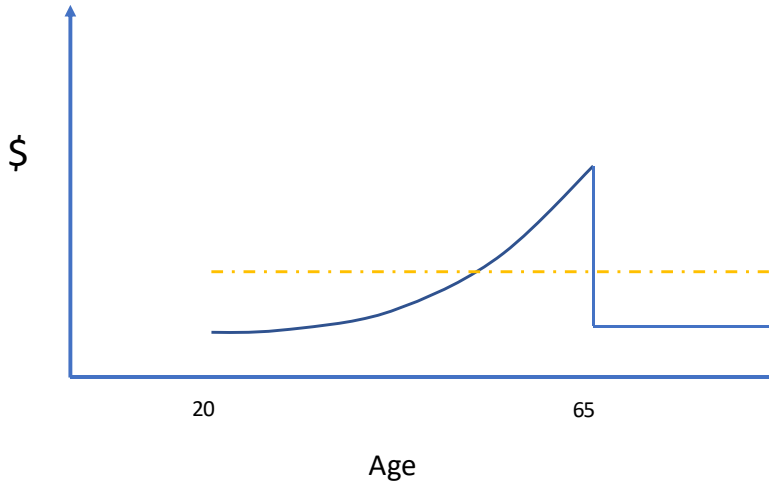

Figure 32. If a universal care funding system removes all consideration of age, costs will go up significantly for the young and old, but go down for middle aged persons. (Schematic Illustration by w.george)

5. POTENTIAL TRANSFERS BASED ON INSURED STATUS

Universal care will affect the uninsured and underinsured differently according to the eligibility status.

a. If they are eligible for Medicare but haven't signed up because of generally good health, they will be eligible for full care at no cost.
b. Many young people who do not qualify for Medicare choose to be uninsured because the cost of signing up for medical care is so high relative to their low probability of needing its services. Assuming that payments into the system are mandatory, these people, who pay nothing now, will be forced to pay.
c. A few high-income people have remained uninsured since they can pay less for their care directly. They can limit their cost by choosing their care prudently and negotiating with providers. Assuming that payments into the system are mandatory, they will be forced to pay much more than they do now.
d. A few Oregonians participate in Christian sharing ministries whereby they share directly in the cost of each other's medical bills without using other programs or insurance. Such programs were granted an exemption under the ACA and continue to operate in Oregon. Statistically, these people are counted as being uninsured. It is not at all clear how these people would be affected by a universal care system.

If everyone is covered and there are no more patients who are uninsured or underinsured, providers will benefit significantly through a reduction in the amount of uncompensated care.

6. **POTENTIAL TRANSFERS BASED ON NUMBER OF DEPENDENTS**
   Disregarding Medicare and ACA subsidies, private insurance policy costs increase with the number of dependents. On the other hand, for government programs participant costs are reduced with more dependents. Depending on how the system is designed, moving to a government model of subsidizing all dependents could result in lower costs to middle- and upper-income families with a large number of dependents.

SOME RECOMMENDATIONS FOR ACTION:

1. CONCENTRATE MORE ON COST REDUCTION: System cost and the potential for cost savings is a critical element of universal care and should be receiving priority attention by the Finance and Revenue TAG. **Cost reduction though system efficiencies must become a higher priority than solving the problem through transferring the cost.**

2. SERIOUSLY INVESTIGATE SALES TAXES: Not enough is known about the effect of different kinds of sales taxes. Outside expertise should be retained so that sales taxes can be fully understood before recommendations are made.

3. CONSIDER A LOW PER-PERSON PREMIUM TO REDUCE TAX TURMOIL: To achieve a publicly funded system will require converting the approximately 43% of cost currently covered by private insurance, into a public funding revenue collection. Trying to immediately replace this flat-per-person funding distribution with a proportional or progressive tax will create huge transfers which will probably prevent enactment of universal care. A per-person premium, even as small as $100 or $200 per person per month for people above a certain income level would help reduce the shock effect of transitioning the remaining cost onto a proportional or progressive tax. It is arguable that making the system feel familiar and have the fewest dramatic changes will help its public acceptance.

4. TRY TO RETAIN CURRENT EMPLOYER BASED REVENUE: Every dollar currently being paid by employers that can be retained in that format at least in the first years of universal care reduces the amount that must be raised as a tax. If 75% of that revenue can be retained, the required tax rate on individuals could be far lower than has been discussed to date. Outside expertise on employer benefits should be retained to offer suggestions on how to retain most of this revenue.

5. WRITE A PRINCIPLE STATEMENT ABOUT TRANSFERS: A good starting place, instead of jumping straight to choosing taxes, is to write a statement of what funding changes are necessary or desired relative to the current system. This statement could place limits on how much more can be charged to any particular group relative to their current payment.

6. TRANSITIONING FROM EMPLOYMENT TO INCOME: Currently much health care cost is collected as an effective tax against employment. With a desire to encourage employment, and as a requirement of SB 770 to base payments on ability to pay, a long-term strategic shift is recommended away from employment taxes and toward assessments based on individual and business income. Although probably not feasible immediately, a policy statement should be drafted affirming this as a long-term goal.

7. PLAN FOR SENIORS: Seniors will make the difference in public acceptance of universal care but the extra benefits they might receive under a universal care system vs the extra costs they might incur are complex. Outside expertise should be retained and charged with developing a financial plan to include seniors.

8. CONSIDER THE FINANCIAL IMPLICATIONS OF ALLOWING PEOPLE TO OPT OUT: It may be helpful to think in terms of dividing health care cost into two portions as attempted in this report: what people pay for their own care, and what they pay for the humanitarian ability of others to seek care. With this distinction it may be possible for people to opt out of their own care if for example they have a religious opposition to all forms of modern medicine. But people should not be allowed to opt out of contributing to the humanitarian cost. A statement should be drafted and submitted to the EBA TAG or CAC.

9. CONSIDER SEPARATING AN OREGON HEALTH CARE TAX FROM THE OREGON INCOME TAX: The income taxes discussed to date have been a matter of taking the existing Oregon income tax and increasing the tax rates. Consideration should be given to whether this creates undesirable transfers, such as allowing taxpayers with mortgage interest to pay a lower rate for health care than would a renter with the same income. A separate health care tax could be based on total household income without the special restrictions, income exemptions, tax deductions, or credits created by Oregon's income tax statutes, or by the federal tax codes to which Oregon's income tax is currently tied. If the LRO is not available to provide their expertise in a timely manner, outside expertise should be acquired for their recommendations.

10. TAKE A PROACTIVE STANCE TOWARD WAIVERS: Outside experts were initially brought in to discuss the need for federal waivers related to Medicare, Medicaid, ERISA, and possibly the ACA. More action needs to be taken, and recommendations need to be formalized. Since one of largest impediments against transitioning away from employer-based health care is the federal tax laws providing tax subsidies for employer paid care, a federal waiver should be drawn up requesting that state-based universal care systems will still be entitled to the existing favorable tax effect even though payments to the state system may be paid by individuals instead of through employers.