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UNIVERSAL COVERAGE: BUILDING ON MEDICARE AND EMPLOYER FINANCING

by Karen Davis and Cathy Schoen

Prologue: Ever since World War II the United States has relied on an employer-based system of health insurance coverage. Although a majority of workers still rely on employer-based insurance, a structural shift away from large-employer, capital-intensive industries to labor-intensive, smaller employers that provide a service is eroding this coverage. In this paper two economists-Karen Davis, executive vice-president of The Commonwealth Fund, and Cathy Schoen, an associate professor at the University of Massachusetts, Amherst-discuss actual legislative proposals that policymakers have introduced to achieve broader insurance coverage. As they point out, there are a limited number of ways to finance universal coverage: employer premiums, individual premiums, tax mandates, or some combination of the three. To make coverage universal, they urge consideration of an expansion of Medicare, whatever the mix of financing. This approach is consistent with that being pursued by Rep. Pete Stark (D-CA), chairman of the House Ways and Means Subcommittee on Health. Unlike many policy analysts, Davis and Schoen do not subscribe to the view that a government mandate requiring employers to provide insurance to their workers would necessarily lead to a dollar-for-dollar reduction in wages of Uninsured workers. Some of the costs may be covered by an increase in prices to all consumers. Davis, who holds a doctorate in economics from Rice University, was a key figure in the development of the Carter administration’s national health insurance plan. Later she became chair of the Department of Health Policy and Management at The Johns Hopkins University. Schoen directs the Commonwealth Health Care Reform Program, which is based at the University of Massachusetts. Previously, she headed the Research and Policy Department at the Service Employees International Union.
Abstract: Universal coverage requires a strategy to sever the link between insurance coverage and employment in order to build a more stable insurance base. Universality also will require subsidies to make coverage affordable. Given these realities, the authors evaluate different financing proposals—employer and individual premium mandates and taxes—in terms of equity, affordability, and administrative and political criteria. An expansion of Medicare offers an insurance alternative that takes advantage of existing administrative structures of national scope.

The debate on how to finance universal coverage depends critically on acknowledging that universality requires mandated financing. If one accepts universal coverage, the issue is not mandates but how to share the financing burden between employers and individuals and whether premiums (flat contributions) or taxes (income-related contributions) should be the primary financing mechanism. Criteria for evaluating alternative schemes are essential to weigh the relative merits of different financing mixes and the transition issues that would result. Whatever the theoretical merits of different approaches in a historical vacuum, we must move from our current complex mix of tax, individual, and employer financing to a new mix that covers everyone.

Affordability. In 1992, 38.5 million people—one in seven—had no health insurance at any point in time, two million more than in 1991. A survey by The Henry J. Kaiser Family Foundation and The Commonwealth Fund in August 1993 found that only 7 percent of the uninsured are uninsured by choice. The main reason is that uninsured people either cannot afford coverage or have an employer that does not pay for coverage. The income distribution of the uninsured underscores the need for subsidies or income-related financing to achieve universality. Nearly two-thirds of the uninsured live at or near poverty. With incomes of $24,000 or less, these are families who simply cannot afford family premiums, which today average more than $5,000 a year. We must either require employers to bear a portion of this cost, provide tax-financed subsidies, or use tax-like contributions linked to ability to pay to make coverage affordable.

The attraction of extending employment-based financing grows out of the fact that most of the twenty-three million low-income uninsured persons work. Altogether, 84 percent of the uninsured live in families headed by either full- or part-time workers.
Changing structure of work. Although employment remains the pillar on which health insurance coverage in the United States is based, structural changes undermine the viability of employment as a foundation for the future, whatever the decisions on financing. Three structural changes are particularly relevant: the shift in the employment base away from large-employer, capital-intensive industries toward small-employer, labor-intensive industries; the rapid increase in the proportion of “contingent jobs” that are part time, temporary, and contracted rather than full time, year-round for a single employer; and high rates of turnover in the job market as people change jobs more rapidly than in the past.

The shift to labor-intensive, small-employer service industries erodes voluntarily provided, employment-based health insurance. It is not surprising that about 30 percent of the uninsured work for firms with fewer than ten employees, and 31 percent work for firms with ten to ninety-nine employees. For small employers, health benefit costs tend to be high relative to labor and overall costs, and the task of administering a health benefit program is cumbersome at best.

For the 30 percent of all working Americans that make up the contingent work force of part-time, temporary, and independent contractor workers, no natural, stable employment group exists for insurance purposes. Rapid technological change has added to job instability for the full-time work force as well. One in ten Americans reportedly are now switching jobs or are without a job for at least some period of each year. People increasingly move in and out of temporary jobs.

The willingness of employers with more stable, full-time work forces to provide and pay for family coverage has partially offset and hidden the impact of these structural changes. People in jobs that do not offer health insurance often can enroll as dependents in their spouse’s employer plan. This voluntary social commitment by larger employers to pool costs of family coverage is already eroding. Given these structural changes, financing strategies must consider how to sever the link between employment status and insurance coverage while mandating universality.

Financing Criteria: Evaluating The Alternatives

To evaluate the choices for mandating and financing universal coverage, we must identify values or criteria with which to judge their relative merits. At least six economic criteria and two political concerns apply: (1) Equity: Families with similar incomes should pay similar costs, and all firms in the same financial condition should make the same contribution (horizontal equity). (2) Financial burden: The full cost of health care premiums is now beyond the means of many families. Payments should be related to ability to
pay (vertical equity). (3) Fiscal soundness: Premiums or tax rates should be sufficient to cover the cost of coverage. (4) Efficiency and employment: Financing should minimize employment impacts of higher labor costs and high marginal tax rates. (5) Continuity and stability of health insurance: Financing policies should assure continuous, stable coverage as people age or change various aspects of their family and work lives. (6) Administrative simplicity, efficiency, and enforceability: Administrative expenses should be minimized, and mechanisms should be adequate for collecting the necessary funds. (7) Political support of the insured: The design and explanation of the policies should garner support from both the insured and the uninsured. (8) Federal budget costs and taxes: If taxes are to be a source of financing, alone or combined with mandatory premiums, we must address the misperception that they will necessarily increase payments by families.

### Mandates: Evaluating Basic Choices

Mandates to require and pay for universal coverage can be achieved in three ways: employer premiums and individual premiums (fixed contributions per person or family) and tax mandates (income-related contributions). The U.S. health system now relies on a mix of all three, plus direct patient payments to finance care. The question is how to use mandates to shift and augment this mix to build a base for stable, universal coverage.

Any choice has advantages and disadvantages that become more or less important depending on the overall approach to reform and on which values are dominant. The policy challenge is to choose the mix that best meets basic social criteria while addressing transitional concerns, including perceptions about who is now paying the costs of care.

In evaluating strategies, we also must examine specific proposals rather than more abstract constructs. While in theory the same distributional outcome might be achieved by varying mixes of mandates and subsidies, proposals before Congress differ widely in distributional outcomes as well as in mandate strategies.

On close inspection, those national proposals that require mandates are generally mixed financing approaches, whatever the labels. For example, President Bill Clinton’s Health Security Act would mandate employer payments of up to 80 percent of premiums for full-time workers and partial premium contributions for part-time workers. By capping employer premiums as a percentage of payroll ranging from 3.5 percent to 7.9 percent for firms with fewer than 5,000 employees, the proposal effectively converts the flat mandatory per person premium into a payroll-related “tax” up to an earnings threshold. Moreover, the Clinton plan would require families to pay a share of the premium directly, with subsidies related to income to ease
the financial burden. Under the Clinton proposal, income-related caps effectively convert the individual premium mandate to an income-related “tax” up to the income threshold for subsidies, after which mandates revert to a flat premium or head tax.\textsuperscript{10}

Similarly, proposals with individual premium mandates depend on a mixed approach. For example, Sen. John Chafee’s (R-RI) Health Equity and Access Reform Today proposal would mandate individual purchase of health insurance, with sliding-scale subsidies up to 240 percent of the federal poverty level.\textsuperscript{11} A family of three earning $28,500 (240 percent of poverty) would pay 13.3 percent of income for the premium. The plan also implicitly relies on employers to maintain existing levels of premium financing. It would finance subsidies from cuts in Medicare and Medicaid, effectively using federal and state general tax revenues to cover the uninsured. To be fiscally sound, the plan might require new general tax revenues to achieve guaranteed coverage at proposed subsidy levels.\textsuperscript{12}

**Employer-Mandated Premiums**

While an employer-mandated premium could be designed in many ways, the following discussion assumes that employers would be required to pay 80 percent of premiums for full-time workers and a partial contribution for part-time workers, and that subsidies would be available to employers to offset a portion of health benefit costs that exceed a given percentage of payroll. It is important to distinguish employer-financed health insurance from employer-provided health insurance. In the Clinton plan, for example, employers with fewer than 5,000 employees would contribute to coverage for workers, but coverage would be provided through health alliances. A worker’s coverage, therefore, would not necessarily change when he or she changed jobs; only the source of financing for that coverage would change. Plans that mandate both employer premiums and employer provision of coverage would inevitably entail considerable instability and turnover of coverage as workers change jobs, become unemployed, or shift from full-time work to the contingent labor force.

**New federal budget costs minimized.** Perhaps the single greatest advantage of employer premium mandates is that they minimize the extent to which new federal budget costs and explicit taxes are necessary to achieve universality. By retaining and building on the $200 billion already spent by employers to pay health care premiums for employees and retirees, mandated employer premium contributions reduce the level of direct public subsidies required for low-income uninsured families. Government subsidies to individuals could be largely targeted to low-income nonworking families. Subsidies to employers to offset a portion of their costs would, of
course, increase total governmental costs. However, it is likely to cost the
government less to subsidize nonworking low-income families and target
partial employer/employee subsidies to working low-income families than
to subsidize premiums directly for all low- and middle-income families.

Other distributional impacts moderated. By building on the current
employer-paid financing base, employer premium mandates moderate
swings in the distribution of financing when compared with mandates
financed entirely by payroll, income, or other taxes. The major changes are
for firms that do not now provide health benefits. According to estimates
from Lewin-VHI, 21 percent of firms that now provide some insurance for
their workers would see their costs go up more than $1,000 per worker. Costs
would go down in firms that now cover workers and their working
spouses, as spouses would obtain coverage from their own employers.

Improved horizontal equity. An employer premium mandate improves
horizontal equity by requiring all firms in a similar situation to pay similar
costs. Complex cross-subsidies across employers now encourage firms to
seek a competitive advantage by shifting the costs of health benefits onto
other employers without a compensating increase in wages or other bene-
fits. A firm that provides health benefits often finds itself competing with a
firm that does not. ‘While economic theory may argue that noninsuring
firms would have to provide compensatory higher wages to attract and
retain workers, labor markets rarely work so perfectly in practice.

If combined with community rating, employer premium mandates would
ensure that firms in the same industry or area would play on a more level
field. Variations in the age and health status of covered workers and
dependents can result in different costs of fringe benefits for firms in the
same industry that do not reflect productivity differences. For example, a
new Japanese auto plant in the United States may have more single,
younger, healthier workers than does an existing U.S. plant and thus may
face lower labor costs although paying the same wages. Employer mandates
(especially when combined with community rating and pooling across a
large population base) redistribute costs and, in effect, establish a new
minimum labor cost for jobs throughout the economy based on the mini-
mum wages plus health premiums per hour worked.

Lighter fiscal burden on working families. Employer premium man-
dates can increase the affordability of health insurance for low-income
workers and their families while reducing the need for additional govern-
mental subsidies. Simply put, requiring a currently uninsured family (with
children) earning $20,000 to pay 20 percent of a $5,000 premium, or
$1,000 (5 percent of income), imposes a lighter financial burden than
requiring the same family to pay the full $5,000 premium (25 percent of
income).
Again, true believers in perfect labor markets may argue that the employer will pay the worker $4,000 less under the employer mandate so that the cost to the worker is $5,000 in either case. However, employers may choose simply to pass the cost on to consumers in the form of higher prices (especially if all firms in the industry are under the same requirement). While economists note that in that case workers as a whole still would pay through lower real wages, it makes a great deal of difference whether all consumers bear part of the cost or whether costs are borne solely by workers of uninsured firms. Empirical evidence on whether health costs are shifted forward to consumers or backward to workers is largely inconclusive.

Even if employers trade off wages and health benefits, the costs may be spread across their work force. For example, if two workers are doing the same job, would the employer pay the worker who has a family health insurance policy less than the worker with an individual policy, or more to the younger worker than to the older one to compensate for the difference in their premium costs? Even if employers shift health benefit costs back to workers, those costs may be pooled and distributed across the entire work force, including shifting more of the costs to higher-wage workers.

The struggle by workers to keep employer-paid health coverage is driven in part by the fact that health benefits are one of the few fringe benefits provided equally, regardless of income. Unlike pensions or life insurance, the value of health benefits does not rise with wages. Thus, the $20,000-a-year line worker typically receives the same health benefits as the $100,000-a-year vice-president. Middle- and low-income employees do not believe that employers would voluntarily give workers at all wage levels a uniform raise of, say, $4,000 a year if they no longer had to provide health benefits.

Similarly, employers’ opposition to required employer premium payments reflects an employer/employee consensus that the financial burden differs when employers rather than employees are required to pay premiums. Although over the long term employer-paid premium costs may reduce total wage income in the economy through the impact of higher prices or reduced wage increases overall, this impact is unlikely to be distributed dollar for dollar per employee based on that employee’s health cost. For workers at or near the minimum wage, in particular, employers are unable to reduce wages if health costs increase. Thus, employer premium mandates are likely to lower the financial burden for low-income-worker families without an offsetting equal reduction in their earnings.

Administrative enforceability and efficiency. Employer premium mandates could rely on the same enforcement mechanisms as Social Security payroll taxes do now. Compared with individual premium mandate approaches that would require large payments from low- and middle-income families, such mechanisms are likely to be relatively easy to enforce.
and to produce more reliable and stable sources of financing.

Adverse employment effects. The principal disadvantage of employer premium mandates is the possible adverse impact on low-wage workers and small businesses. These premiums hit low-wage, small businesses the hardest and give all employers an incentive to substitute capital for labor. The net impact on employment from the redistribution of health benefit costs is difficult to assess. The Lewin-VHI analysis has estimated that as costs are shared more equally across employers, the mandates would change costs by $500 or more for three out of four employers that now provide some health insurance: Costs would increase for 34 percent and decrease for 44 percent.

Studies of minimum wage increases find negligible overall employment effects. For example, no detectable change in employment accompanied the last such increase—from $3.55 to $4.25 an hour. This is equivalent to an annual increase of $1,400 a year for a full-time worker—more than most firms would experience under an employer premium mandate. Under the Clinton plan, employer contributions for firms with 5,000 or fewer workers would be capped at 3.5 to 7.9 percent of payroll, mitigating any adverse employment effect. This is at most thirty-four cents an hour for a minimum-wage worker, or barely half the last increase in the minimum wage.

Administrative complexity. Employer-paid premium mandates must establish complex rules for the range of diverse work relationships. In addition, employer premiums may vary for workers with single or family coverage, or according to whether employees have a working spouse. If employer contributions are tied to specific workers, a complex tracking system must be established to assure that combined employer/employee/government contributions cover the premium costs for each family. Administrative mechanisms for determining and enforcing accurate subsidy payments to firms and to low-income families also must be developed, including adjustments for changes in family income, family composition, and employment arrangements.

Regressivity and inequities. Employer and employee premium mandates maintain the current regressive insurance financing base. Even in light of income-related premium caps for firms and individuals, the portion of income the premium consumes declines as income rises. Premium mandates also mean that families with dependents will pay more of their income for coverage than will single-person households with the same income.

### Individual Premium Mandates

Existing congressional proposals that would mandate individual purchase of health insurance do so through premium mandates. Individual premium mandates, such as those proposed by Senator Chafee, would require all legal
residents to purchase health insurance either directly or by participating in group plans provided by employers. The Chafee proposal would provide full public premium subsidies for the poor and partial premium subsidies for families with incomes up to 240 percent of poverty.

Avoidance of new burdens on business. The primary advantage of individual mandates is avoidance of new burdens on business or adverse employment effects. For business, the cost of labor remains unchanged if families are required to purchase coverage directly.

Severed link between insurance coverage and employment status. To achieve universal coverage, individual premium mandates must also establish insurance administrative structures independent of employment status. The Chafee plan would keep coverage employment-based by requiring employers to offer, but not pay for, coverage. However, individual mandates could be designed to provide a more secure insurance base for coverage. The wide variety of coverage options includes buying the uninsured into Medicare or Medicaid or new private insurance purchasing pools.

Substantial federal subsidies to make insurance affordable. If coverage is to be universal, individual premium mandates must include substantial federal subsidies. Even if subsidies could be restricted to those now lacking insurance, full or partial subsidies to low- and middle-income families would be needed to make premiums affordable.

Analysis of the Chafee proposal illustrates the problem. At present, twenty-three million poor or near-poor persons are uninsured, and six million purchase at least some insurance themselves. Assuming that all would become eligible for public subsidies, an individual mandate would add twenty-nine million people to the twenty-one million already receiving public subsidies, according to our estimates.

Full vouchers for the working poor, however, would encourage employers now paying for a share of premiums to drop coverage. Even if employers were required to cover all employees equally, employers could provide incentives for workers to turn down employer-paid coverage in favor of public subsidies. For sliding-scale as well as full-subsidy families, employers would have an incentive to lower employer-paid contribution rates and shift costs to public programs. If employers reduced premium contributions for all currently insured low-income workers, an additional twenty-two million persons would be eligible for public subsidies, for a total of seventy-two million. New incentives to drop coverage are likely to accelerate the ongoing erosion in voluntary employer-financed coverage.

Regressivity and high marginal tax rates. Individual premium mandates are highly regressive. For example, a sliding-scale subsidy to 240 percent of poverty for family coverage would mean that a family of three earning $28,500 would pay 13 percent of its income for health insurance,
while families earning $95,000 or more would pay less than 5 percent (assuming a benefit package similar to that in the Clinton plan).

If premium subsidies are phased out over a fairly narrow income range (up to 240 percent of poverty under the Chafee plan), sliding scales impose high marginal tax rates as incomes increase. For example, under the Chafee proposal, as low-income families worked their way out of poverty, they would pay nearly one out of every four dollars in wage increases for health premiums. On top of the existing federal income and payroll taxes, mandates would mean a cumulative marginal tax rate of more than 50 percent for low-income families, not counting the loss of benefits such as food stamps or earned income credits, or increases in state or local taxes. Such policies work against current federal and state efforts to remove disincentives to work and to relieve tax burdens on those who can barely buy necessities without welfare.

**Inequality.** Individual premium mandates also would treat households with the same income differently depending on family status. At current premium rates, an individual would pay a maximum of about $2,000, while a family of three would pay nearly $4,000. Premiums also would differ depending on whether persons lived in a high- or low-cost medical care market. Most important, an individual mandate that assumes employers that now insure would continue to do so leaves major inequities among firms in the same industry or in the same area. Firms that voluntarily provide coverage are at a disadvantage relative to those that do not.

**Difficulty of enforcement.** Policies that require the uninsured to buy insurance are likely to be difficult to enforce. Mandates would require low- and middle-income families to pay regular premiums amounting to a substantial share of family income. Mandates would apply to the homeless and others with unstable work and family situations. Delinquency and failure to pay are likely to be regular problems. Unless insurance coverage were continuous regardless of whether families met premium obligations, enforcement difficulties could undermine the goal of universal coverage.

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**Tax Financing Options**

The policy decision to make universal coverage mandatory is at its core a decision to share the costs of health care across society. Like universal public education, universal health care coverage sets a moral standard and a community commitment to provide access to a basic necessity in a modern economy.

Alternatives to employer or individual premium mandates lie in a variety of tax financing options. Alone or in combination with some form of premium mandate, they could minimize or eliminate some of the disavant-
tages of “head tax” premium mandates while building on current financing mixes. For example, converting flat premium contributions into a “payroll premium” tax, with an 80 percent employer and 20 percent employee share, could continue employment-based financing. Private business expenditures for group health insurance premiums now amount to roughly 7–8 percent of total private wages and salaries. Employee contributions to private insurance amount to an additional 2 percent (counting purchases of individual policies by the self-employed).\textsuperscript{14} A conversion to a 9 or 10 percent payroll premium tax shared by employers and workers on an eighty-twenty basis would retain current levels of employment-based spending in the aggregate, although redistribution among firms would occur. Income-related premium taxes could be used to finance coverage for nonworking individuals and families. General tax revenues or a portion of the payroll premium tax and income-related premium taxes could subsidize coverage for the poor. Alternatively, there could be a mix of a premium mandate for full-time employees of large firms and payroll premium taxes for all part-time, temporary, and contractual workers.

Income-related contributions collected from employers and families could be deposited in private purchasing pools similar to those proposed by the Clinton plan or could pay to extend Medicare-like coverage to all. An intermediate option would cover everyone under a Medicare-type plan financed by payroll taxes for workers and income taxes on nonworkers; employers could opt out of their payroll tax obligation by purchasing comparable coverage privately.\textsuperscript{15}

**Insurance stability and security.** Income-related contributions or tax mandates require insurance coverage strategies that break the link between employer financing and administration of insurance. While such severance is possible with employer premium mandates, financing based on wage and other income rather than employment status drives structural decisions toward administrative mechanisms that pool purchase of coverage in a way that does not change when people change work or family status.

**Regressivity and equity.** Tax mandates offer a less regressive route toward universality than does premium financing. By moving away from a flat premium per person, or head tax, and instead relating contributions directly to ability to pay, a tax option could distribute costs more equitably across income classes and low- and higher-wage firms than either employer or individual premium mandates could. At the same time, by relating contributions to income at the outset and thus directly addressing ability to pay, tax mandates avoid the need for complex subsidy arrangements. Single-person and family households with the same income would pay similar amounts. Health costs for dependents would be shared through a common pool of funds to cover services. Employers and families would not
be penalized for being in high-cost health care areas.

**Labor-market efficiency.** Premium financing, whether mandatory or voluntary, gives employers an incentive to discriminate among employees by personal characteristics likely to be related to higher health costs. Employers can reduce fringe benefit costs by hiring and retaining single, younger employees and by avoiding workers with families, single-parent families, older workers, women of child-bearing age, pregnant women, and workers with other characteristics likely to require health care. Premium financing based on employment also gives employers an incentive to use temporary, seasonal, or part-time workers or independent contractors. Employers thus can shift health insurance obligations off corporate budgets and onto family budgets or other employers.

Tax mandates based on payroll, income, or other broad-based taxes would minimize these incentives. In particular, payroll-related contributions should make employers less sensitive to whether workers work part or full time or on a temporary or permanent basis. A payroll-based mandate should eliminate concerns about the personal health characteristics of employees that are not related to productivity.

**Horizontal equity.** Tax-based strategies also spread health costs more equally across firms, thereby removing competitive advantages based on location or employee characteristics. In addition, they can narrow differentials that develop because older, stable companies tend to have more retirees relative to current employees than do start-up firms or firms that have recently relocated.

**Administrative enforceability.** Tax mandates rely on existing tax collection procedures to enforce financing obligations. Thus, employer withholdings from wage and salary payrolls would provide an enforceable base with which to finance health insurance. For low-income families and transient workers, collection mechanisms are likely to be less complex than those associated with premium mandate strategies.

**Distributional changes.** Distributional swings from current financing are the primary disadvantage for tax financing. The percentage of payroll that business contributes for health insurance now varies widely across industries and across firms within an industry. Workers similarly find that widely disparate shares of their total compensation go to health fringe benefits and that compensation rates vary by hour and by employment arrangements within the same company. Thus, even if tax mandates were set near the current averages, new premiums related to wage and salary bases would produce transitional swings in the distribution of labor costs.

**Perception of tax increase and on-budget federal costs.** Popular misconceptions regarding the amounts paid for premiums, and the difficulty of understanding that hidden “taxes” subsidize care for others, create a percep-
tion that conversion of existing premium payments to more tax-like, income-related contributions would be an increase in taxes even if total expenditures remained the same. These perceptions add to the appeal of premium mandates or individual mandates. In addition, even if collections were paid out to state regional funds or quasi-private purchasing alliances or trust funds, conversion of financing to a mix including tax-like mandates might be counted as new on-budget federal costs.

Reaching Consensus

As this discussion of the advantages and disadvantages illustrates, financing universal coverage is likely to require a mixed approach that weighs social, economic, and political concerns. The goal must be to determine a mix that is equitable, has a minimal burden on the economy, is easy to administer, and assures stable coverage. Phasing can ease transitional issues such as redistribution of costs among employers and families.

One attractive alternative is to build on the current mix of employer coverage and Medicare. The uninsured could automatically be covered by Medicare, if they were not otherwise covered. Employers that do not finance coverage for workers could be required to contribute either a flat premium per worker or a payroll tax to Medicare. Uninsured families also could be assessed an income-related contribution for Medicare coverage administered through the personal income tax. This would achieve universal coverage, assure an equitable basis of financing, be relatively easy to administer since it builds on the current Medicare program and tax collection system, and provide minimum disruption to current private insurance coverage. In the short term, Medicare would be open only to the uninsured but eventually could provide an option for coverage for all, including current Medicaid beneficiaries and workers now covered through their employer.

Regardless of the mix of financing chosen, achieving universal coverage quickly is an important policy priority. Each year the voluntary employment foundation of our current insurance system deteriorates further, and efforts to cope create an ever more complex mix of hidden taxes and cross-subsidies. We now have an opportunity to move to a new, more secure health system and to correct health financing policies that are more an accident of history than the result of explicit policies.

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NOTES

1. Employer-based health insurance today covers just over half of the U.S. population (55 percent). Another 8 percent purchase health insurance individually. About one in five Americans are covered by public programs—Medicare and Medicaid.


4. While Medicaid is an important source of health insurance coverage for low-income Americans, it has significant gaps. Thirty-four states have eligibility levels that are less than half the federal poverty level. Because of categorical restrictions, 46 percent of the poor and only 10 percent of the near-poor (with incomes between the poverty level and twice the poverty level) have Medicaid coverage. House Energy and Commerce Subcommittee on Health and Environment, Medicaid Source Book: Background Data and Analysis (Washington: U.S. Government Printing Office, January 1993).

5. Of the poor, more than half are in families in which someone works at least part time or part of the year. Of the near-poor, five out of six are in such families.


7. EBRI, Sources of Health Insurance and Characteristics of the Uninsured.


9. Any legal requirement that residents and businesses participate and pay for a service is to some extent a “tax.” This paper refers to required flat payments per person or family or head taxes as premiums and wage- or income-related contributions as taxes.

10. Subsidies would apply to working families with incomes up to 150 percent of poverty and to nonworking families with incomes up to 250 percent of poverty. The income-related cap under the Clinton proposal is 3.9 percent for income under $40,000.


12. There is a serious question whether sufficient savings could be found in Medicare and Medicaid to finance coverage for both working and nonworking low-income individuals and families eligible for subsidies.

