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The Dedicated VAT Solution

By Victor R. Fuchs and John B. Shoven

The National Commission on Fiscal Responsibility and Reform, co-chaired by former Clinton White House Chief of Staff Erskine Bowles and former Republican Senate Whip Alan Simpson, faces two over-riding problems. First, it must find a new source of revenue for the federal government, a source that is relatively stable, produces substantial proceeds, and does not create large disincentives for employment, saving, and investment. Second, it must bring the rate of growth of health care spending closer to the rate of growth of the rest of the economy. The gap over the last 30 years, 2.8 percent per annum, is unsustainable. As Alice Rivlin, a member of the new commission, has said, “Long-run fiscal policy is health policy.”¹ Control of health expenditures will require comprehensive

change in the way the country finances and delivers health care. A value-added tax (VAT) dedicated to funding basic health care for all through enrollment in accountable care organizations would help solve the revenue and health spending problems at the same time.

A VAT, by itself, has much to recommend it. Unlike a payroll tax, it does not discriminate against employment. Unlike the income tax, it taxes only consumption, not saving. The base (consumer expenditures) is more stable than payroll or income over the business cycle and is large enough to provide a substantial yield at a relatively modest rate. While it is not immune to evasion or avoidance, a VAT is not as vulnerable to these problems as the income tax.

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¹ Alice M. Rivlin. *Perspective On the Long-Run Fiscal Outlook*. SIEPR Policy Brief, July 2007. Stanford University, Stanford, CA.

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One objection to the VAT that is often raised is that it tends to be regressive. But if the VAT were dedicated to funding universal health care vouchers, the combination would clearly be progressive. Lower income individuals would get the same benefits (basic, high quality health insurance) as those with higher incomes, even though they consume less and, therefore, pay less tax via the VAT. The voucher would entitle each individual to choose an accountable care organization that assumes responsibility for delivering a defined set of health insurance benefits. The plan would be paid a risk-adjusted flat fee per enrollee, i.e., the payment would depend on age, gender, past health history, and other predictors of utilization but would be fixed for a particular participant for the coverage year. Given risk adjustment, plans would have less incentive to “cherry pick” or “lemon drop.” Given a risk-adjusted fixed price for all plans in the same region, they would compete on the basis of service and quality of care. Every plan would be required to accept all applicants. Enrollees would be free to switch plans annually. They would also be free to buy more than the basic plan with their own after-tax dollars. Switzerland and the Netherlands have successfully implemented health plans with similar features. Australia is proposing to dedicate a fixed percentage of the revenue from a general sales tax to fund all public hospitals.

Advantages of the Dedicated VAT

The advantages of this approach to funding and organizing health care are numerous and compelling. Liberals should appreciate the fact that everyone is insured for basic care. Even with the passage of the 2010 health bill it is unlikely that current policies will produce anything close to universal coverage. Implicit subsidies to the poor and sick (the difference between the value of the insurance to the individual and the amount of VAT paid) would adjust automatically with changes in income or health status. The bureaucratic hassle of Medicaid would be completely eliminated. Individuals would not risk losing their insurance coverage or having to switch to a different health plan as a result of a change in employment, income, health status, marital status, or any other characteristic. Everyone would bear a fair share of health care costs in proportion to consumption.

Conservatives should appreciate the fact that elimination of employer-sponsored insurance would sharply reduce administrative costs and bring in at least \$200 billion in tax proceeds that the government currently loses through the tax exemption of employer contributions to premiums. The mechanism of collecting the extra \$200 billion would be that as employers get out of the business of paying compensation in terms of untaxed health benefits, labor

market competition would force them to increase taxable wages and salaries. With the same overall compensation levels, the change in the composition of compensation would increase income tax proceeds by the \$200 billion unless Congress lowered tax rates and returned the money to taxpayers in a deficit neutral manner. Labor markets would work more efficiently: Workers would not be locked into jobs and a major source of labor-management friction would be eliminated. State governments would be freed from the administrative and financial burden of Medicaid and related programs. Moreover, we suggest that the VAT could be used only to fund the health insurance voucher program and the program can use only the VAT as the source of funding. Thus, if the public and Congress want to increase benefits, they must be willing to support a higher tax rate. No deficits would be allowed. The well-known political resistance to tax increases would cause everyone to search long and hard for ways to control costs.

Physicians and hospitals would appreciate the fact that all patients have insurance. The inefficient and inequitable system of uncompensated care would be unnecessary. Finally and importantly, a small portion of the yield from the VAT could fund an institute for the assessment of new medical technologies. Such an institute would weigh the benefits and costs of new drugs, procedures, devices, and equipment. An

independent institute with an assured source of funding is essential for slowing the rate of growth of health care expenditures without cutting off real progress in medical care.

There is growing support for a VAT across the political spectrum. If enacted alone, however, it would pour money into general revenues without any direct impact on expenditures. By contrast, if dedicated to fund a universal health voucher program, all the advantages of a VAT remain, and it becomes the basis for badly needed control of health care costs. Thus, the Commission could meet its two most important objectives with one policy.

VATs in the Real World

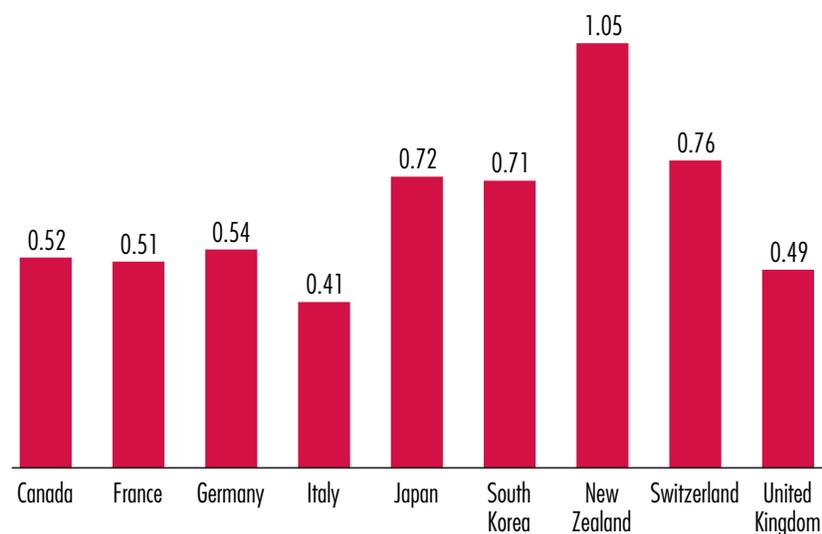
All value-added taxes are not created equal, and those

that exist in other countries seldom resemble their textbook counterparts. While the theoretical base is total consumption, there always is pressure to exempt items such as food, children's clothing, rent, financial services, education spending, and postal services. These exemptions should be minimized.

Figure 1 shows the actual revenue of the VAT in several countries relative to what the revenue would have been if the standard rate applied to all consumption as in the textbooks. For several leading countries such as Canada, France, Germany, and the U.K., the VAT brings in roughly half as much revenue as it would if it had been applied to all consumption. There is another group of countries (Japan, South Korea, and Switzerland)

where the revenue collected is between 70 and 75 percent of the theoretical level. New Zealand has implemented a VAT that taxes all or almost all of consumption. The reason that New Zealand actually collects slightly more than it would if it applied to all consumption is that the tax is applied to investments in residential housing, which are not included in aggregate consumption. If the United States adopts a VAT, it would be economically desirable that we have the tax broadly applicable like New Zealand. If we cannot do that, and we have our doubts that we can, we should at least aspire to be as efficient as Switzerland and collect 75 percent of the theoretical revenues. It would be a terrible mistake to implement the tax in the way that Canada, France, Germany, and the U.K. have, where effectively only half of consumption is taxed. If you only tax half of consumption, you must double the rate in order to raise the required revenue. High tax rates, even high VAT tax rates, lead to serious economic inefficiencies. Exempting some items has other bad economic consequences. It leads some firms to distort production and marketing in order to take advantage of exemptions.

Figure 1
Ratio of VAT Revenue to Potential VAT Revenue



Source: Figures are the 2005 numbers from Table 3.14 of Consumption Tax Trends 2008, OECD

A U.S. VAT Dedicated to Health Care Spending

What VAT rate would be necessary to finance all federal

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government spending on health care? The answer depends on two things—how the VAT is designed (like New Zealand or Switzerland or like Canada) and whether and how our suggestion of universal basic health insurance vouchers is, in fact, implemented. Currently, health care accounts for about 25 percent of federal spending or roughly 6.4 percent of GDP. This spending is financed by the Medicare payroll tax and general government revenues (the personal and corporate income tax and, more realistically, by part of the deficit). If we were to implement a VAT that is as efficient at raising revenue as that of Japan, South Korea, and Switzerland, we would need a 13 percent rate just to fund the current level of federal health spending. You get to the 13 percent figure by recognizing that consumption is about 70 percent of GDP, and a VAT like Japan, South Korea, or Switzerland would effectively tax 70 percent of consumption meaning that the effective base is about half of GDP and that the rate needs to be twice the fraction of GDP to be raised. If we followed the better New Zealand VAT model, an 8 percent rate would fund all current federal spending on health care.

Of course, we suggest a complete overhaul of federal health programs with an immediate replacement of Medicaid and the ultimate

replacement of Medicare (and the replacement of the employer-sponsored health insurance system) with universal vouchers for enrollment in private health plans. The federal government spending on health care would clearly increase, but the degree to which it would increase would depend on the details of the voucher plan. Because of that, the following calculations should be treated as preliminary and approximate. Ezekiel Emanuel and Victor Fuchs² estimated that providing a high quality universal voucher for the entire non-Medicare population would cost about 6.5 percent of GDP. Current Medicare recipients would be allowed to stay on the current program and that costs just about 3.5 percent of GDP. While we think that it is important to allow current Medicare enrollees the choice to stay with their current plan, we would eliminate the 2.9 percent Medicare payroll tax and replace the funding with part of the VAT proceeds. We take that position to break the feeling of future entitlements that the payroll tax conveys to all American workers. We expect that the new program would spend roughly the same amount on the Medicare population. The bottom line of all these percentages is that a universal health insurance voucher system with existing Medicare recipients being permitted to keep the current program would cost the federal government just about 10 percent of GDP.

This gives us the ballpark target for the necessary revenue from the VAT that would pay for all federal spending on health care. Raising 10 percent of GDP would require a 14 percent VAT rate if we followed the example of New Zealand; more realistically, we would need a 20 percent rate if we followed the examples of Japan, South Korea, and Switzerland. These are high rates indeed. It is important to remember that we spend this much and more on health care now; it is just that the means of paying for it are diverse and hidden. The dedicated VAT would make our extremely large health tax readily apparent and salient.

If we introduced a VAT to pay for all federal health spending, other taxes could be reduced or eliminated. The 2.9 percent Medicare tax, which applies to an unlimited amount of labor income, would be history. The personal income tax revenue would grow by \$200 billion or roughly 20 percent. Federal general revenues would no longer be responsible for Medicare Part B and Part D and the federal share of Medicaid would also be eliminated. This would allow for a major reduction in income tax rates or for deficits to be significantly reduced. State budgets and state taxpayers would be huge beneficiaries. One of the biggest ticket items in state budgets is the contribution to Medicaid. There would be no Medicaid under universal health vouchers and

² Ezekiel J. Emanuel and Victor R. Fuchs. *A Comprehensive Cure: Universal Health Care Vouchers*. *The Hamilton Project Discussion Paper 2007-11*, July 2007. Brookings Institution, Washington, DC.

therefore there would be no state expense for this purpose. Once again, state income taxes and sales taxes could and probably should be reduced. Then there is the fact that most Americans would get a pay raise if their employer stopped contributing large percentages of their compensation to health insurance. Social Security recipients, whose benefits are adjusted for inflation, would get a benefit increase to offset the impact of the VAT on retail prices.

The Efficiency Gains from Dedicated VAT Financing of Universal Health Care

The bottom line to remember is that we are not

proposing to spend more on health insurance than we do now. In fact, the changes we propose in the financing and delivery of care would result in spending considerably less. Only a universal plan such as described in this brief can achieve countrywide reductions in the inefficiencies in financing, organization, and delivery of health care.

Table 1 breaks down the potential cost reductions from real health reform of this type. There would be many channels of improved efficiencies. Significant savings would be realized in the sales, claims processing, underwriting, and administrative expense

areas. We estimate that these efficiencies would reduce health spending by a minimum of 10 percent. In addition, the universal voucher/accountable care organization structure would result in significant savings in the organization and delivery of care. We estimate that the largest single category of saving would come from the reduction in overutilization incentives inherent in the fee-for-service model of Medicare and most employer-sponsored plans today. The voucher/accountable care organization structure with risk-adjusted payments per plan year would result in much less overutilization, more efficient use of specialized personnel and equipment, and application of information technology and other modern management methods to reduce the cost and improve the quality of care.³

These are not merely speculative hopes or claims. Every one of the sources of cost reduction listed in Table 1 has already been proved by one or more health care organizations in various parts of the country. Unfortunately, under existing systems of financing and delivering care, there are considerable barriers to their widespread diffusion. Health care, unlike most industries, is primarily a locally produced product that does not enjoy large economies of scale. Thus, even when an organization

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Table 1
Percentage Reductions in total health spending associated with VAT-Financed Universal Health Vouchers

	Potential Cost Reductions in %
FINANCING OF CARE	
Marketing and Sales	4 to 7
Claims Submission and Processing	3 to 5
Underwriting and Other Administration	3 to 5
Subtotal	10 to 17
ORGANIZATION AND DELIVERY OF CARE	
Elimination of overutilization related to FFS	7 to 12
Improved efficiency of specialized personnel and equipment	3 to 5
IT and other management tools	3 to 5
Subtotal	13 to 22
Grand total of potential cost saving	23 to 39

³ Stephen M. Shortell, Lawrence P. Casalino, and Elliott S. Fisher. "How The Center For Medicare And Medicaid Innovation Should Test Accountable Care Organizations," *Health Affairs*, vol. 29, no. 4, July 2010, pp. 1293-1298.

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introduces a more efficient way to organize and deliver care, the incentives and possibilities that would bring about the spread of the innovation over the country or force other health care organizations in other parts of the country to adopt the more efficient methods are weak or non-existent. Moreover, even as a health care deliverer becomes more efficient at producing health care, there is little that it can do to improve the current inefficient and inequitable system of financing health care—an expensive mixture of employment-based insurance, income-tested insurance (e.g., Medicaid), individual insurance, and uncompensated care.

Figure 2 contrasts the current cost of health in the United States with what it would cost under the most conservative of the efficiency gains listed in Table 1 under the structure we propose. In 2009, the United

States spent 17.2 percent of GDP on health care, significantly more than any other country in the world. Figure 2 shows that private sector (individual Americans and corporations) paid 8.8 percent of GDP and governments (federal, state, and local) spent 8.4 percent of GDP. Individual Americans, both directly and as present and future taxpayers, paid for the full 17.2 percent of GDP.

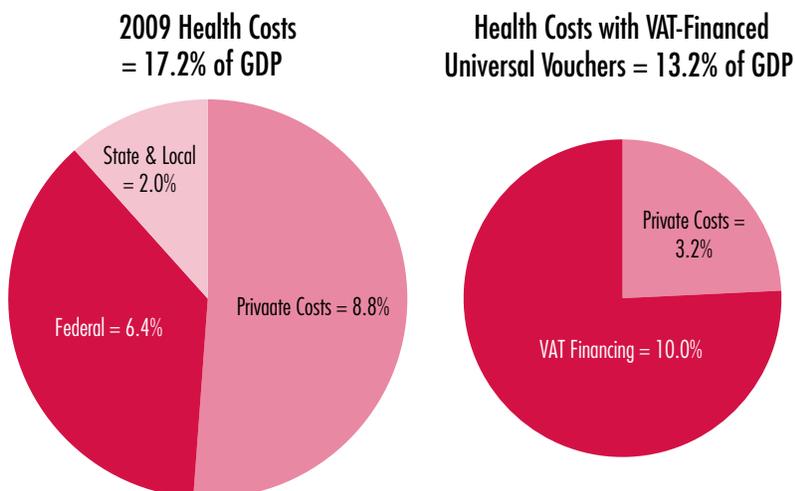
We are proposing a rather radical reform—VAT financed universal medical vouchers. Our best guess is that the cost savings resulting from the better incentives of everyone being attached to accountable care organizations and the reduced administrative and sales expenses would amount to at least 4 percent of GDP. It is this health care efficiency gain that makes this radical reform worthwhile. Four percent of GDP is roughly \$550 billion per

year. We could use half of the health cost savings to reduce the long-term deficit and still enjoy an immediate improvement in our standard of living. This 4 percent of GDP efficiency gain doesn't even count the efficiency improvement associated with partially switching from income taxation to consumption taxation. These are the gains that should attract the interest of the National Commission on Fiscal Responsibility and Reform.

Linking the VAT and federal health spending is a key first step in controlling federal health spending; it puts it on a budget and makes budget increases politically painful. A dedicated VAT would do just that. So-called general revenue financing hides the cost of federal health programs today. The federal support for Medicaid, Medicare parts B and D, and the Veterans Hospital system, for instance, are all paid out of general revenues. General revenues have to come from present and future taxpayers. In the end, Americans are paying all of the costs.

To illustrate why a dedicated tax would tend to restrain health spending consider the 2003 decision to introduce drug benefits for Medicare participants (Medicare Part D). The new program is definitely attractive to seniors with the federal government paying 75 percent of the cost of the insurance and participants paying 25 percent of the cost. Now, ask yourself, how was that new benefit paid for? What tax was increased in order to provide this new benefit beginning in 2004 (an

Figure 2
Health Costs as Percent of GDP, Public & Private Shares, in 2009 & Under Dedicated VAT



election year)? The answer is that no tax was increased. The American public can be forgiven for thinking that this valuable new benefit was provided for free—new benefits and no new taxes! It is pretty easy politically to vote to improve benefits without voting to increase taxes. Now, consider what would have happened if all federal health spending had to come from the revenues of a VAT. Just for concreteness, say that the Congressional Budget Office determined that the 18 percent VAT would have to be increased to 20 percent in order to pay for the new benefit. These numbers are only illustrative, but now members of Congress and the White House would have to weigh the value of the new benefits against the economic and political cost of increasing taxes. But, this is exactly what our government should do before it spends any of our money—compare the costs with the benefits. One can be sure that improving benefits would be much more difficult if the cost of doing so was out in the open instead of hidden within the pool of general revenues and the federal deficit. We think that

better decisions would be made if the extra costs were tied to the extra spending.

Health care costs are pretty much out of control. We spend a grand total of 17.2 percent of GDP on health care (much more than any other country) and that total is expected to push upward toward 20 percent in the not too distant future. What could possibly get us off this spending path? The first step is to highlight how much we are spending now. The “sticker shock” of a 20 percent VAT will do just that. The search for cheaper solutions will begin in earnest once we put health spending on a budget. The VAT’s revenue, at a constant rate, will only grow as fast as GDP. Efforts to contain health spending to the growth rate of GDP will really get serious if the alternative is the politically tough alternative of raising taxes.

Summary

- The National Commission on Fiscal Responsibility and Reform must find a new source of revenue for the federal government and must
- slow the rate of growth of health care expenditures.
- It is time to eliminate the confusion, the hidden and inefficient ways that we pay for federal health care.
- A value-added tax (VAT) dedicated to funding basic health care for all through enrollment in accountable care organizations would address the revenue and health care problems at the same time.
- The accountable care organizations should be paid a risk-adjusted capitation fee per enrollee.
- The VAT revenue should be used only to fund health care and should be the only source of funding for that program.
- To be most effective, the base for the VAT should be very broad, not loaded with exemptions.
- This approach serves both liberal and conservative goals by providing universal coverage, cost control, and deficit reduction.

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