

The Politics Of Paying For Health Reform: Zombies, Payroll Taxes, And The Holy Grail

There can be no universal coverage without health care financing reform.

by **Jonathan Oberlander**

ABSTRACT: This paper analyzes the politics of paying for health care reform. It surveys the political strengths and weaknesses of major options to fund universal coverage and explores obstacles to changing how the United States finances health care. Finding a politically viable means to finance universal coverage remains a central barrier to enacting health reform. [*Health Affairs* 27, no. 6 (2008): w544–w555 (published online 21 October 2008; 10.1377/hlthaff.27.6.w544)]

HOW SHOULD WE PAY FOR HEALTH REFORM? That question has long defied any easy answers. It at first appears to be a straightforward issue—where to find the \$120 billion a year it would cost to cover the uninsured?¹ But it inevitably opens up a Pandora's box of politically explosive issues: who should pay for reform? How (much) should they pay? Who will emerge as the financial winners and losers? And how should the financing system be restructured? Reform proposals that seek ambitious system overhauls, so that universal coverage is funded through savings rather than additional spending, cannot evade these dilemmas. Such plans (for example, single payer) hold out the promise of health reform that pays for itself, yet they still require politically daunting changes in the financing status quo and the flow of medical dollars.

Funding universal coverage, then, means introducing new funding sources and redistributing existing ones in a \$2 trillion economic sector, and that triggers debates over taxes, the economy, and budgets. And therein lies a major reason why comprehensive health reform perennially fails in the United States: reformers have yet to fashion a politically acceptable solution for funding universal coverage that can win those debates. Indeed, the Clinton administration's ill-fated Health Secu-

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rity Act imploded during 1993–94 largely because the administration could not secure a congressional majority for its financing strategy.

This paper explores the politics of paying for health reform. I begin by briefly sketching out the political environment for financing reform. Next, I analyze the political feasibility of available funding options for universal coverage. Finally, I discuss the implications for health reform in 2009 and beyond.

The Political Context

Health reformers looking for new revenues to pay for universal coverage face a difficult political environment. For starters, it is worth highlighting the status quo since it has proven so resistant to change. The United States currently finances medical care through a mix of public and private sources, via a wide array of funding instruments including employer- and employee-paid health insurance premiums, earmarked payroll taxes, federal and state general revenues, so-called sin taxes, and out-of-pocket payments.

That mix is far from ideal, but it is politically entrenched. Key constituencies, such as workers with employer-sponsored insurance, are accustomed to and benefit from (or believe that they benefit from) current arrangements, making dramatic shifts in health financing difficult. That those arrangements (including cost shifting and the tax subsidy for employer-sponsored insurance) are often implicit and invisible makes rationalizing U.S. health financing through explicit, visible payment mechanisms that much harder.

Moreover, universal coverage requires raising new revenues from existing sources or introducing new taxes, yet tax increases have not come easily in recent decades. The 1993 Clinton budget plan that increased taxes won enactment only after Vice President Al Gore broke a tie in the Senate; President George H.W. Bush faced a backlash from the Republican party after abandoning his “no new taxes” pledge in 1990 to support deficit reduction legislation. Antitax ideology continues to shape American politics and limit health financing options.

Even if taxes are raised, health reformers will have to compete for revenues (and political attention) in coming years with everything from the Wall Street bailout and extending tax cuts to spending on the wars in Iraq and Afghanistan. And the long-term budget outlook is for sizable federal deficits that could further constrain efforts to pay for universal coverage.

Finally, pay-as-you-go (PAYGO) budgeting rules in Congress complicate efforts to finance universal coverage. PAYGO requires that new mandatory spending and revenue laws must be budget-neutral, with the costs of any new spending or tax cuts offset through higher taxes or spending cuts.

PAYGO consequently means that proposals to expand coverage must be paid for with real revenues and real savings. During the 1990s, PAYGO gave the Congressional Budget Office (CBO) a prominent role in health policy making, as the entity that scored different reform proposals’ fiscal impact.² If PAYGO results in a

similar process during the next administration, the temptation for reformers to count savings from “cutting waste” or “improving quality” and other laudable but vague aims with uncertain fiscal consequences could run head-on into the CBO’s preference for savings that can be credibly scored. As a recent CBO report on health information technology (IT) illustrates, popular reform ideas might not score as well as proponents hope.³

The Financing Menu

I now turn to a political analysis of major options for funding universal coverage. A few caveats: I am primarily concerned with political feasibility rather than the desirability and economic efficiency of financing options, which have been evaluated elsewhere.⁴ Economic claims play an important role in health reform debates, since reforms’ projected economic impact affects judgments about their viability. But how to refinance American health care is ultimately a political decision. No funding scheme will be adopted on the basis of economic merit alone—a reality our current, crazy-quilt financing arrangements make abundantly clear.

Second, the options presented here are not necessarily mutually exclusive. Real-life health reform plans can and do combine various funding alternatives listed separately in this menu. Third, my focus is on the federal government, not states, which face a somewhat different set of financing choices (state coverage expansions such as that in Massachusetts, in fact, depend on federal dollars). Finally, this paper explores options for funding universal coverage, but clearly that is a contested goal.

The Holy Grail: Tax Treatment Of Health Insurance

The first place many health reformers look for funds to cover the uninsured is the tax code. The tax exclusion for employer-sponsored insurance presents a particularly inviting target. Advocates contend that reforming the tax exclusion could generate funds for expanded coverage, slow health spending, and make health financing more equitable. It is little wonder, then, that for more than two decades policymakers and analysts have entertained the idea of capping or eliminating the tax subsidy for employer coverage. Such proposals have been a staple of conservative health reforms since the Reagan administration, including 2008 Republican presidential nominee Sen. John McCain’s proposal to replace the tax exclusion with a refundable tax credit. Although this reform is usually identified with conservatives, some liberals might also support reducing the tax subsidy if savings were dedicated to financing universal coverage.

Limiting the exclusion for employer coverage is an appealing funding option because so much revenue is at stake. The tax exclusion costs state and federal governments more than \$200 billion in forgone revenues a year.⁵ Capping the exclusion at about \$4,000 for individuals and \$11,000 for families would generate an estimated \$1 trillion in revenues over the next decade.⁶ Eliminating the exclusion

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altogether would generate \$3.6 trillion in revenues over that same time period.

The subsidy is also regressive, with its benefits disproportionately accruing to higher-income workers. In 2004, the tax expenditure on health benefits averaged \$2,780 for families with incomes of \$100,000 or more, but only \$102 for families with incomes below \$10,000.⁷ The redistributive argument is compelling: why not redirect the money now spent on a regressive subsidy toward the progressive cause of covering the uninsured?

Many analysts also believe that the subsidy encourages employers and workers to purchase overly generous, expensive insurance policies, leading to greater use of services and higher health care spending.⁸ Limiting the exclusion is consequently a form of cost control, although the potential of tax-subsidy changes to slow health spending is highly uncertain.

The tax exclusion for employer coverage thus offers a seemingly irresistible pot of money: its \$200 billion prize is more than enough to pay for universal coverage. To date, however, it has proved to be the political equivalent of fools' gold. When middle-class, insured Americans think about health reform, what they have in mind is not a proposal to make their health insurance benefits subject to taxation. Many tax-subsidy beneficiaries probably don't understand how it works or even know that it exists, but proposals to tax health insurance could get their attention in a hurry.

The “Cadillac coverage” that some health policy analysts rail against is not an insurance policy that most Americans would recognize as their own. There is not much of a popular constituency (outside of economists) for health reform that taxes health insurance to induce less comprehensive coverage. And because insurance premiums reflect the risk profile of different employer groups as well as regional differences in medical care prices and practice patterns, proposals to tax so-called gold-plated plans that do not, in reality, offer especially generous coverage could trigger opposition from people in (and politicians representing) higher-cost geographic areas and insurance pools.⁹

In addition, unions that have fought long and hard to maintain health benefits will likely fight any policy that imposes a health insurance tax on their membership. And despite their distaste for the current system, many employers oppose eliminating the exclusion and moving away from employer-sponsored coverage.¹⁰ Apparently they prefer maintaining a bad but familiar status quo to embracing more radical reforms that would remake the existing system.

Proposals to eliminate the exclusion are often accompanied by the establishment of a new tax credit or deduction that is indexed to inflation. Although indexing a deduction or credit to the Consumer Price Index rather than medical infla-

tion generates considerable revenues over the long run relative to the current budgetary baseline, a growing tax on health insurance could also anger voters. However, many taxpayers could fare well in the short run under such tax credit systems, which could mitigate their anger (pleasure before pain is, after all, a more attractive political formula than the reverse)—especially if they didn't appreciate the long-term consequences of indexation formulas.

Simply converting the exclusion into tax credits (as Senator McCain has proposed) without accompanying reforms ensuring that insurance is accessible and affordable would not move the United States anywhere near universal coverage. Yet eliminating the exclusion could generate revenues for reform plans that do aim for universal coverage, such as the legislation sponsored by Sen. Ron Wyden (D-OR) and Sen. Robert Bennett (R-UT), which replaces the exclusion with a new health care tax deduction while also proposing insurance market reforms, new purchasing pools, and an individual mandate.

In the end, the sizable revenues available from the tax exclusion represent a grail that, although not impossible to obtain, is not easily taken. Capping the exclusion is surely a more attainable goal than eliminating it, though that limits savings, but “more attainable” does not mean “easily attainable.” The political barriers to greatly altering the employer coverage subsidy remain daunting.

The Zombie: Employer Mandate

There is a familiar litany of problems with employer-sponsored insurance. It is inequitable; leaves many Americans uninsured; promotes “job lock”; does not accommodate part-time, self-employed, and other “new economy” workers; places companies in the burdensome and intrusive position of making health care choices for their employees; and doesn't effectively control costs.¹¹

Nevertheless, an employer mandate has repeatedly emerged as reformers' health financing strategy of choice. Richard Nixon's 1974 reform plan relied on an employer mandate, as did Jimmy Carter's (1979) and Bill Clinton's (1993) national health plans. A modified employer mandate, the “play-or-pay” option, emerged as the favorite reform of many congressional Democrats in the early 1990s and reemerged as the foundation for the health reform plans of 2008 Democratic presidential candidates John Edwards, Hillary Clinton, and Barack Obama. Clearly, the employer mandate enjoys enduring appeal: like a zombie, it is a policy option that simply will not die.¹²

There are substantive advantages to employer-sponsored insurance, including risk pooling. Yet the explanation for employer mandates' persistence in health reform debates has much more to do with perceived political advantages. First, employer coverage has been the cornerstone of the U.S. health system since the 1940s, and despite its erosion, 158 million nonelderly Americans continue to obtain coverage this way. As Lawrence Brown explains, an employer mandate “can wear the halo of incrementalism” by building on the status quo.¹³

Second, an employer mandate privatizes health care financing and thereby makes universal coverage appear possible without resorting to new broad-based taxes—no small advantage in a country with strong antitax politics. The Clinton administration chose to anchor its health plan around an employer mandate largely for this reason. Instead of creating a new direct tax that flows to the government, a mandate finances health insurance through premiums paid by (mostly) employers and employees.

In economic terms, there may be no difference between a mandated employer premium contribution and a payroll tax, especially given the axiom that employers' health care expenses are largely shifted to workers in the form of lower wages. But in political terms, the gap is huge, because many workers believe that employers are paying for their health insurance when they pay the lion's share of premium costs. Employers now pay on average 84 percent of premiums for single coverage and 73 percent for family coverage.¹⁴ Thus, introducing a mandate that requires employer contribution rates in that range maintains the status quo for insured Americans and reinforces the rhetoric of shared responsibility.¹⁵ The (mis)perception that employer-sponsored insurance is paid for by employers remains a large part of employer mandates' political appeal.

Third, an employer mandate could command broad public support. It embodies the idea that employers should help pay for their employees' health insurance, while tapping into cultural notions that workers are deserving beneficiaries of social protections. Well-insured Americans who are satisfied with their employer coverage could look favorably at reforms that reinforce rather than replace the employer-sponsored system.

Like a conventional employer mandate, play-or-pay systems seek to score political points by building on the status quo, drawing on notions of employer responsibility for financing insurance, and preserving a prominent role for private insurance. The play-or-pay version of the employer mandate has an additional advantage: it gives employers a choice between offering coverage and paying a payroll tax. That choice could soften employers' opposition to a mandate, especially if the tax level is set relatively low so that it doesn't seem like a bad option. Opposition can be further softened by exempting small businesses from the mandate or extending subsidies to them.

Yet whatever their advantages, employer mandates—as evidenced by the failure to adopt them into law over the past four decades—also carry political liabilities. An employer mandate imposes compulsory financial obligations on businesses that do not currently provide insurance. Those obligations, as the Clinton administration discovered during 1993–94, can provoke fierce resistance, especially among small businesses, and because much of that resistance is ideological, no amount of subsidies may temper the opposition.

An employer mandate is also vulnerable to arguments that it will hurt the economy, reduce wages, and cost jobs, especially among small businesses (again, the

economic reality could be different, but political perception is what counts here). And even many larger employers that provide insurance will not welcome a government mandate and federal regulation. Moreover, the status quo that an employer mandate builds on is shaky and moving in the wrong direction. In 2007, only 60 percent of all firms offered health benefits, down from 69 percent in 2000.¹⁶ As health care costs increase and the percentage of firms that provide insurance drops even further, the distance that a mandate must cross to achieve universal coverage by compelling all firms to pay for health insurance grows.

Play-or-pay mandates have additional political problems. By establishing a system that calls for creating an employer mandate and a payroll tax, play-or-pay plans potentially take on the political liabilities of both financing options: conservative opponents can argue that play-or-pay simultaneously means a big new tax and a big new mandate on employers. Although payroll taxes have long been a successful foundation for funding Medicare and Social Security, it has become increasingly difficult to raise payroll taxes in recent decades despite these programs' popularity, a sign that they have been caught up in broader antitax currents (indeed, those currents have helped push discussions of payroll tax-funded national health insurance off the political agenda).

In addition, because workers whose companies pay the payroll tax as well as other uninsured people are enrolled in or given access to a government insurance program, play-or-pay plans are subject to the charge that they open a back-door path to national health insurance. If the payroll tax is set low enough so that it is a financially more attractive option for many employers to pay the tax rather than to provide insurance themselves, a sizable shift in enrollment toward public insurance could in fact occur (depending on how insurance options are structured). Public insurance advocates view this possibility as a crucial virtue of play-or-pay models, but opponents see it as a fatal vice that smacks of "government-run health care." Any proposal for a new national health plan under a play-or-pay system will trigger intense opposition.

Finally, the more that play-or-pay systems hold down the payroll tax level and increase subsidies or provide exemptions from the mandate to win political support from small businesses, where the uninsured population is concentrated, the more they require additional funds from sources other than the tax to pay for universal coverage.

The Foreigner: Value-Added Tax

Another alternative to financing universal health insurance is a value-added tax (VAT). VATs have much to recommend. They are broad-based and can generate substantial revenues (their revenue potential helps explain the Clinton administration's interest in them during the last health reform debate as well as the renewed attention they are now drawing from reformers).¹⁷ VATs are compatible with a range of different comprehensive reform plans, from vouchers to single-

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payer national health insurance. And they can be implemented so that the total tax is not a visible part of sales receipts, reducing public hostility.¹⁸ Broad-based consumption taxes are widely used in other industrialized countries: in fact, the United States is now the only country in the Organization for Economic Cooperation and Development (OECD) without a VAT.

Funding the health care system exclusively through an earmarked VAT could also, as Ezekiel Emmanuel and Victor Fuchs argue, promote cost control, because any increase in health care funding that exceeded general economic growth would require explicitly raising the VAT level. A VAT would thus provide a transparent instrument that reflected the public’s willingness to pay more for medical care.¹⁹ And since a VAT-funded health care system would replace employer financing, it could attract support from businesses that, buffeted by rising costs, want to get out of the business of paying for health insurance.

But a VAT faces formidable political barriers. As advocates of the metric system can attest to, widespread use abroad does not necessarily make a foreign innovation—even a sensible one—any easier to import in the United States. The same antitax strain that might keep a VAT from rising too fast could also keep it from being enacted in the first place. Introducing a major new tax to the United States is an extraordinary political task: will members of Congress who are reluctant to raise existing taxes step up to sponsor a VAT that is unfamiliar to the public and whose benefits and economic logic few voters are likely to understand?

Opponents would have a field day attacking the VAT’s alleged economic and administrative impact, warning (regardless of the reality) of escalating consumer prices, excessive tax burdens, and burdensome administrative requirements on businesses. And while the VAT has a potential bipartisan constituency, it also faces bipartisan opposition: conservative Republicans fear its potential as a revenue-raising machine to fund expanded government, while liberal Democrats worry about its distributional impact on lower-income Americans.

Moreover, although a VAT is broad-based, it is not broad enough to serve as the sole financing source for health care. A VAT would raise net revenues equivalent to 0.4 percent of gross domestic product (GDP) for each percentage point of the tax; in 2005, a VAT of 5 percent would have raised an estimated \$250 billion in revenues.²⁰ Given that U.S. health care costs now consume 16 percent of GDP and more than \$2 trillion, it is apparent that it would take a very high VAT—so high as to be politically untenable—to finance all U.S. medical care spending.

Alternatively, a VAT could pay for part of the nation’s health care bill. Excluding the Medicare and Medicaid populations would lower the tab significantly, but such a financing system would still require a double-digit VAT—a prospect few

politicians are eager to embrace. Even a more incremental VAT would ignite considerable controversy, although perhaps as escalating health care costs put more pressure on the federal budget (pressure that will build regardless of whether we expand coverage), the VAT's capacity to generate sizable revenues will improve its political fortunes.

The All-American: General Revenues

Universal coverage could also be funded without any new revenues at all. In theory, the bill could simply be added to the federal budget and to the federal deficit, with the costs of a universal system paid for through general revenues (however, that would require the suspension of PAYGO rules). Before dismissing that proposition as fiscally irresponsible, consider that we have financed a number of recent public policies through deficit financing, including the wars in Afghanistan and Iraq, the Medicare prescription drug benefit, and tax cuts. Apparently, these activities were deemed sufficiently socially (or politically) desirable that they required no dedicated funding or offsetting savings and simply could be added to the federal ledger. However, because the uninsured are evidently not a priority, affordability concerns block their claim on the federal budget.

There are ways to responsibly pay for health reform through general revenues (which finance such all-American programs as education and defense) without adding to the deficit. One is simply to raise more general revenues. And here we find liberals' Holy Grail: paying for universal coverage by rolling back the 2001 and 2003 Bush tax cuts for the wealthy. That option, embraced by Senator Obama, makes health reform explicitly redistributive. Health insurance coverage is funded for mostly low-income Americans by raising taxes on higher-income Americans so that the health care and tax systems are both made fairer in one fell swoop.

There is ample money to be had from canceling the Bush tax cuts: up to \$65 billion a year in additional revenue could be generated from rolling back tax cuts for those subject to the top two tax rates as well as tax rates on capital taxes and dividends. And if policymakers wait until 2010, they don't have to pass new tax increases for the wealthy but can instead just let provisions of the 2001–2003 tax cuts expire. It thus appears that a large share of the universal coverage bill can be paid for without imposing any new broad-based taxes or raising taxes on most Americans.

Unfortunately, that appearance is deceiving. Since the CBO already assumes in its projections that all of the tax cuts will expire at the end of 2010, letting selected provisions expire won't produce any new revenues for health reform that satisfy congressional budget rules.

An alternative way to fund universal coverage without exacerbating the deficit is to find offsetting savings in current programs, namely Medicare and Medicaid. With big, expensive health insurance programs comes the opportunity for big savings, from lower payments to medical providers and health plans, higher pre-

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 mium payments from Medicare beneficiaries, and reductions in the use of high-price services. The federal government has previously demonstrated the capacity to impose Medicare reforms on providers that generate sizable budgetary savings.²¹ This is, in other words, a familiar budgetary option that has a proven track record of attracting bipartisan congressional and presidential support.

But there are downsides. How much money can be squeezed out of Medicare and Medicaid without jeopardizing patients’ access to medical care? Targeting Medicare for savings could cost reformers the support of consumer organizations, Medicare beneficiaries, and advocacy groups like AARP. Targeting Medicaid will raise the ire of states that depend on federal dollars.

Concluding Comments

There are no easy paths to financing universal coverage. All of the major financing options have serious political liabilities; they risk arousing either public opposition and antitax sentiment or stakeholder opposition, or both. And any plan that seeks to displace employer-based financing invites political sticker shock at the visible revenues that must be raised to replace the largely invisible financing system that now exists.

Although proposals for incremental coverage expansions require less revenue than comprehensive plans, that does not mean that they can escape controversy. If modest coverage expansions are linked to bold funding reforms—such as replacing the tax exclusion for employer coverage with a tax credit—they too will trigger conflict. And although modest financing changes, such as increasing cigarette taxes, can attract bipartisan and public support, they cannot raise sufficient funds to pay for bold plans to expand coverage.

However, if adopting a major new revenue source proves politically impossible, there is another financing option: stronger cost control. Indeed, financing and cost control are two sides of the same coin, and the more effectively a reform proposal controls costs, the less it has to rely on new taxes and other financing sources.

This possibility, however, does not solve the political problem, because more cost control means less income for the providers and other stakeholders who will resist proposals to reduce the rate of medical inflation. Promising-sounding targets for savings quickly run into political trouble. For example, reducing geographic variation in health care spending so that high-spending areas more closely resemble low-spending regions is an appealing policy reform, especially since there isn’t much value added for the extra spending.

Yet this reform has precious little political appeal, because it requires taking substantial money away from high-spending regions whose political representa-

tives are far less enthusiastic about reducing variation than health policy analysts are. That politics of redistribution helps explain why we have not made much progress in reducing geographic variations in health spending despite ample documentation of this pattern. Other delivery system reforms (such as redirecting patients to primary care) that promise to deliver big savings similarly require politically daunting changes in the flow of medical dollars. As Henry Aaron notes, universal coverage remains a long-odds proposition not because it “is costly—it isn’t—but because it requires massive shifts in who writes the checks to pay for health care and who cashes those checks.”²²

Given the difficult politics of financing universal coverage and controlling costs, it is no surprise that American politicians put their faith in savings from promoting prevention, improving quality, moving to electronic medical records, reducing waste, and other reforms whose fiscal impact is at a minimum uncertain and, in reality, is probably often overstated. These faith-based cost control strategies might work on the campaign trail, but they are unlikely to pass muster with the CBO in a PAYGO budget process.

Absent a generous CBO score for these strategies, reformers will have to look elsewhere to fund universal coverage. It is possible to combine some of the options discussed here. Jonathan Gruber has argued, for instance, that Democrats’ plan for a play-or-pay mandate should be combined with Republicans’ proposal to eliminate the tax exclusion, although that sort of grand compromise is difficult to envision right now (capping the exclusion offers a more palatable, albeit still difficult, basis for compromise).

THE CHANCES FOR HEALTH REFORM, including financing reform, in 2009 and beyond depend crucially on the 2008 (and future) elections. Financing options that aren’t politically possible now could become more feasible under a new president and Congress. Regardless of how the stars align, though, reformers face a sobering political reality: universal coverage proposals confront many barriers, but financing remains one of the toughest to surmount, and there is no universal coverage without financing reform. Moreover, the next president will take office with a \$400 billion federal deficit that will make raising money for health reform even harder. And as health care costs rise, the challenge of financing universal coverage will only get more difficult.²³

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