

Can We Get There from Here? Universal Health Insurance and the Congressional Budget Process

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“It is so true here that he who frames the question determines the answer.”

—Representative Roscoe Bartlett¹

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1. 153 CONG. REC. H1803 (daily ed. Feb. 16, 2007) (statement of Rep. Bartlett) (It should be noted that Mr. Bartlett was describing the war in Iraq, not the subjects discussed herein).

INTRODUCTION

There is renewed political interest in universal health insurance in America. Massachusetts, California, and a number of other states are considering different forms of legislation.² Presidential candidates from both parties have plans and are discussing them.³ All of this is happening now because the U.S. health insurance system is no longer working for many people for whom it had worked in the past. Employer-sponsored insurance (ESI), the source of most private coverage in the United States, is declining.⁴ Even in those workplaces in which insurance is still being offered, the expenses of premiums and other forms of consumer cost-sharing are rising far more rapidly than wages.⁵

At the same time, there has been renewed interest in the Congress in restoring the budget rules and processes to their pre-2001 strength and centrality.⁶ Between 2001 and 2006, the federal annual deficit has ballooned to near-record levels⁷ and the total federal debt has rocketed beyond \$9 trillion.⁸ The political leadership in the Congress has committed itself to reviving fiscal discipline through these rules and processes.⁹ Opinion leaders have applauded them loudly.¹⁰ In both the House and the Senate, the Pay-as-You-Go (or PAYGO)

2. See Jennifer Steinhauer, *California Plan for Health Care Would Cover All*, N.Y. TIMES, Jan. 9, 2007, at A1.

3. See Robin Toner, *2008 Candidates Vow To Overhaul U.S. Health Care*, N.Y. TIMES, July 6, 2007, at A1.

4. BIANCA DIJULIO & PAUL D. JACOBS, HENRY J. KAISER FAMILY FOUND., CHANGE IN PERCENTAGE OF FAMILIES OFFERED COVERAGE AT WORK, 1998–2005, at 1 (2007), available at <http://www.kff.org/insurance/upload/7667.pdf>.

5. HENRY J. KAISER FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS: 2006 ANNUAL SURVEY 1 (2006), available at <http://kff.org/insurance/7527/upload/7527.pdf>.

6. See H.R. Res. 6, 110th Cong. § 405 (2007) (enacted) (codified at RULES OF THE HOUSE OF REPRESENTATIVES, R. XXI(10), at 35 (2007), available at <http://www.rules.house.gov/ruleprec/110th.pdf>); S. Con. Res. 21, 110th Cong. Title II (2007); 153 CONG. REC. S3308–3312 (daily ed. Mar. 20, 2007) (statement of Sen. Conrad) (describing the inclusion of budget process provisions in the Rules of the Senate for the 110th Congress); JAMES HORNEY, CTR. ON BUDGET & POLICY PRIORITIES, THE SENATE BUDGET COMMITTEE'S BUDGET PLAN: A BRIEF ANALYSIS 1 (2007), available at <http://www.cbpp.org/3-16-07bud.pdf>; see also 153 CONG. REC. H14–15 (daily ed. Jan. 4, 2007) (statement of Rep. Spratt) (describing the inclusion of budget process provisions in the Rules of the House of Representatives for the 110th Congress); RICHARD KOGAN, CTR. ON BUDGET & POLICY PRIORITIES, THE NEW PAY-AS-YOU-GO RULE IN THE HOUSE OF REPRESENTATIVES 1 & n.1 (2007), available at <http://www.cbpp.org/1-12-07bud.pdf>.

7. Tim Westmoreland, *Standard Errors: How Budget Rules Distort Lawmaking*, 95 GEO. L.J. 1555, 1564 n.46 (2007).

8. See Bureau of the Public Debt, U.S. Dep't of the Treasury, *The Debt to the Penny and Who Holds It*, <http://www.treasurydirect.gov/NP/BPDLogin?application=np> (last visited Oct. 8, 2007) (website calculating total public debt outstanding, updated each business day).

9. See, e.g., Press Release, Nancy Pelosi, Democratic Budget Resolution Restores Fiscal Responsibility and Accountability (Mar. 27, 2007), available at <http://www.speaker.gov/newsroom/pressreleases?id=0122>; Press Release, Kent Conrad, Statement by Senator Kent Conrad (D-ND) on Paygo Amendment to the FY 2007 Budget Resolution (Mar. 9, 2006), available at http://budget.senate.gov/democratic/statements/2006/stmt_budgetresolutionmarkuppagoamend030906.pdf.

10. See, e.g., David S. Broder, Editorial, *Democrats' Welcome Discipline*, WASH. POST, Apr. 15, 2007, at B7; Editorial, *Hello Pay-Go*, WASH. POST, Mar. 30, 2007, at A16; Editorial, *The Much-Needed*

rules, and their scorekeeping corollaries, are alive and well and stronger than ever.¹¹ Indeed, these rules have already made new initiatives (including one to expand children's health insurance) more difficult by requiring that new spending be balanced with cuts or new revenues.¹²

This confluence of pressures raises the question of whether legislation to create universal health insurance can survive the current Congressional budget process. Can we get there from here? Virtually any new proposal for coverage will increase federal spending. In an era of budget constraint, how the spending for universal coverage plans is estimated and the ultimate size of that spending will preordain how heavy the political lift will be. Conversely, attempts to reduce the estimated costs of a proposal will allow the budget process to skew the direction of subsequent health policy. In the past, I have spent some time trying to understand and describe what damage the budget rules have done to legislation.¹³ Now we should look forward to try to predict some pitfalls and find ways to avoid them.

Two problems are readily identifiable. First, the budget process systemically favors policies that let sick people die rather than incur future government-financed health costs. Second, the process also structurally favors policies that keep expenses off the federal books by working through mandates rather than spending. Both of these problems should be addressed before the Congress considers universal coverage legislation.

This Essay is laid out in four parts. Part One discusses a few relevant aspects of the Congressional budget process now in place. Part Two explores two elements of that process that distort the budgetary evaluation of health insurance legislation. Part Three compares how several models of universal coverage fare under these procedural elements. Part Four suggests some ways to ameliorate these distortions.

At the outset, I should also point out what this Essay is not. It is not a detailed description of any proposal for universal insurance. It is not a comparison of the effectiveness of such proposals in reaching all uninsured people or in providing them with access to care. Finally, this Essay is in no way an attempt to estimate the costs and values of universal health care proposals. Rather, it is a short illustration of some problems that all such proposals will meet when they confront the budget rules.

Return of Pay-Go, N.Y. TIMES, Mar. 22, 2007, at A24; Editorial, *Who's Afraid of Pay-Go?*, N.Y. TIMES, Apr. 30, 2007, at A20; Press Release, Ctr. on Budget and Policy Priorities, Joint Statement on the Need for Pay-as-You-Go Discipline (Mar. 21, 2007), available at <http://www.cbpp.org/3-21-07bud.htm>.

11. For an example of the strength of the newest iterations of the rules, see the gyrations that the House of Representatives went through to consider legislation to give the District of Columbia voting rights. See H.R. Res. 317, 110th Cong. (2007) (as engrossed).

12. See Jonathan Weisman & Lori Montgomery, *Partisan Payback Over 'Pay-as-You-Go'*, WASH. POST, Aug. 2, 2007, at A6.

13. See generally Westmoreland, *supra* note 7.

I. CURRENT FEDERAL HEALTH SPENDING AND THE BUDGET PROCESS¹⁴

A. OVERVIEW

At its most basic, the Congressional budget process is a set of accounting tools that both allows the Congress to assess overall patterns of revenues and spending, and restrains (although does not totally prevent) the Congress from increasing the debt. All spending is budgeted, although the various forms of spending are treated quite differently. Most grants and contracts for health activities—such as biomedical research or grants to public clinics—are funded through “discretionary spending,” that is, money that is provided on an annual basis by the Congress. It is not guaranteed from year to year and has no pre-set amount. Discretionary spending is not, however, generally used for health insurance programs and is beyond the scope of this brief discussion.

The federal government’s largest health insurance programs—Medicare and Medicaid—are funded through mandatory spending.¹⁵ Briefly put, mandatory spending is an advance statutory commitment that money for a program will not be subject to annual appropriations and will be available when needed. For instance, Title XVIII of the Social Security Act promises that Medicare will pay for all hospital and medical benefits for those people who meet the statutory criteria for eligibility.¹⁶ There is no pre-set amount of spending; instead, there is a prospective promise that payment will be made. The Congress can, of course, amend the statute to expand or reduce the terms of the commitment. Medicare could be expanded to cover prescription drugs.¹⁷ It could be reduced to cover only people at an older age.¹⁸ But whatever the promise in the statute is, money *will* be there to meet its terms.

In addition to these programs, there are also significant subsidies for private health insurance provided through the tax code in a form generally known as “tax spending.” For budget purposes, targeted tax “breaks” (such as deductions, credits, and refundable credits) that help a taxpayer subsidize a specific activity

14. For a more thorough discussion of the budget process, see Westmoreland, *supra* note 7, at 1564–80.

15. The State Children’s Health Insurance Program (SCHIP) is funded through a variant on mandatory spending: mandatory spending up to a legislatively set maximum. See Centers for Medicare & Medicaid Services, Low Cost Health Insurance for Families and Children (Sept. 24, 2007), <http://www.cms.hhs.gov/LowCostHealthInsFamChild/>. Notably, veterans’ health care is not funded through mandatory spending, although there have been repeated calls to change that in the face of regular shortfalls. See The Official Site of Veterans of Foreign Wars of the United States, *Budget Reform Needed for Veterans Health Care*, Nov. 2, 2006, <http://www.vfw.org/index.cfm?fa=news.newsDtl&did=3652&tok=1> (last visited Oct. 8, 2007).

16. 42 U.S.C. §§ 1395(c)–1395(w) (2000).

17. See, e.g., Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 641, 117 Stat. 2066.

18. Raising the age of Medicare eligibility has been regularly discussed as one potential response to the financial problems afflicting the program. See RICHARD W. JOHNSON, URBAN INST., CHANGING THE AGE OF MEDICARE ELIGIBILITY: IMPLICATIONS FOR OLDER ADULTS, EMPLOYERS, AND THE GOVERNMENT 29–35 (2003), available at http://www.urban.org/UploadedPDF/410902_changing_age_medicare.pdf.

are defined as a form of government spending.¹⁹ For deficit-calculation and budgeting purposes, failing to bring money into the Treasury is effectively the same as sending money out of it. Also, as with mandatory spending, tax statutes generally make an advance commitment that the subsidy will be there unless the Congress makes a change in the law.

B. BUDGET LIMITS

Congressional budget rules allow the rate of mandatory spending and tax spending to grow automatically to continue to meet the statutory promise. If the cost of health care grows because of inflation, the spending will automatically grow; likewise, if costs grow because new technologies and drugs become the medical standard of care, the spending will grow also. Without such automatic growth, the promise itself would become eroded and hollowed out, purchasing progressively less of what the statute committed to provide.

Instead of limits on the growth of the programs, budget rules place limits on the ability of the Congress to pass legislation that would increase mandatory spending or tax spending. These limits are generally known as “Pay-as-You-Go” (PAYGO) requirements. PAYGO restricts the Congress to passing only legislation that has a net estimated cost of zero (or less). If a bill would increase spending above the current level,²⁰ the Congress must also pass commensurate reductions in other mandatory or tax spending programs. Alternatively, the Congress could raise revenues to meet the cost of the new spending, but that has been politically unpopular for some time now.

The enforcement of PAYGO is legislatively severe. Any bill that does not have cuts or new revenues equal to its new spending cannot be considered at all by either the House or the Senate.²¹ This means that no matter how popular a measure may be, it cannot even be debated or voted on unless program cuts or tax increases can be passed, too.²²

19. For political and rhetorical purposes the two actions may be quite different. *See* Victor Thurnoyi, *Tax Expenditures: A Reassessment*, 1988 DUKE L.J. 1155, 1178 n.140 (1988) (“[S]ome personal tax deductions including interest paid on home mortgages are being referred to as tax expenditures . . . indicating the idea, it’s the government’s money that they are expending on you—a pretty scary prospect for a country that believes in free enterprise and democracy.” (quoting H. Wells, Remarks at the Meeting of the Business and Commerce Political Action Committee (Feb. 20, 1986)), *reprinted in* 132 CONG. REC. E899 (daily ed. Mar. 20, 1986) (extension of remarks of Rep. Bentley)); *see also* GEN. ACCOUNTING OFFICE, TAX POLICY: TAX EXPENDITURES DESERVE MORE SCRUTINY 2 (1994), *available at* <http://archive.gao.gov/t2pbat3/151813.pdf> (“Some observers believe that labeling these provisions tax ‘expenditures’ implies that all forms of income inherently belong to the government.”).

20. There are many debates about what the “current level” is. *See* Westmoreland, *supra* note 7, at 1569–73.

21. *See* H.R. Res. 6, 110th Cong. § 405 (2007) (enacted) (codified at RULES OF THE HOUSE OF REPRESENTATIVES, R. XXI(10), at 35 (2007), *available at* <http://www.rules.house.gov/ruleprec/110th.pdf>); S. Con. Res. 21, 110th Cong. Title II (2007). This prohibition can be waived by a super-majority of each house, but given the closely divided membership of the current Congress, such super-majorities are unlikely.

22. The debate about the reauthorization of the State Children’s Health Insurance Program that is ongoing as of this writing illustrates these difficulties. Few members of Congress oppose the underlying

The implementation of PAYGO necessarily presupposes a means by which the prospective budgetary effects of legislation can be estimated. The projection of costs and savings from proposed changes is known as “scorekeeping,” and is, for most purposes, done by the Congressional Budget Office (CBO). If legislation is proposed to make a new health service available under Medicare, the CBO estimates the increased costs of this proposal over the expected year-to-year automatic increases. In doing so, the CBO also offsets increases with any expected decreases.²³ For example, if legislation would newly require a drug to be covered by Medicare or Medicaid, the scorekeeping exercise would include both the costs of the drug and any offsetting reductions in the need for hospital care.

The scorekeeping by the CBO of proposed legislation is complex. It involves gathering data, making key assumptions and subsidiary ones, and constructing economic models. For example, even in an estimate as apparently simple as one for an increase in childhood immunization, the CBO would consider the price of vaccines (and how manufacturers might change that price under a large government purchase program), the number of specific products that would be recommended for purchase (and how public health authorities might change their recommendations under a large government purchase program), the uptake rate (that is, the proportion of parents who will get their children immunized), and also any offsetting savings from preventing pediatric illnesses and their consequent medical and hospital costs.

And that is just a simple score. In responding to the recent legislation to create a prescription drug benefit in Medicare, the CBO published a seventy-four-page paper just to describe its methodology.²⁴ Legislation to create a system of universal health insurance will necessarily be several orders of magnitude more complex. But such an estimate nevertheless would be required by the Congressional budget rules in order to meet the PAYGO requirements.

II. SURVIVORS’ COSTS AND SOLIPSISM—OVERINCLUSIVE AND UNDERINCLUSIVE SCORING²⁵

While there are many structures within the budget process that might skew policymaking (for example, short snapshots that discourage long-term investment, the distributive nature of tax spending, etc.), there are two problems that are particularly troubling in their effect on health insurance. The first, Survivors’ Costs, should be regarded as a form of over-inclusive scoring: it counts

program, but a number have voiced their concern about the means to offset this spending; for example, cuts in Medicare spending and increases in tobacco taxes. See Weisman & Montgomery, *supra* note 12.

23. See generally MARTHA COVEN & RICHARD KOGAN, CTR. ON BUDGET & POLICY PRIORITIES, INTRODUCTION TO THE FEDERAL BUDGET PROCESS (2007), available at <http://www.cbpp.org/3-7-03bud.htm>.

24. CONG. BUDGET OFFICE, ISSUES IN DESIGNING A PRESCRIPTION DRUG BENEFIT FOR MEDICARE (2002), available at <http://cbo.gov/ftpdocs/39xx/doc3960/10-30-prescriptiondrug.pdf>.

25. For a more detailed account of CBO scorekeeping systems and their strengths and shortcomings, see Westmoreland, *supra* note 7, at 1592–99.

spending in a manner that is useful for accounting purposes but untenable for moral reasons. The second, solipsism, should be regarded as a form of under-inclusive scoring: it fails to recognize financial benefits to non-government actors.

A. SURVIVORS' COSTS

First, consider Survivors' Costs. Cost analyses in health policy take a very unreconstructed-Scrooge-like view of the value of humanity: people with chronic illnesses, disabilities, or a likelihood of either, "had better [die], and decrease the surplus population."²⁶ It may take many columns of numbers to prove it, but it is almost always cheaper for very sick people to die. In the past, for instance, it was estimated that the value to Medicare of providing a newly licensed, highly effective pneumonia vaccine would be a net cost rather than an overall benefit—not principally because of the vaccine's price but because of the "costs . . . for the treatment of illnesses [other than pneumonia] . . . in extended years of life."²⁷ More recently, CBO counted the same such costs in its scoring of the new Medicare prescription drug benefit, noting, "[T]o the extent that a drug benefit helps people live longer, they may consume more health care over their remaining lifetime than they would have without the benefit."²⁸

These increased costs associated with keeping people alive are known as "Survivors' Costs,"²⁹ and they are undoubtedly real in many instances. They must be estimated to run an insurance program and the administrator should be told to adjust the cash flow on this basis. But, as a part of the scorekeeping process on which PAYGO is based, they have become an on/off switch about whether to consider a policy at all. It is, at best, morally questionable for a health policy decision to be made on this basis. In essence, the consideration of Survivors' Costs penalizes any policy that might keep people with expensive health problems alive.

Moreover, this element is deeply hidden in the overall process of scorekeeping and the overall rhetoric of taxes, spending, and borrowing. It will be difficult to explain how the various elements of any universal coverage are boosted or hobbled by their allocation of the responsibility (and costs) of the care for—or neglect of—the sick.

B. SOLIPSISM

Another counterintuitive effect of scorekeeping that merits attention in the case of universal health insurance proposals is the budget process's totally

26. CHARLES DICKENS, *A CHRISTMAS CAROL* 10 (Holiday House 1983) (1843).

27. See OFFICE OF TECH. ASSESSMENT, *A REVIEW OF SELECTED FEDERAL VACCINE AND IMMUNIZATION POLICIES* 78 (1979), available at <http://www.wws.princeton.edu/ota/disk3/1979/7915/7915.pdf>.

28. CONG. BUDGET OFFICE, *supra* note 24, at 33.

29. See Michael A. Riddiough et al., *Influenza Vaccination: Cost-Effectiveness and Public Policy*, 249 *JAMA* 3189, 3191 (1983); E-mail from Jane Sisk, Professor of Health Policy & Dir., Div. of Health Care Statistics, Nat'l Ctr. for Health Statistics, to Timothy M. Westmoreland, Visiting Professor of Law, Georgetown Univ. Law Ctr. (June 9, 2003) (on file with the author).

inward-looking view of spending, referred to here as solipsism. Budget rules focus only on federal costs and federal savings. There is no estimation of the value of a proposal for the common good or of savings to the private sector. There is some matter-of-fact truth to this view: preventing illness among people who are not federally insured is of no immediate budgetary interest to the government. But if the government makes an investment that has wide benefit beyond its insurance coverage, the savings to other insurers, to hospital emergency rooms, and to individual people go unrecognized. This makes government activities appear artificially expensive. Looking at policy with these budgetary blinders on, the Congress often chooses narrow actions when broad ones would be more valuable and efficient.

Consider a hypothetical example involving the prospect of pandemic influenza, as laid out in Table 1. Let me begin with a full disclaimer: with the exception of the population data and the insurance status of the population, all the assumptions in this example are imaginary; we cannot know the probabilities of getting pandemic flu until the strain emerges; we cannot know the price or effectiveness of the vaccine until it is developed. Having said that, the hypothetical illustrates the problem of solipsism clearly. Additional real-life complexities—including partial effectiveness of the vaccine, less-than-perfect immunization rates, cost-sharing, federal-state administration of Medicaid, and lowered productivity from absenteeism—all are likely to be true, but they do not alter the main point of PAYGO and solipsism that can be seen readily in this stripped-down version.

The base for comparison is a pandemic flu epidemic with no vaccine. Assuming that all people with full-blown illness get treated, the result for the nation is thirty-one million cases of flu at a treatment cost of \$85 billion. Assuming only a 10% mortality rate, there are 3.1 million deaths.

In Scenario 1, there is—God willing—sufficient warning of the epidemic's onset that a vaccine can be developed and the federal government can purchase it for all Americans. The cost to the federal government of the vaccine purchase is \$81 billion, and the result for the nation is no cases of flu and no deaths.

Overall, this would seem like a very good outcome: zero cases of flu and a nationwide savings of \$4 billion. But from a federal PAYGO perspective it is not so good. In the base, the government expenditure is only \$29 billion. Spending \$81 billion for vaccine—a net cost of \$52 billion—looks like a very bad deal for the government. The budget rules do not allow for offsetting savings for any foregone treatment costs to either the privately insured or the uninsured public. Only federal costs—or savings—count.

So, a Congress guided by PAYGO will move on to Scenario 2. The government buys only the vaccine for those people for whose hospital bills it will be liable. Likewise, the private sector will buy vaccine only for its own. But no one

Table 1.

	Popula- tion (in mil- lions)	Vac- cinees (in mil- lions)	Cost of Vac- cina- tion	Total Vac- cination Cost (in millions)	Cases of Flu (in millions)	Cost of Treat- ment	Total Flu Treat- ment Costs (in millions)	Total Costs (in millions)
Base: Flu Epidemic								
Total	310	0	\$260	\$0	30	\$2,750.00	\$85,250	\$85,250
Priv. Ins.	160	0			16		\$44,000	\$44,000
Gvt. Ins.	105	0			10.5		\$28,875	\$28,875
Unins.	45	0			4.5		\$12,375	\$12,375
Scenario 1: Federal Purchase of Vaccine for All								
Total	310	310	\$260	\$80,600	0		\$0	\$80,600
Priv. Ins.	160	160		\$41,600	0		\$0	\$0
Gvt. Ins.	105	105		\$27,300	0		\$0	\$80,600
Unins.	45	45		\$11,700	0		\$0	\$0
Scenario 2: Federal Purchase of Vaccine for Only Gov't Insured								
Total	310	265	\$275	\$72,875	4.5	\$2,750	\$12,375	\$85,250
Priv. Ins.	160	160		\$44,000	0		\$0	\$44,000
Gvt. Ins.	105	105		\$28,875	0		\$0	\$28,875
Unins.	45	0		0	4.5		\$12,375	\$12,375
Assumptions								
Vaccine Cost	\$250							
Vaccine Admin Cost								
Scenario 1	\$10							
Scenario 2	\$25							
Probability of Flu if Unvaccinated	10%							
Probability of Death from Flu	10%							
Probability of Flu if Vaccinated	0%							

buys vaccine for the uninsured.³⁰

The result is an overall cost of \$85 billion—only \$29 billion of which is incurred by the government. This is a perfect PAYGO. The costs of vaccine and administration are perfectly offset by the treatment costs foregone. The same is true for the private sector. But, because the uninsured are not immunized, there will be 4.5 million cases of flu at a treatment cost of \$12 billion, most of which will undoubtedly be paid through hospital emergency rooms and uncompen-

30. The first predictable outcome is that administrative costs will go up. In a universal purchase program, no one has to spend time looking up eligibility and seeking reimbursement; a public health nurse or doctor simply gives out pre-paid shots. But in a selective program, trying to separate the eligible from the ineligible costs money.

sated care. There are also 450,000 deaths.

In sum, the careful application of PAYGO in this hypothetical produces an outcome that costs the nation billions more than a mass immunization campaign and also allows for a good-sized epidemic. What a bargain. But in this every-man-for-himself-and-devil-take-the-hindmost view, that is the best outcome for the government.³¹

C. EFFECTS

The clear result of these two problems is that the budget process itself is capable of overwhelming more sensible health policy—even in the relatively transparent realm of immunization policy, an intervention that has been shown repeatedly to be both beneficial and cost-effective.³² Survivors' Costs would drive policymakers to pay for fewer vaccines for Americans who are elderly or disabled. Solipsism would drive policymakers to pay for fewer vaccines for anyone not in a federal insurance program. Neither immunization policy would likely be the considered judgment of health experts,³³ but when facing program cuts or tax increases, they would certainly be the paths of less resistance. If these two budget structures distort a policy as straightforward as immunization, imagine what they can do to those decisions that are hard. (And remember that there are many other strange factors in the budget process that are beyond the scope of this article.³⁴)

III. UNIVERSAL HEALTH INSURANCE MODELS AND OVERINCLUSIVE AND UNDERINCLUSIVE SCORING

There is little question that universal health coverage, at least initially, will require new funding. One could reasonably ask whether fifteen to twenty percent of the nation's gross domestic product might be enough if it were allocated more rationally, but that reallocation will certainly take a long time to accomplish.

But the estimate of *how much* new funding will be required will be a make-or-break matter when Congress begins comparing different models of health insurance. Politicians are always reluctant to create new taxes; politicians have been even more so recently. But, with PAYGO in place, each incremental cost must be accompanied by an incremental cut in other mandatory spending programs or by an incremental hike in taxes. Using only the two artifacts of PAYGO discussed here, however, we can see that this is neither a transparent

31. Indeed, one could argue that the outcome displayed on the chart actually illustrates the entire U.S. health system in a nutshell: a drive toward minimizing individual costs produces a higher collective cost and more illness.

32. Cf. INST. OF MED., FINANCING VACCINES IN THE 21ST CENTURY: ASSURING ACCESS AND AVAILABILITY 27–29 (2004).

33. Cf. *id.* at 39–62.

34. See generally Westmoreland, *supra* note 7, at 1556, 1580–1602 (discussing the unseen forces that produce seemingly inexplicable legislative choices).

nor a neutral exercise. Survivors' Costs and solipsism are devils in the details, and they will exercise a strong skewing toward one plan over another. These two structures will make any aspect of a program that keeps elderly and disabled people alive or that adds people to public programs appear to be more expensive. The greater the apparent expense, the more program cuts or tax increases PAYGO will require. The more program cuts or tax increases a proposal includes, the more difficult its passage will be. And the more difficult the passage, the higher the likelihood that health policy will be tailored to respond to the budget structures rather than to public health and medical needs.

On top of these problems, however, the skewing effects of these budget rules are not evenhanded. Different insurance structures incur different costs under the budget process—not because they keep more or fewer people alive but because of how the plans are set up.

Consider three different models of health insurance being discussed (with almost endless variations, many of them quite important): “Single-payor,” “Employer mandate,” and tax-credit-based “Health Savings Accounts” (HSAs).

Single-payor is what is usually referred to as “national health insurance,” a model in which the government becomes the sole provider of insurance. This is perhaps made clearer in the vernacular as “Medicare for all.”

Employer mandate is a system in which each employer is required to provide health insurance to its employees or to pay into a common pool from which its employees can seek insurance; individual employees are also required to buy insurance, much like drivers are required to buy car insurance. The government usually serves as a back-up plan for the unemployed and for those for whom private insurance is too expensive. A version of employer mandate is being set up in Massachusetts now.³⁵

Health Savings Accounts are essentially two plans in one package. The first plan consists of IRA-like personal savings accounts that are funded by tax-favored contributions (usually pre-tax income, although some proposals for refundable credits have also been made).³⁶ These savings are to be used, at the account holder's discretion, to buy most primary care. Second, these accounts are accompanied by high-deductible private health insurance policies for unusually high expenses.³⁷ To be truly universal, HSAs would have to include some form of government assistance to help people with low incomes purchase these

35. See 2006 Mass. Legis. Serv. 1484 (West) (enacted Oct. 26, 2006) (discussed in HENRY J. KAISER FAMILY FOUND., MASSACHUSETTS HEALTH CARE REFORM PLAN: AN UPDATE (2007), available at <http://www.kff.org/uninsured/upload/7494-02.pdf>).

36. See U.S. Dep't of the Treasury, HSA Frequently Asked Questions: The Basics of HSAs, http://www.ustreas.gov/offices/public-affairs/hsa/faq_basics.shtml; see also BOB LYKE, CONG. RESEARCH SERV., HEALTH SAVINGS ACCOUNTS: SOME CURRENT POLICY ISSUES 5 (Order Code RS22437, May 5, 2006), available at http://openers.cdt.org/rpts/RS22437_20060505.pdf (noting that President Bush proposed a “small refundable income tax credit to offset employment taxes on HSA contributions not made by the employer”).

37. There are proposals for HSAs without the accompanying high-deductible policy. These are not insurance, they are savings, and they are not addressed here.

policies.

Consider how these three models are differentially affected by Survivors' Costs and solipsism. For purposes of this discussion, this article will assume, in passing, that Medicare and Medicaid are retained, essentially unchanged, and that the reach of the proposals is only to those who are currently insured privately or who are currently uninsured.

A. THE SINGLE-PAYOR MODEL

Single-payor will produce the largest Survivors' Costs for PAYGO consideration. All successful efforts to keep people with chronic illnesses, disabilities or other expense-producing conditions alive count as future government spending and will score as added future expense to the system. Under PAYGO, these expenses must be offset with either cuts to existing programs or new taxes at the time of enactment.

Moreover, because of solipsism, the financial relief experienced by employers and individuals who are now paying billions for insurance will not count fully as offsets. Under current law, the tax spending for employer-sponsored insurance is only a percentage of the full cost of insurance. Consequently, if it is replaced by a single-payor plan, the reductions in tax spending will only partially offset the cost. Because of these rules, single-payor will be estimated to be very expensive, indeed. (One small silver lining would be that savings from future public health initiatives (such as Scenario 1, above) will always score as part of the budget.)

B. THE EMPLOYER-MANDATE MODEL

The employer-mandate model will have a somewhat easier time of it than the single-payor model. The health costs of most people will never make it onto the federal books; instead, they will stay a private matter. Consequently, Survivors' Costs will be small, arising as a federal budget matter only on behalf of those people who enter the government-financed backup plan for the unemployed or those for whom employer-based insurance is too expensive. Even in this instance, Survivors' Costs will stretch only for as long as it is estimated that a person remains in the back-up plan, and will end if the person returns to employer-sponsored insurance.

Likewise, this plan differs little from the current system in the way of solipsism. Public investments, such as a flu vaccine, will still not be scored for their private benefits. It is possible that some scorekeepers might see solipsism in this instance as actually producing savings for the government: the proposal will provide an ongoing private source of insurance for people who might otherwise have eventually impoverished themselves to Medicaid-eligible levels. This insurance is an expense, but not a government expense.

C. THE HSA MODEL

Finally, consider the HSA model and its budget treatment. To some extent, it

is an amalgam of a single-payor system (in this case, the Internal Revenue Service financing care through foregone tax revenue) and a personal mandate (since the tax status of the HSA is predicated on the purchase of the high-deductible insurance plan). To the extent that it reaches all Americans,³⁸ it would incur Survivors' Costs in the form of consumers spending from their HSAs during the years that their lives have been extended by access to health care. These costs, however, will only partially be government costs. By its nature, tax spending is discounted or limited by the tax liability of the taxpayer. For instance, if a taxpayer with a \$300 tax liability spends \$1,000 from her tax-credited HSA, the government loss is only \$300 and the taxpayer is personally absorbing the remaining \$700. Thus, Survivors' Costs for the affluent are totally government expenses, while most of those for low- or middle-income individuals are borne by the taxpayers themselves. Since most taxpayers are in the latter groups,³⁹ the HSA model would incur much fewer Survivors' Costs than would single-payor.

In addition, in some cases there would also be expenditures from the high-deductible policies that are subsidized by the government for low-income people. To the extent that individuals spend their HSAs every year in the future and begin using this insurance, there would be Survivors' Costs, which would be reflected in future premium increases. To the extent that the insurance pool includes government and non-government payors, these costs would be scored as being lower than in the parallel single-payor insurance model because the private payors would absorb them as well. If the insurance plans are government-only plans, the costs would be similar to those in a single-payor model, with the obvious exception of the costs of the high deductible.

The HSA model would only be affected by solipsism to the extent that the after-tax costs are borne by the taxpayer. In a system based on a truly refundable credit, all cost-saving innovations (such as universal flu immunization) would be scored as government savings in the form of reduced tax spending. If, however, the system is based on a tax deduction or a non-refundable tax credit, such cost-savings would be only partially reflected as government savings, again limited by the tax liability of the individual. Thus, the value of vaccinating affluent people would be reflected as savings in the budget, but the value of vaccinating middle-class and low-income people would not be.

In sum, if appropriately structured, all three models could provide universal coverage. While there are myriad debates about incentives and efficiencies, all three would be paying the same bills. In a PAYGO estimate, however, they

38. There are distributional effects of relying on the tax code that are beyond the scope of this Essay. The form of the tax-spending here makes a great difference. Tax deductions and credits are far more valuable to affluent people than to low-income people. See Westmoreland, *supra* note 7, at 1590. A refundable tax credit, however, might actually reach the low-income population, the group that now has the lowest rate of health insurance.

39. See U.S. CENSUS BUREAU, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2006, at 29–35 (2007), available at <http://www.census.gov/prod/2007pubs/p60-233.pdf>.

would appear to have radically different costs to the government. Single-payor would count all Survivors' Costs as government costs and yet include none of the offsetting savings from relieving employers and insurers of paying for insurance. Employer-mandate would keep most Survivors' Costs off the government's books as well as most offsetting savings. HSA accounts would incur costs and savings in proportion to how progressive the tax treatment of the accounts is; likewise, the accompanying high-deductible insurance would be scored in proportion to the extent its expenses are pooled with private payors.

As a result, the budget process itself will not be neutral about the form that universal coverage takes. Not only does it include the structural problems of favoring the death of sick people and ignoring broad investments in health, but it allocates them differently depending on the insurance model. There are many debates to be had about the structure of insurance in the United States, but surely the budget rules should not be the ultimate—and invisible—arbiter.

IV. HOW TO FRAME THE QUESTION BETTER

The budget process was originally created as a tool to help the Congress raise and spend money systematically and to help it set priorities.⁴⁰ It was supposed to help the Congress frame financial questions. Over its history, however, it has evolved into a force in itself. It has re-ordered much of the legislative process and structurally skewed decisionmaking. As the nation heads toward possible restructuring of its health insurance system to create universal coverage, the budget process threatens to do so again.

This need not be so. It is, after all, a tool—not a Constitutional principle or a core value. If the process does not help frame the question, it can be re-tooled. In this brief overview, two potential problems have been outlined. Both represent true accounting issues: if people do not die, they will likely incur more health costs in the future; if investments produce savings to payors other than the government, the government does not directly receive financial benefit. Anyone keeping the books on an insurance program would need to take these into account.

However, when they are embedded in a decision about whether legislation can be considered, they create policy perversions. Consequently, they should be sidestepped in policy development whenever possible.

A. SIDESTEPPING SURVIVORS' COSTS

The distortions of Survivors' Costs should be most directly avoided in policy development. In the future, the PAYGO process should simply not include Survivors' Costs. Legislation should be allowed to be considered and voted on not only if it is budget-neutral, but also if it adds costs to the deficit that arise because more people are kept alive. The use of Survivors' Costs is immoral, and

40. Westmoreland, *supra* note 7, at 1561.

their concealed use in the estimating process is anti-democratic camouflage. Using such estimates to slow policies because they keep people—especially low-income, chronically ill and disabled people—alive is a form of involuntary euthanasia.

Moreover, no member of Congress openly opposes legislation because it keeps people alive. The decision to stop legislation because it keeps people alive should not be hidden among tables of numbers and footnotes about assumptions.

This is not to say that Survivors' Costs should not be a part of scorekeeping. They will eventually have to be paid in order to keep the insurance system solvent. But these costs should not be part of the on/off switch of whether legislation can be debated or not. A bill that is budget-neutral except for its Survivors' Costs should be allowed to proceed. If the eventual need to raise revenues or cut costs to pay that bill is a reason for a member to oppose legislation, then at least she should have to say it outright as part of an open debate, rather than relying on PAYGO to prevent the discussion.

B. PUTTING SOLIPSISM IN CONTEXT

The problem of solipsism can also be addressed, although not so cleanly avoided. It arises because of the genuine need to define which expenses will be the government's responsibility, and which will not. But as a question-framing tool, the budget process could be improved by going beyond that definition alone. The budget process should recognize that public decisions can have private consequences for individuals, employers, insurers, and the nation. The most obvious way to take account of those consequences in scorekeeping on health insurance proposals is to produce not just an estimate of government spending, but also one of national spending on health care. If that were done, the Congress could appreciate that overall spending under different proposals might be comparable, even if the source of spending were different.

This is, in fact, already done, albeit not by the Congress. It is called the National Health Expenditures Accounts, and it includes all health spending in the United States—not just federal payments but also those by other levels of government, of businesses, and of households.⁴¹ Indeed, when the Congressional Budget Office studied the Clinton Health Reform Plan in 1994, it used National Health Expenditures as its base of comparison.⁴²

Again, this is not to say that estimates should not be made specifically about federal expenses. Rather, these estimates should be placed in the context of all expenses. If this were done, even as the Congress considers increasing federal expenses, it could see that it was also reducing expenses for businesses or

41. U.S. Dep't of Health & Human Servs., National Health Expenditure Data: Overview, <http://www.cms.hhs.gov/NationalHealthExpendData/> (last visited Sept. 12, 2007).

42. CONG. BUDGET OFFICE, AN ANALYSIS OF THE ADMINISTRATION'S HEALTH PROPOSAL 25 (1994), available at <http://www.cbo.gov/ftpdocs/48xx/doc4882/doc07.pdf>.

families. The invisible and unarticulated pressure to act by mandates rather than spending would be revealed. While that would not solve the ultimate PAYGO financing problems of programs that involve a larger role for the federal government, it would perhaps make the issues of raising revenues or finding offsetting cuts somewhat more palatable.

These changes would require changes to the House and Senate rules,⁴³ an action that usually takes place only at the beginning of each two-year Congress. Since it is unlikely that universal coverage will be seriously debated before 2009, there is time to fix these flaws before the flaws begin to distort the future of health insurance.

CONCLUSION

After an extended absence, budget rules have returned to the Congress. Universal health insurance debates are coming. The former threatens to distort the latter in ways that are both unacceptable and invisible. Before that happens, the Congress should revise its budget process to help it frame the questions in a manner that is moral, transparent, and contextual. The health insurance issues are difficult enough without artificially being made more confusing by a tool that was supposed to help make things clearer.

43. *Cf.* RULES OF THE HOUSE OF REPRESENTATIVES, R. XXI(10), at 35 (2007), available at <http://www.rules.house.gov/ruleprec/110th.pdf> (prohibiting the consideration of legislation that would have a net effect of increasing the deficit); S. Con. Res. 21, 110th Cong. § 201(a)(1) (same).