An Update to the Budget and Tax Effects of a Public Option

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ABSTRACT

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In the wake of pandemic spending and recent increases in inflation, a politically realistic public option would increase deficits by $1.23 trillion in its first ten years and eventually surpass Medicaid as the second-largest federal health care program.

Without spending offsets or tax increases, long-term federal debt would rise to 228 percent of GDP, up from 195 percent.

Paying for the public option would require more than doubling the corporate tax rate, increasing the top three income tax rates by one-third, or raising the Medicare Hospital Insurance (HI) payroll tax by over 150 percent. Limiting tax increases to high-earning families would push top marginal income tax rates to over 50 percent. Over the long run, using broad-based revenue increases would raise taxes for middle-income families by $3,400. Recent federal legislation provides further evidence that lawmakers expand health care programs during economic shocks, making it unlikely that premiums would rise as initially proposed.

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INTRODUCTION

A government-run health insurance plan, often called a public option, remains a popular answer to rising health insurance premiums. Proponents promise dramatic savings to individuals and families, while also touting the public option's potential to reduce the federal deficit. Underlying these promises, however, are two unlikely assumptions.

First, public option proposals generally assume that the government will reimburse medical providers and hospitals at rates far below what private insurers pay. Combined with low administrative costs, the reduced reimbursements would allow the government to offer lower premiums than private insurers. This would mean significant premium savings for American families, reduced federal outlays for health care subsidies, and more tax revenue from reduced health premium tax expenditures.

Second, public option proposals assume that enrollees will pay actuarially fair premiums that fully cover the plan's costs. This ensures that taxpayers would not subsidize public option enrollees regardless of actual reimbursement rates.

If both assumptions held, a public option would result in a dramatic shift in enrollment from private health insurance to the government-run plan, disrupting insurance coverage and reducing incomes for doctors and hospitals. Maintaining either of these assumptions, however, is politically unrealistic.

Past congresses have repeatedly enacted health legislation with similar underlying assumptions but have quickly had to walk them back in the face of opposition from interest groups and political opposition. Typically, Congress both raises reimbursement rates faster than expected and caps premium growth at lower rates, leading to direct subsidies. In Church, Heil, and Chen (January 2020), we identified similar political pressures that could undermine the key assumptions of a public option plan. We argued these pressures could eventually lead to a public option plan that bears little resemblance to its initial design. Reimbursement rates would begin at Medicare levels but would rise as providers and hospitals objected and lobbied for higher rates. Likewise, premiums for enrollees would begin at actuarially fair levels but would quickly be subsidized to shield enrollees from higher costs. We call this plan the politically realistic public option.

A broadly available public option would significantly affect the nation's health care system and the federal budget. Thus, policymakers must have a sense of the potential magnitude of these effects, particularly if the plan evolves as past federal health programs have. In Chen, Church, and Heil (October 2020), we estimated a politically realistic public option would increase ten-year non-interest deficits by $792 billion, with even larger deficits after the first decade.

Since 2020, however, there have been significant economic and budget changes that would affect the underlying costs of a politically realistic public option. In light of these changes, this paper offers an update to the earlier score to better inform policymakers about the fiscal risks of a public option.

After accounting for economic and policy changes following the COVID-19 pandemic and the ensuing inflation, we find that a politically realistic public option would increase non-interest deficits by $1.23 trillion over the next ten years (from 2024 to 2033). Without spending offsets or tax increases, long-term federal debt would rise to 228 percent of GDP by 2053, up from 195 percent. Paying for the public option would require more than doubling the corporate tax rate, increasing the top three income tax rates by one-third, or raising the Medicare HI payroll tax by over 150 percent. Limiting tax increases to the top 2.2 million highest-earning families would push top marginal income tax rates to over 50 percent.

Over the long run, using broad-based revenue increases to fund a politically realistic public option would raise taxes for middle-income families by $3,400 or over 16 percent.

The paper is organized as follows:

- **Section I** reviews the underlying assumptions of the public option and the politically realistic public option.
- **Section II** discusses recent legislation that further highlights the likely political pressures Congress would face.
- **Section III** summarizes the results of our earlier estimates.
- **Section IV** reviews the economic and budget changes that could alter our earlier estimates.
- **Section V** provides an update on a politically realistic public option's likely outlay, revenue, and deficit effects.
- **Section VI** reviews potential methods for financing the program.
- **Section VII** provides a conclusion.

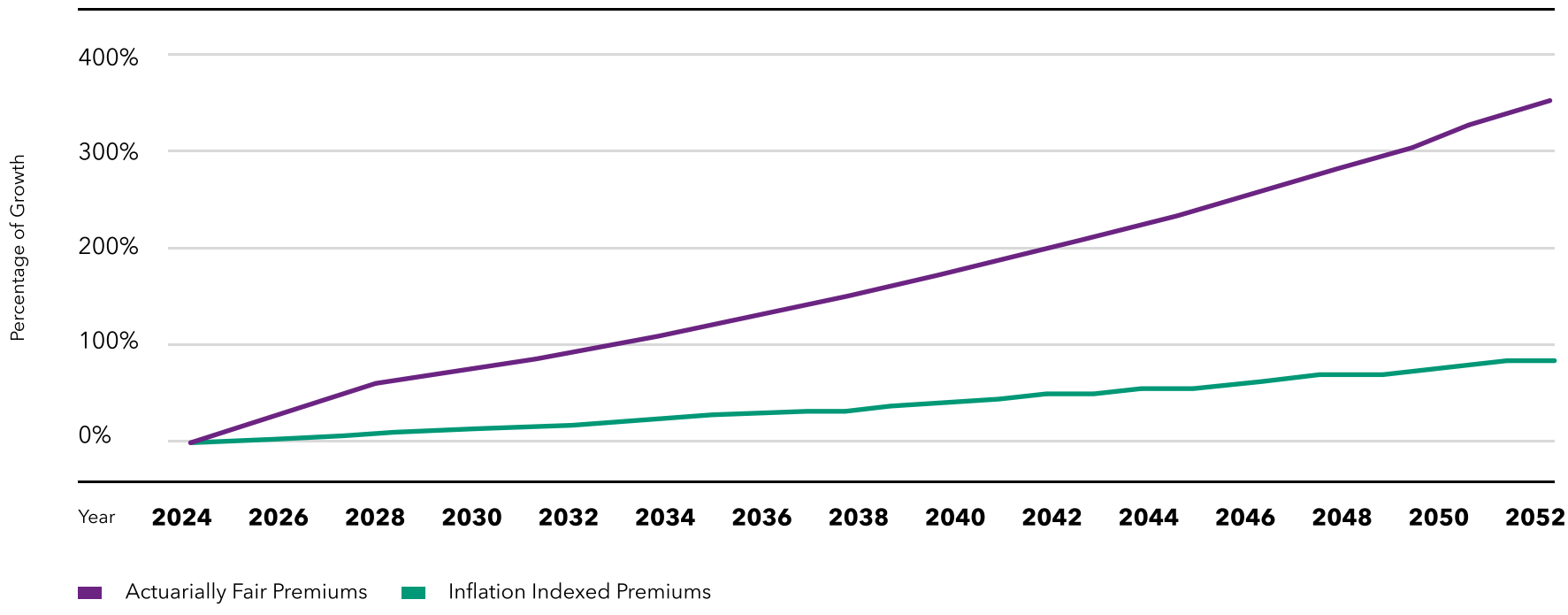
I. THE POLITICALLY REALISTIC PUBLIC OPTION

To lower premiums and reduce budget costs, federal public option proposals assume that enrollees would be charged actuarially fair premiums, and hospitals and providers would be reimbursed at rates below private levels. As discussed in Church, Heil, and Chen (January 2020), the history of federal health care programs suggests that future congresses are unlikely to maintain these assumptions. Instead, they would raise provider reimbursement rates while shielding enrollees from the higher costs. In this paper, we update our estimate of the potential budget effects if such a "politically realistic" public option came to fruition.

Our politically realistic public option assumes Congress enacts a program that initially meets the promises of its supporters.[2] It covers individual, small-group, and large-group health insurance markets. We assume that consumers perceive no differences between a public option plan offered and their private plan options. In other words, the plans' provider networks, cost-sharing rules, and services provided are the same; the only material difference is the premium.[3] Reimbursement rates are set at Medicare-level rates, and premiums are set to cover the program's costs.[4] Quickly (in the second year of enrollment), the reimbursement rates prove unsustainably low. Providers and hospitals lobby Congress or refuse to accept new public option enrollees. The result is that future congresses increase reimbursement rates. In our primary example, we assume reimbursement rates rise to private-level rates over a five-year period.

Because public option plans call for actuarially fair premiums, rising costs would be passed on to enrollees in the form of higher premiums. Thus, all else constant, rising reimbursement rates wouldn't have a significant effect on the federal budget.[5] But again, this is politically unlikely. Rising reimbursement rates would result in large year-

FIGURE 1: GROWTH IN PREMIUMS UNDER ALTERNATIVE ASSUMPTIONS



[2] For a detailed discussion about the assumptions underpinning our politically realistic public option see Church, Heil, and Chen (January 2020).
[3] There are reasons to suspect this would not be the case. For example, Washington state's public option, the Cascade Select Plan, initially required lower cost sharing than private plans. If policymakers are pressured to increase the generosity of the public option (e.g., reduce cost-sharing, providing additional services) and refuse to raise premiums accordingly, the cost of a politically realistic public option plan could be even more expensive than we estimate here. See Carlton, Kahn, and Lee (2021) for more on Washington's public option expansion.
[4] Administrative costs for the public option plan are set at 8.5 percent of total health expenditures. See the appendix in Church, Heil, and Chen (January 2020) for a discussion on how we reach this estimate.
[5] There would be some effect primarily because the higher premiums would increase the value of the tax expenditure for those with employer-sponsored insurance plans.

over-year premium increases for enrollees and lower enrollment totals. Instead, in our politically realistic public option, we assume Congress shields enrollees from these increases and sets the growth in premiums to the rate of inflation. The result is an increasingly costly public option where costs rise much faster than premiums.

As shown in Figure 1, the growth in actuarially fair premiums under a politically realistic public option would far outpace the growth in inflation-indexed premiums. Initially, actuarially fair premiums would need to grow sufficiently to finance both the reimbursement rate increases and the overall increase in expected health costs. If a politically realistic public option began in 2024, actuarially fair premiums in 2028 would need to be 63 percent larger than when they began. In 30 years, inflation-indexed premiums would be 90 percent larger, while actuarially fair premiums would have increased 362 percent.

The fiscal cost of the politically realistic public option comes from the implicit subsidy: the difference between the actual premiums charged to enrollees and the actuarially fair premium needed to break even. As the implicit subsidy grows, more enrollees would choose the public option instead of their private insurance, further increasing the cost of the proposal.

II. RECENT CONGRESSIONAL ACTIONS

The threat of a costly health program that grows to be far more expensive than its proponents intended is not a mere hypothetical. In Church, Heil, and Chen (January 2020), we used the legislative history of Medicare to show how Congress has repeatedly overruled cost-control measures that preceding congresses had enacted.

For example, Congress attempted to control Medicare spending by limiting the program's reimbursement rates to providers and hospitals. Subsequent congresses then undermined these controls by instituting temporary rate increases that shielded providers from scheduled cuts.[6] From 1999 to 2014, Congress regularly enacted "doc fix" legislation that overrode scheduled cuts to physicians under the sustainable growth rate (SGR) formula. By 2015, the "doc fixes" meant that scheduled reimbursement rates under the SGR were 21 percent lower than actual reimbursement rates.[7] Congress finally repealed the SGR in the Medicare Access and Children's Health Insurance Program Reauthorization Act of 2015 (MACRA).

Similarly, in Chen, Church, and Heil (2021), we considered the effects of economic shocks and probable expansions to public options. Using past congressional actions, we showed how political pressures that have led to past increases in federal health spending could lead to similar increases in the long-term costs of a public option.[8]

Recent experience provides further evidence that the assumptions underpinning a low-cost public option are likely unsustainable over the long term. Since 2020, Congress has regularly suspended scheduled cuts to Medicare providers. We discuss these recent changes below.

First, Congress has repeatedly enacted temporary increases in Medicare's physician fee schedule. MACRA substituted the SGR with new scheduled updates for Medicare's physician fee schedule. The act also installed a new incentive-based method for paying providers. When it was passed, MACRA called for a 0.5 percent increase in the fee schedule for July to December 2015. From 2016 to 2019, payments were scheduled to rise 0.5 percent per year. From 2020 to 2024, payments were to remain at a fixed level. From 2015 to 2020, MACRA's schedule growth rates went unaltered by Congress. However, beginning in 2021, Congress has regularly overridden MACRA and increased the fee schedule, raising payments by 3.75 percent in 2021, 3 percent in 2022, 2.5 percent in 2023, and 1.25 percent for 2024.[9]

Second, Congress has repeatedly suspended sequestration cuts that would have reduced Medicare payments by up to 6 percent. In recent years, Congress has attempted to restrain federal spending growth through budget sequestration.[10] The process requires the executive branch to make across-the-board cuts to non-exempt budget accounts when certain budget conditions are met. Two budget sequestration processes can affect Medicare: The Statutory Pay-As-You-Go Act of 2010 (or Statutory PAYGO) and the mandatory sequestration process under the

[6] Beyond the SGR, Church, Heil, and Chen (January 2020) highlighted other historical examples of Congress overriding reduced-physician reimbursement rates. In 2013 and 2014, for example, Congress offered enhanced subsidies to states to temporarily raise reimbursement rates for primary care physicians serving Medicaid. For an overview, see page 14.

[7] See page 3 in Hahn and Blom (2015).

[8] Specifically, we considered three stylized shocks. First, we considered a freeze on premiums for public option enrollees in response to a recession. Second, we modeled premium freezes for unemployed enrollees both in expansionary and recessionary climates. Third, we estimated costs if medical inflation grew faster than expected.

[9] The Consolidated Appropriations Act of 2021 (P.L. 116-260, Division N, Title 1, Section 101) raised all provider payments by 3.75 percent for 2021. The Protecting Medicare and American Farmers from Sequester Cuts Act of 2022 enacted a temporary 3 percent increase for 2022 (P.L. 117-71, Section 3). The Consolidated Appropriations Act of 2023 (P.L. 117-322, Section 4112) followed with a 2.5 percent update for 2023 and a 1.25 percent update for 2024.

[10] For an overview of sequestration rules affecting Medicare, see CRS (2022).

Budget Control Act of 2011. Unsurprisingly, Congress has repeatedly suspended or reduced the scheduled cuts to shield providers and hospitals from cuts to their reimbursement rates.

The Statutory Pay-As-You-Go Act of 2010 aimed to prevent Congress from enacting legislation affecting mandatory spending or revenue that added to the federal deficit. Under the act, legislation that adds to five- or ten-year federal deficits triggers a required budget sequestration to all mandatory spending except Social Security, federal tax credits, Veterans Affairs programs, and several smaller programs. While Medicare is not exempt, Statutory PAYGO limits Medicare sequestration to a 4 percent cut for benefit payments to hospitals, providers, and insurers receiving payments under the Medicare Advantage program.[11]

Since the act's passage, Congress has generally avoided Statutory PAYGO by including provisions in deficit-increasing legislation that exclude the legislation's deficit from the Statutory PAYGO scorecards. In 2021, however, Congress enacted the American Rescue Plan Act of 2021 (ARPA) without any exempting language, meaning ARPA's $2 trillion deficit spending was added to the five- and ten-year Statutory PAYGO scorecards. Consequently, Medicare was scheduled to cut benefit payments by 4 percent in January 2022. In December 2021, under pressure from providers and hospital groups, Congress suspended the sequester, transferring the scorecard balances to 2023.[12] They did so again in December of the following year, transferring the scorecard balances for 2023 and 2024 to 2025.[13]

Similarly, the Budget Control Act of 2011 established the Joint Select Committee on Deficit Reduction to identify at least $1.23 trillion in deficit reductions from FY2012 to FY2021. When the Joint Committee failed to deliver these reductions, the result was a mandatory sequestration of the same amount over the ten-year period. Much like the Statutory PAYGO experience, Medicare sequestration cuts were limited, in this case to 2 percent. Over the last decade, Congresses repeatedly extended the mandatory sequestration to offset legislative increases in other spending. As a result, Medicare faces sequestration through 2032.

Since the beginning of the COVID-19 emergency, Congress has repeatedly suspended the mandatory sequestration orders. The Coronavirus Aid, Relief, and Economic Security Act (CARES) of 2020 suspended the sequestration through December 2021.[14] The Protecting Medicare and American Farmers from Sequester Cuts Act extended the suspension of the sequestration cuts through March 2022 and then capped the cuts at 1 percent through June 2022.[15] The Congressional Budget Office (CBO) (2021) expected this would raise federal outlays by $5.9 billion in FY2022 and FY2023.

The political case for suspending sequestration and temporarily increasing the physician fee schedule is similar to the arguments made during the regular "doc fix" debates.

In 2021, a bipartisan group in Congress sent a letter to House leaders noting that between the two sequestrations and the expiration of 3.75 percent update to Medicare's physician fee schedule, providers were facing a year-over-year cut of "at least 9 percent." They argued that "these cuts will strain our health care system and jeopardize patient access to medically necessary services."[16]

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[11] Not all of Medicare is protect by the 4 percent cap. Administrative costs are subject to the same sequestration percentage affecting other mandatory budget accounts.
[12] The Protecting Medicare and American Farmers from Sequester Cuts Act, P.L. 117-71, Section 7. Available at: https://www.congress.gov/117/plaws/publ71/PLAW-117publ71.pdf.
[13] Consolidated Appropriations Act of 2023, P.L. 117-328, Title X, Section 1001. Available at: https://www.congress.gov/bill/117th-congress/house-bill/2617.
[14] P.L. 116-136, Section 3709. Available at: https://www.congress.gov/bill/116th-congress/house-bill/748/text.
[15] P.L. 117-71, Section 2. Available at: https://www.congress.gov/117/plaws/publ71/PLAW-117publ71.pdf.
[16] See https://bera.house.gov/media-center/press-releases/reps-bera-and-bucshon-lead-over-245-members-urging-action-looming.

Meanwhile, Congress has again shown a willingness to shield enrollees in government health plans from rising health premiums. ARPA liberalized the income requirements to receive premium subsidies for Affordable Care Act (ACA) insurance plans on the individual market. It lowered the required contribution from no more than 9.83 percent of family income to 8.5 percent. It reduced required premium contributions even more for lower-income enrollees, with some participants seeing their required premium share falling to zero. The premium changes in ARPA were set to expire in December 2022, but were extended by the Inflation Reduction Act of 2022 for an additional three years, increasing spending and tax subsidies by an additional $64 billion.[17]

These recent congressional actions further illustrate how difficult it is for today's lawmakers to bind future congresses to artificially low reimbursement rates or avoid subsidizing premiums. Proposed public option plans with aggressive reimbursement rates and premium assumptions will face similar pressures.

[17] See Table 1 in CBO (August 2022).

III. EARLIER BUDGET AND TAX ESTIMATES

In Chen, Church, and Heil (October 2020), we estimated a politically realistic public option would increase ten-year non-interest deficits by $792 billion, with even larger deficits after the first decade. We estimated that by 2050, the public option would become the third largest government program, behind only Medicare and Social Security. Without any tax increases, we estimated that the federal debt would rise by an additional 31 percent of GDP by 2050.

To avoid increasing the debt, lawmakers would need to cut spending elsewhere or raise taxes. We considered five hypothetical tax increases that could pay for the public option:

1. Raising the Corporate Income Tax Rate,
2. Increasing the Affordable Care Act's additional medicare tax and the net investment income tax,
3. Raising tax rates on the top three income tax brackets,
4. Raising all income tax rates, and
5. Raising the HI Tax Rate.

In each case, the tax increase needed to pay for the public option was significant. For example, we estimated the HI tax rate would need to rise to 8.1 percent by 2050.

Importantly, our baseline tax rates were higher than under current law. This assumption was based on the idea that policymakers would eventually raise taxes to keep the federal debt below 150 percent of GDP, the projected 2050 debt level before the COVID-19 pandemic. We referred to this tax increase as the "base tax increase." In our earlier work, we estimated the base tax increase would be 10.4 percent if it began in 2026. Including this base tax increase made sense in our earlier work, as it was meant to represent a return to the pre-COVID-19 trend line on federal debt. In this paper, we instead use the current-law tax schedule as our baseline for making estimates about the revenue requirements for a politically realistic public option. This will lower our top-line rate numbers but have little effect on the size of the tax increase needed to fund a politically realistic public option.

In Chen, Church, and Heil (February 2021), we modeled three stylized economic shocks in anticipation of future recessions. Considering the history of congressional expansions to federal health care entitlement programs, any new economic shock would likely result in higher reimbursement rates, lower costs for enrollees, or expansions in eligibility.

In the context of the public option, we considered a freeze on premiums for public option enrollees during recessions, a freeze on premiums for unemployed enrollees beginning in the recession and remaining indefinitely, and an increase in costs motivated by higher-than-predicted medical inflation. Freezing the growth in premiums during recessions increased long-term debt by 3.9 percent of GDP, requiring over $2,800 in middle-class tax increases. Freezing premiums for unemployed enrollees raised the cost by 18 percent in the first ten years. Finally, higher unexpected medical inflation would have increased long-term deficit effects by 71 percent.

IV. ECONOMIC AND BUDGET CHANGES AFFECTING THE ANALYSIS

Since our 2020 analysis, there have been several economic and policy changes that could affect the estimated budget effects of a politically realistic public option.

First, inflation has risen considerably. Since our last estimates, the consumer price index (CPI-U) has risen by over 16.4 percent. In comparison, at the time of our last score, CBO had projected an increase of 4.4 percent over the same period. Thus, without any other changes, our nominal cost estimates would be about 11.5 percent higher.

Second, the politically realistic public option score depends heavily on the assumed initial reimbursement rates. In our early estimate, we used 2018 estimates from the Centers for Medicare and Medicaid Services (CMS). Our new reimbursement rate assumptions are based on 2022 estimates.[18] Over that period, estimated reimbursement rates for Medicare as a share of private-level rates have fallen by two percentage points for hospitals and three percentage points for providers. All else equal, lower assumed reimbursement rates will mean premiums will be set at lower levels. As we increase reimbursement rates over time, the gap between actuarially fair premiums and premiums charged rises more quickly than if reimbursement rates begin at higher levels. The result is significantly higher outlays.

Third, our 2020 baseline enrollment estimates were based on CBO's projected enrollment as of 2020. Since then, Congress has temporarily expanded Affordable Care Act subsidies and broadened eligibility. These changes will expand the number of people included in our analysis. The ACA expansions reduce ten-year deficit estimates because any premium reduction for subsidized ACA recipients will lower ACA-related outlays or tax expenditures. These effects will be small as the expansions only last until 2025.

Beyond these changes, there are smaller changes in economic projections, including expected growth rates for health care spending and premiums. In particular, the long-term expected growth in medical inflation is lower than previously projected. Small changes in demographic projections will also affect our estimates.

Finally, we have also refined the microsimulation used for the estimates.[19] Among other changes, we have introduced more variation in group premiums to better reflect the distribution of employer-sponsored-insurance (ESI) premiums. This change will have little effect on enrollment, but it will increase the projected tax savings from a politically realistic public option. All else constant, this will lower the long-term deficit effects of the plan. Our new estimates also begin two years later (2024) than our 2020 estimates (2022).

[18] In both cases, we rely on estimates from CMS actuaries that compare Medicare reimbursement rates for inpatient care and physician services to private-insurance rates. For this paper, we use the estimates in Shatto and Clemens (2022).

[19] Our microsimulation is developed using the Current Population Survey with imputed medical spending and premium data from the Medical Expenditure Panel Surveys. Income, premium, and inflation variables grow at rates consistent with CBO's ten-year and long-term economic projections. Population changes reflect U.S. Census projections. Health spending and premium growth projections are based on National Health Expenditure data and CBO's long-term projections. For more details, see Church and Heil (2019).

Thus, even without the unexpected increase in inflation, our estimates would be higher than previously projected. In addition, though historically low, expected population growth will increase enrollment slightly, raising the cost estimates.

Excluding the changes discussed above, we maintain similar assumptions in modeling a politically realistic public option. As with our earlier estimates, we limit our analysis to those under age 65 who would otherwise have private insurance coverage (including through the ACA marketplace exchanges). We also assume the public option would not affect the premiums offered by private health insurers; an individual's private insurance options would remain the same.

V. THE BUDGET EFFECTS OF A POLITICALLY REALISTIC PUBLIC OPTION

We now estimate that a politically realistic public option would increase ten-year deficits by $1.23 trillion. Like our earlier estimates, the costs would grow dramatically over time. Table 1 reports the ten-year revenue, outlay, and deficit estimates.

TABLE 1: REVISED ESTIMATED BUDGET EFFECTS (BILLIONS)

Year	Revenue	Outlays	Surplus
2024	$116	-$10	$126
2025	$127	$60	$67
2026	$144	$142	$2
2027	$155	$226	-$71
2028	$166	$325	-$159
2029	$180	$359	-$179
2030	$193	$398	-$205
2031	$212	$446	-$234
2032	$231	$501	-$270
2033	$249	$557	-$309
Total:	$1,772	$3,004	-$1,233

In 2024, nearly 130 million enrollees would opt for a public option plan over private insurance. Initially, the public option would reduce federal spending. This is due to the interaction between the Affordable Care Act subsidies and the public option.[20] Beginning in 2025, as reimbursement rates begin to rise above Medicare-level rates, the implicit subsidy discussed in Section II grows, and with it, federal spending. By 2033, we estimate the actuarially fair premium would be 68 percent larger than the premium charged to enrollees. Meanwhile, revenues rise primarily because of reductions in the tax value of the tax exclusion for employer-sponsored insurance premiums. As the implicit subsidy of the public option grows, the difference between an enrollee's public option premium and the premium they would have paid in the private market grows. This, in turn, reduces the tax subsidy enrollees receive through ESI coverage. Revenue also rises slightly due to declines in ACA premium tax credits.

[20] *The ACA subsidy would fall if the introduction of the public option plan alters the benchmark premium for an enrollee. This would occur if the public option were the cheapest or second cheapest plan offered.*

Table 2 compares the deficit effect with our earlier estimate. As we explain in Section IV, the primary reasons for the increase are due to increased inflation and changes in reimbursement rates. We calculate inflation-adjusted ten-year deficits using 2020 dollars to account for these changes.

We also include an additional estimate identical to our current estimate except with the reimbursement rates used in the 2020 estimate. As shown in the table, in current dollars our current estimate is 56 percent larger than our 2020 estimate. After adjusting for inflation, however, the difference falls to 32 percent, suggesting that inflation can explain almost half of the change in our estimates. Reimbursement rate changes explain over half of the remaining gap.

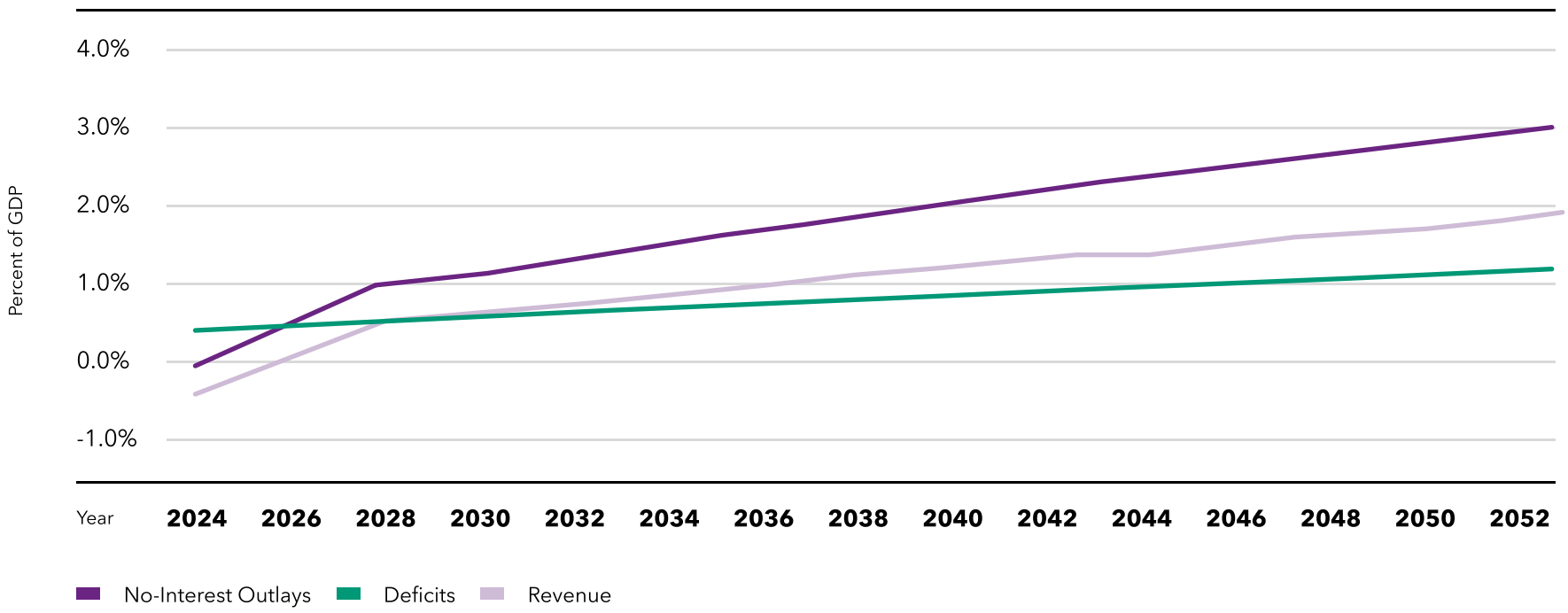
TABLE 2: COMPARISON OF TEN-YEAR DEFICIT EFFECTS UNDER DIFFERENT ASSUMPTIONS (BILLIONS)

	Current Dollars	Inflation-Adjusted (2020 $)
Chen, Church, and Heil (October 2020)	$792	$651
Current Estimate	$1,233	$856
Current with 2020 reimbursement rates assumptions	$1,072	$741

Notes: To adjust for inflation, we use the estimated growth in the CPI-U in CBO ten-year economic projections. We use their July 2020 projections for the 2020 estimates and their February 2023 projections for the current estimates.

Over time, the difference between actuarially fair premiums and actual premiums charged grows. The result is that over the next 30 years, the budget costs of a politically realistic public option would grow dramatically. Figure 2 shows the change in federal revenue, outlays, and deficits from the plan.

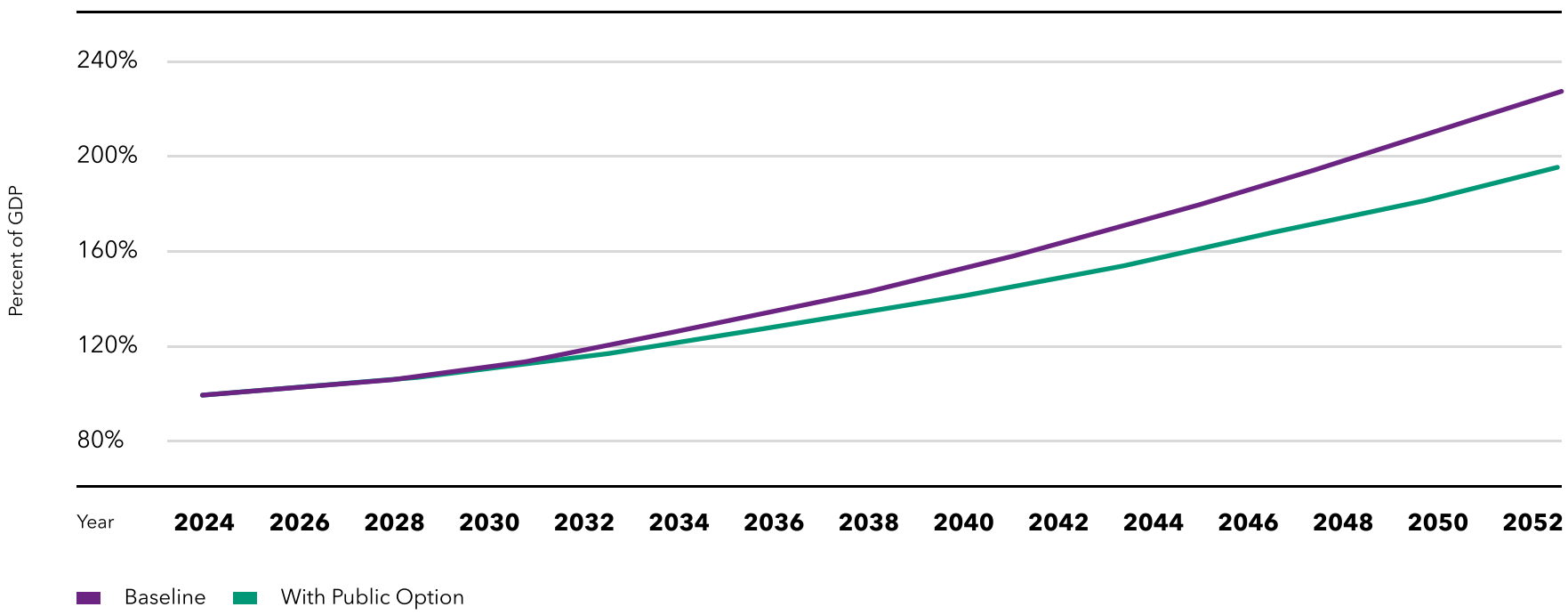
FIGURE 2: THE LONG-TERM BUDGET EFFECTS OF THE POLITICALLY REALISTIC PUBLIC OPTION



By 2053, spending on the public option would reach 3 percent of GDP, accounting for 12 percent of non-interest spending.[21] The federal government would spend more on the program than it would on Medicaid. Even after accounting for increased revenue, this spending would increase the federal deficit by 1.8 percent of GDP in 2053, raising deficits by 16 percent.

The additional deficits would grow the federal debt without spending offsets or tax increases. Figure 3 shows the debt-to-GDP ratio with and without a politically realistic public option. Under the current baseline, CBO projects the federal debt held by the public will rise to 195 percent of GDP by 2053. The public option would push the debt to 228 percent of GDP.

FIGURE 3: FEDERAL DEBT WITH THE POLITICALLY REALISTIC PUBLIC OPTION



A politically realistic public option would thus make an already dire debt picture significantly worse. Avoiding this borrowing would require higher taxes. In the section below, we consider various tax increases that could pay for the public option.

[21] *All long-term budget and economic estimates are based on CBO (2022).*

VI. TAX OPTIONS TO FINANCE THE PUBLIC OPTION

In Chen, Church, and Heil (October 2020), we considered various hypothetical tax increases that could pay for the public option. We make similar calculations here using the current budget effects of a politically realistic public option.

We focus on four potential tax increases: raising the corporate income tax rate, raising tax rates on the top three income tax brackets, raising all income tax rates, and raising the HI tax rate.[22] Like our earlier estimates, we begin with 30-year revenue estimates for various tax categories: corporate income taxes, personal income taxes, the Social Security payroll tax (OASDI), and the HI payroll tax.[23] We then consider the tax rate increases needed to fully offset the annual cost of a politically realistic public option. In our tax calculations, we make only static revenue estimates, i.e., these estimates do not reflect likely behavioral changes from higher tax rates.

As discussed more in Section III, our earlier estimates were based on a revised baseline that included an across-the-board "base tax increase," reflecting the need for higher revenue to keep debt below 150 percent of GDP. We forego this assumption in our analysis here. Thus, our estimated rates will be slightly lower than those estimated in the previous paper.

Option 1: Raising The Corporate Income Tax Rate To Fund A Politically Realistic Public Option

The first stylized tax option looks at the corporate income tax rate increase needed to fund the public option. This option may be politically attractive, as the tax is paid by corporations rather than American families or small business owners. Nevertheless, while companies bear the legal incidence of the tax, the economic incidence of the tax may be borne by shareholders, consumers, or workers. Figure 4 shows the annual corporate income tax rate needed for the public option.

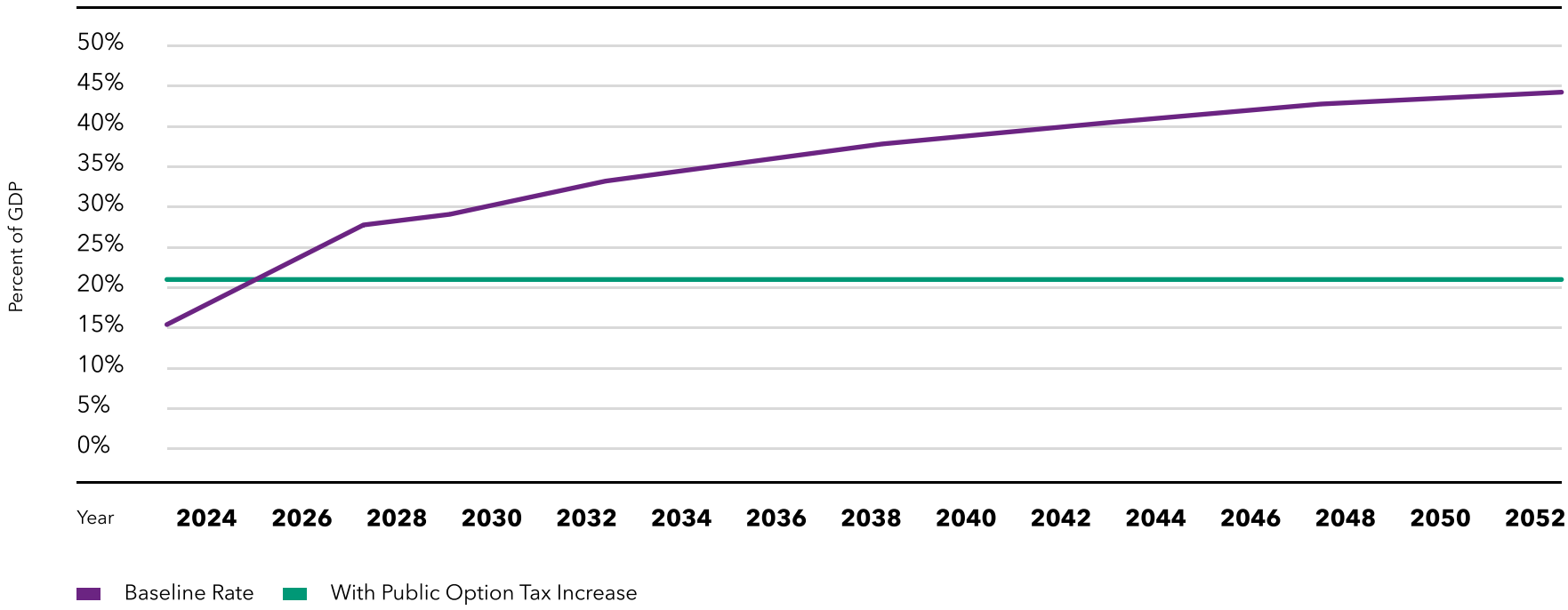
In 2053, baseline corporate income revenue is projected to be an estimated 1.7 percent of GDP, similar to its 2023 level—0.3 percentage points higher than CBO had estimated in 2020. As noted above, a politically realistic public option would add 1.8 percent of GDP to federal deficits in 2053, thus the corporate income tax would need to be more than doubled to pay for the public option. The rate would need to rise from 21 percent today to 44.2 percent in 2053. This tax rate increase is lower than the rate we estimated in 2020; the decline primarily reflects the increased revenue projections by CBO.

Importantly, the above rate changes do not reflect changes in economic behavior due to the increased tax rates. Such large rate increases would lead to significant changes in firm behavior that would reduce revenue. In addition, these estimates do not reflect the change in investment tax collections from capital gains and dividends, which would fall as post-tax corporate profits fell.

[22] In our earlier work, we also considered raising the ACA's additional Medicare tax and the Net Investment Income Tax (NIIT). We estimate those taxes would need to rise by 472 percent by 2050 to pay for a politically realistic public option. Given the outlandish size of the increase needed, we omit the stylized example from our current paper.

[23] When considering increasing the OASDI or HI payroll tax, we assume the tax increase would be levied on the employee side only. If it were levied on the employer side it would reduce taxable income, reducing income tax revenue.

FIGURE 4: TOP CORPORATE TAX RATE TO PAY FOR A POLITICALLY REALISTIC PUBLIC OPTION

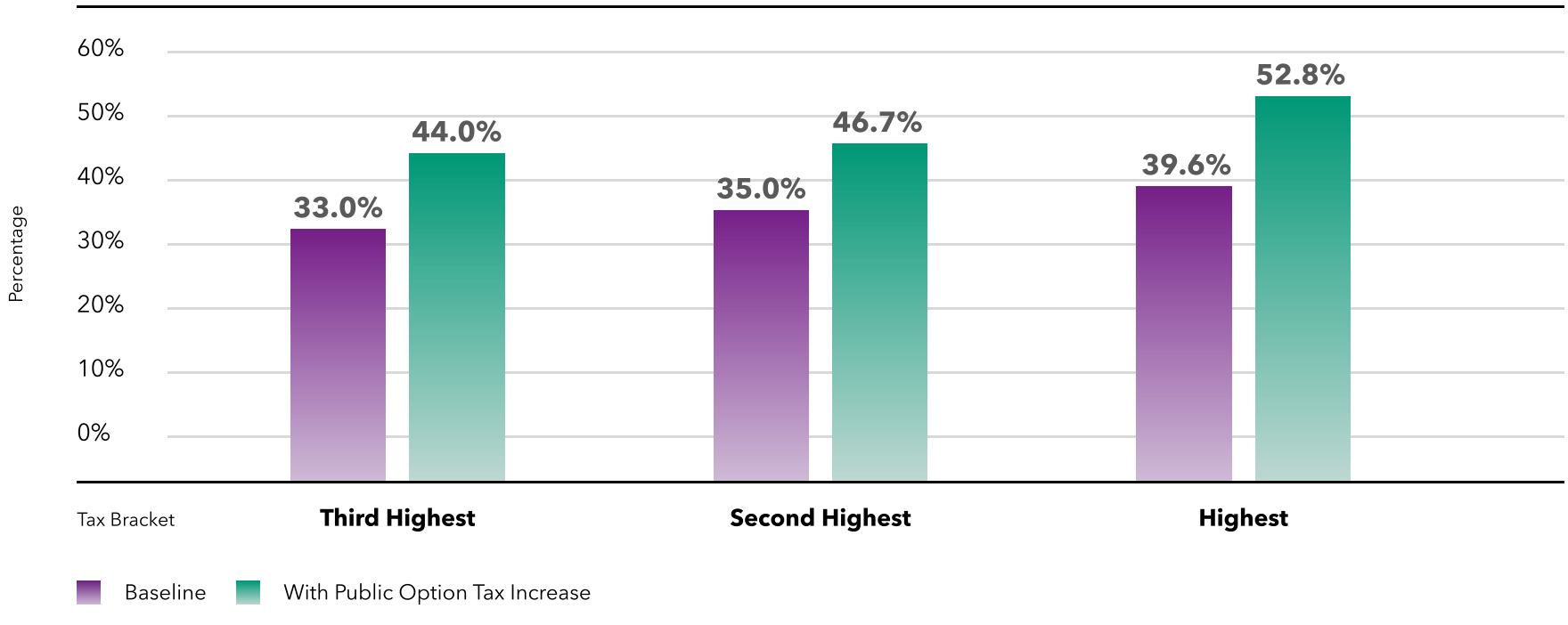


Option 2: Raising The Top-Three Income Tax Rates To Fund A Politically Realistic Public Option

Like raising corporate tax rates, raising rates on the top three income tax brackets could be politically attractive to politicians eager to avoid raising taxes on middle-income Americans. In 2023, the third highest tax bracket begins at $182,100 for single filers and $364,200 for married filers, meaning relatively few taxpayers would be affected by this rate increase. For example, in 2020, only 2.2 percent of taxpayers were in one of these three brackets.[24] Nevertheless, given the small number of taxpayers in those brackets, the rate increases needed to fund the public option would be substantial.

We estimate that by 2053, these rates would need to rise by 33.4 percent to fund a politically realistic public option. The resulting rate increases would be substantial. Figure 5 shows the three top brackets in 2053 with and

FIGURE 5: TOP-THREE BRACKET INCOME TAX INCREASE: 2053 RATES



[24] See Figure B (page 30) in Internal Revenue Service (IRS) (2022).

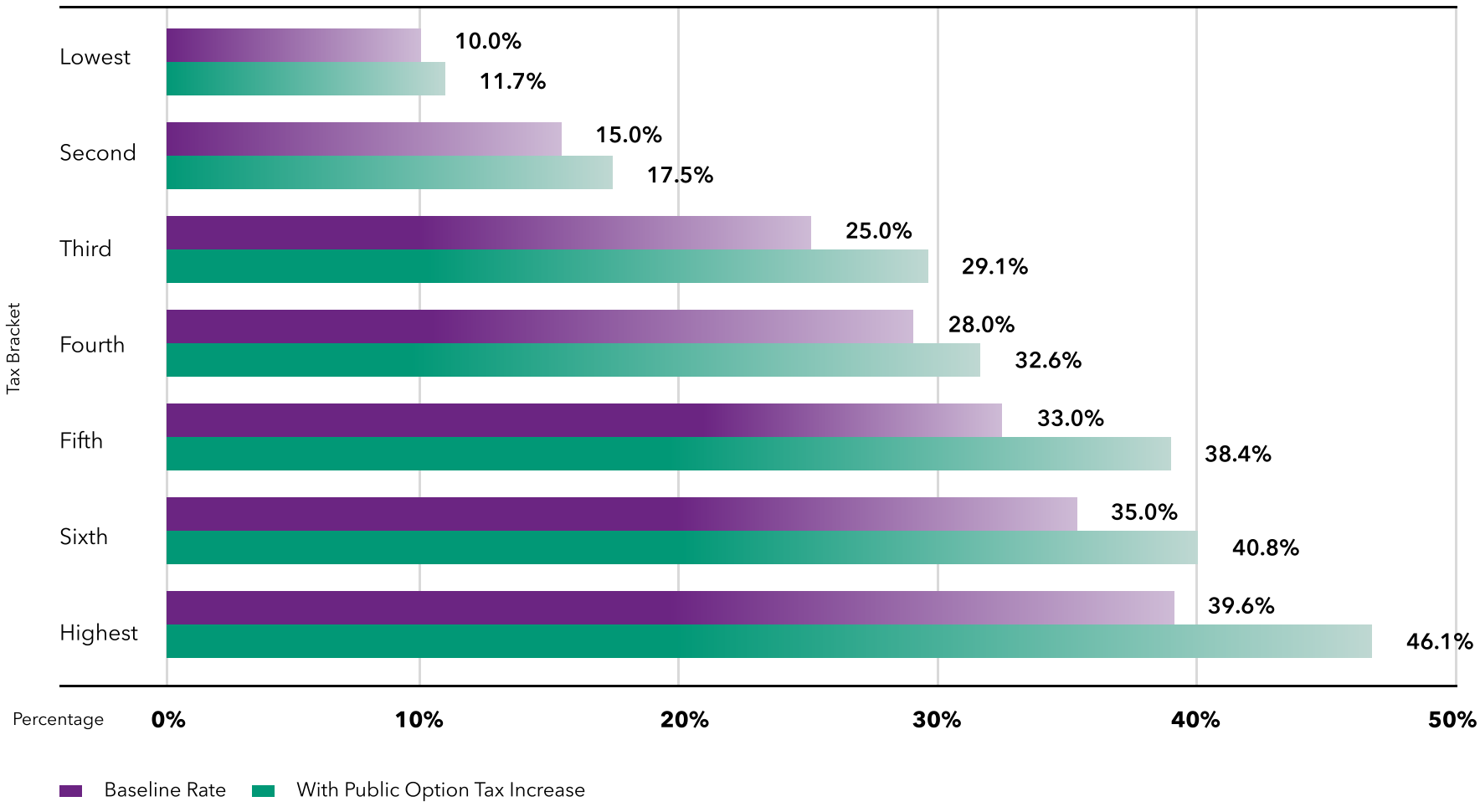
without the tax increase. The top income tax rate would need to rise to 52.8 percent—a 13 percentage point increase in the tax rate.[25] Since this rate is in addition to Medicare taxes, the top marginal tax rate would exceed 55 percent, before accounting for state and local income taxes.

Such high tax rates would lead to changes in economic behavior and the adoption of new tax avoidance strategies. These actions would reduce the actual revenue collected, meaning even higher tax rates would be needed to fully fund the public option. Thus, like increasing the corporate income tax rate, raising rates exclusively on top earners to fund the public option is likely not an economically tenable option. Instead, politicians would need to consider broad-based tax increases to fund the program. We consider two: raising all income tax rates and raising the HI payroll tax rate.

Option 3: Raise All Income Tax Rates To Fund A Politically Realistic Public Option

Raising all income tax rates would moderate the tax increase needed to pay for the public option, but the tax increase would still be substantial. We estimate income taxes would need to rise by 16.5 percent in 2053 to fund the program. Figure 6 shows the tax rates that would result with the public option tax increase. By 2053, middle-income tax rates would rise to nearly 30 percent, while the top rate would exceed 46 percent. Including high-income Medicare taxes (up to 3.8 percent), top earners would face a marginal tax rate of nearly 50 percent, again, before accounting for state and local income taxes.

FIGURE 6: ACROSS-THE-BOARD INCOME TAX INCREASE: 2053 RATES



[25] Like the corporate tax rate hike, the estimated tax increases are slightly lower than we projected in 2020. Again, the differences are due to increased baseline revenue projections at the end of 30-year window.

Since a broad-based income tax increase would affect all income taxpayers, the distributional effects are noteworthy. Table 3 breaks down the median change in taxes paid by households in each income quintile with the rate increase. An across-the-board income tax increase sufficient to finance a politically realistic public option would increase middle-income taxes by $600 in 2033, $1,100 in 2034, and $1,500 in 2053 after adjusting for inflation (using 2023 dollars).

TABLE 3: MEDIAN TAXES PAID BY QUINTILE WITH AN ACROSS-THE-BOARD TAX INCREASE (2023 DOLLARS)

Tax Year	Second	Middle	Fourth	Highest
2023				
Baseline	$6,800	$16,300	$32,600	$82,200
Public Option Tax Increase	$200	$600	$1,300	$4,000
2043				
Baseline	$7,900	$18,300	$37,300	$94,600
Public Option Tax Increase	$300	$1,000	$2,600	$7,800
2053				
Baseline	$8,700	$20,600	$42,800	$108,000
Public Option Tax Increase	$400	$1,500	$3,800	$11,500

Notes: Bottom quintile excluded as median taxes paid is zero. Figures are for household units.

Option 4: Raise Medicare's Hospital Insurance Tax Rate To Fund A Politically Realistic Public Option

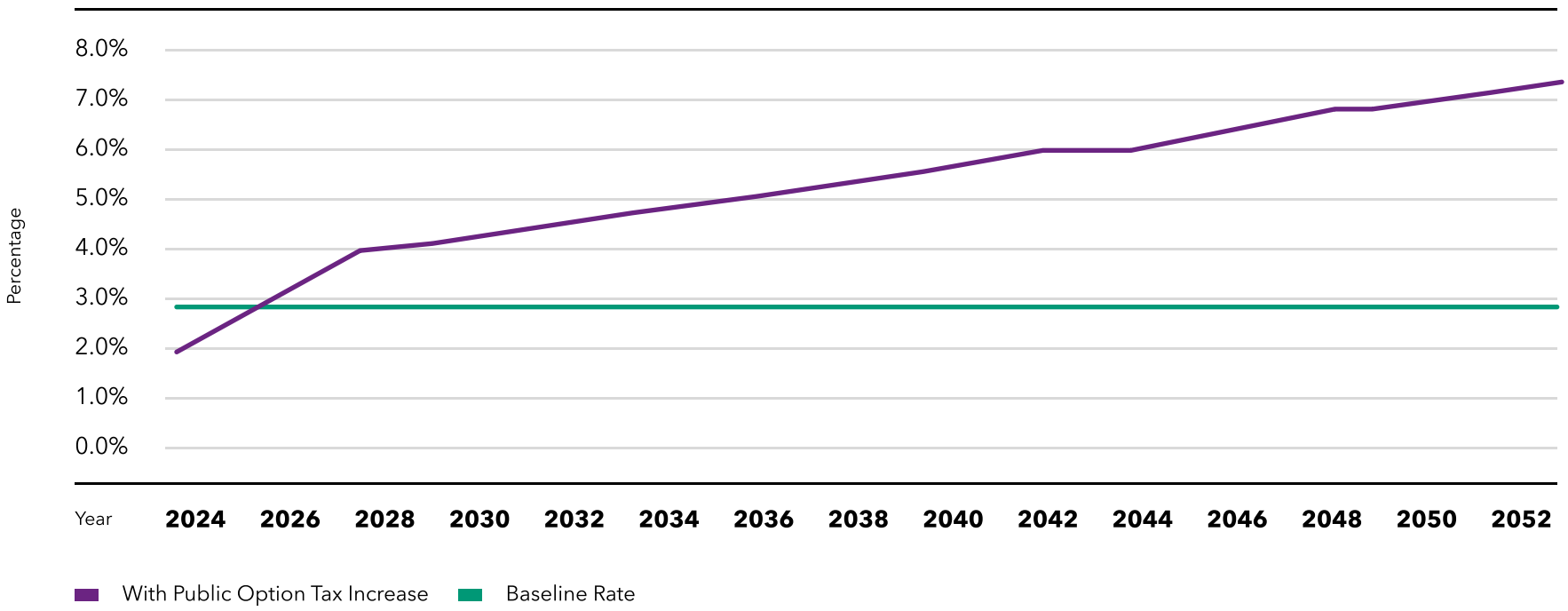
Finally, we consider an increase in Medicare's Hospital Insurance tax. The payroll tax applies to all wage and salary incomes. It is currently set at 2.9 percent, divided evenly between employees and employers.[26] The HI tax is used to fund Medicare's Hospital Insurance trust fund, which finances the program's Part A expenditures.

While using the HI tax to fund non-Medicare spending would represent a departure from Medicare's history, there are historical analogs. For example, the ACA created the additional Medicare tax, a 0.9 percentage point levy on the wages and salary of high-income taxpayers. While the tax is credited to the trust fund, its initial revenue was used as a "pay for" for the ACA's coverage provision.[27]

We estimate that to fund a politically realistic public option, the HI tax would need to rise by 151 percent. Figure 7 shows the trajectory of the tax rate with and without the public option. By 2053, the HI tax rate would need to be 7.3 percent or 4.4 percentage points higher than its current rate.

[26] We assume the tax increase would apply to the employee side.
[27] Our stylized example here need not be considered an increase in the HI tax, but rather a separate tax levied on the same tax base.

FIGURE 7: HOSPITAL INSURANCE TAX RATE NEEDED TO FINANCE A POLITICALLY REALISTIC PUBLIC OPTION



Unlike the other stylized tax increases, the HI tax increase would slightly reduce the progressivity of the tax code since low- and middle-income workers receive a greater share of their income from wages and salaries. The distributional effects are thus more significant. Table 4 provides the increase in median household taxes paid by quintile after adjusting for inflation (using 2023 dollars). Within ten years of the enactment of a politically realistic public option, middle-income families would need to pay $1,000 more in taxes to fund the program. By 2053, middle-income families would need to pay $3,400 (or 16 percent) more to fully cover the cost of a politically realistic public option plan.

TABLE 4: MEDIAN TAXES PAID BY QUINTILE WITH AN HI TAX INCREASE (2023 DOLLARS)

Tax Year	Second	Middle	Fourth	Highest
2023				
Baseline	$6,800	$16,300	$32,600	$82,200
Public Option Tax Increase	$500	$1,000	$1,800	$3,600
2043				
Baseline	$7,900	$18,300	$37,300	$94,600
Public Option Tax Increase	$1,100	$2,100	$3,600	$7,500
2053				
Baseline	$8,700	$20,600	$42,800	$108,000
Public Option Tax Increase	$1,600	$3,400	$5,600	$11,800

Notes: Bottom quintile excluded as median taxes paid is zero. Figures are for household units.

VII. CONCLUSION

Despite promises from proponents of dramatic savings to enrollees and no additional cost to the federal government, the public option could quickly expand into one of the costliest programs in the budget.

Higher inflation and changes to federal reimbursement rates to health care providers suggest an even larger price tag for the public option than our earlier analysis, increasing deficits by $1.23 trillion in its first ten years. This substantial increase in deficits would be accompanied by significant changes in the distribution of health coverage in America, as over a hundred million Americans would change their insurance plans to take advantage of federally subsidized premiums.

By 2053, spending on the public option would account for 3 percent of GDP and be larger than Medicaid. Current projections put long-term federal debt at 195 percent of GDP; the public option would push it even further to 228 percent. Financing the implicit subsidy of a politically realistic public option would require dramatic increases in either the corporate tax rate, income taxes, or the Medicaid HI payroll tax. Each option would require either large increases on narrow tax bases, leading to significant behavioral effects and less revenue than expected, or broad-based tax increases on low- and middle-class families that politicians will be unlikely to support.

Congress has a long history of expanding federal health care entitlement programs for enrollees and shielding medical providers from payment cuts. Unfortunately, this history includes several examples of policymakers enacting legislation with cost-containment provisions that prove politically unsustainable. Given past behavior, today's lawmakers must consider the political pressures future congresses would face. Doing so reveals the inherent fiscal dangers of a public option that begins with overly optimistic assumptions.

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