

A NEW HEALTH CARE PLAN.

Vouchsafe

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requiring people to buy health insurance as if it were a driver's license has become the health care policy initiative du jour. This "individual mandate" model got its first official embrace when former Massachusetts Governor Mitt Romney, working with his Democratic state legislature, used such a scheme to cover all state residents. In January, California Governor Arnold Schwarzenegger proposed to implement a similar program. And, within the last few days, former Senator John Edwards, a leading Democratic presidential candidate, proposed using the same basic structure on a national scale.

It's great that so many prominent public officials are embracing universal health care, an idea whose time has clearly come. But it's not great to see these public officials embracing such a flawed model of reform. These reforms don't envision a wholesale reinvention of U.S. health care. Instead, they attempt to graft universal coverage onto existing arrangements. That's a mistake, because only comprehensive reforms will eliminate the inefficiencies and perverse incentives of the existing system--a series of flaws that leaves Americans with the worst of all worlds. In the United States, life expectancy is lower and infant mortality is higher than it is in other developed countries. Even so, the United States spends \$7,000 per person per year on health care--almost twice as much as is spent on citizens of other high-income countries.

Proponents of individual mandates and other, more incremental reforms insist they are merely being practical--that, if you try to give everybody insurance and make it more efficient, the political system will reject it. But there may be a politically realistic way to establish universal coverage while addressing the more fundamental flaws in U.S. health care. It's an idea we first introduced two years ago: universal health vouchers.

deally, health care reform ought to accomplish several goals, starting with universality: All Americans should be covered by a high-quality basic plan, which they can keep whether they change jobs or marital status. But there are other critical goals, too. Americans want to be able to choose their hospital and physicians; they want the ability to change health plans and to buy extra services. Quality is obviously essential; care should be clinically sound and safe. And then there is efficiency. Over time, expenditures should not rise faster than can be justified by higher national income and advances in health care.

Even the most thoughtfully constructed individual mandate reform can make only partial progress on these fronts. An individual mandate would prop up employment-based insurance, which is inefficient and inequitable. It would also increase the number of Americans dependent on income-tested subsidies for programs like Medicaid, which runs up administrative costs (government has to sort out who's eligible for assistance) while providing many of these people with substandard insurance (since the programs' low reimbursements frequently limit access to doctors).

An individual mandate would not address major problems in the organization and delivery of care, nor would it end the squandering of money on lavish executive salaries and perks. And, precisely because an individual mandate would leave the present system for financing medical care fundamentally intact, it's hard to see how it would do much to reduce current overall costs--or future inflation.

A voucher scheme, by contrast, seems far more likely to accomplish these goals. Here's how it would work: Once a year, all Americans would choose a health plan from among five to eight alternatives. All the plans would be free. All the plans would also meet certain criteria--minimal co-payments and deductibles, plus benefits modeled (initially) on those in the Federal Employee Health Benefit Plan. By law, the plans could not discriminate among customers. They would have to accept anybody and promise unconditional renewal, regardless of preexisting medical conditions or other factors that might put people at higher risk of getting sick.

Who would make the decisions about which plans people could buy? Regional health boards would screen the plans and then monitor their performance over time, using criteria set by a federal health board--with the whole system operating like the Federal Reserve system now does. The health boards would also be responsible for paying the plans. Money would come down from the federal health board, which would decide how to divide health care funds geographically. At that point, the regional boards would pay each plan, based on the number of enrollees in any given year--but with one key adjustment. The regional boards would adjust payments so that plans attracting sicker beneficiaries would get more money. This, along with the prohibitions on denying coverage to people with preexisting conditions, would prevent insurers from profiting by cherry-picking the healthiest subscribers.

So that's how the money would get from the health boards to the health plans. But how would the health boards get their money in the first place? Under the scheme we have in mind, the money would come from the federal government, which would, in turn, draw upon two revenue sources. First, the government would repeal the existing tax exemption on employer-sponsored health insurance--an exemption that would become obsolete once employers stopped providing their workers with basic insurance. That change would raise \$200 billion a year. To cover the remaining cost--some \$750 billion a year initially--the government

would then impose a value-added tax (VAT). Businesses pay VAT at every step of the production and distribution process, adding the cost as they go, so that at the end of the line--when a consumer pays for a good--the consumer ends up picking up the tab at higher prices. The new VAT would be "dedicated," generating money only for health care. A tax of between 10 and 12 percent should be enough to pay for our scheme.

That may sound like a lot--imposing, in effect, a 10 to 12 percent national sales tax--but average Americans would come out ahead. As employers stopped spending money on employee health benefits, wages would go up by 10 to 13 percent. Meanwhile, Americans would no longer have to pay any premiums whatsoever for basic medical coverage. The voucher program would phase out Medicaid and, eventually, Medicare; and, as the programs disappeared, the taxes that support them would disappear, too, leaving the average American even better off. (Medicare would not enroll new members, but it would continue to serve current enrollees until they died or decided--as some might--to opt for the voucher system instead.)

Admittedly, using a VAT would be controversial, because some people believe VATs are too regressive. But the program as a whole would be highly progressive. Indeed, all countries that provide universal health care have a VAT--including the Scandinavian countries, the Netherlands, and Germany. Many liberal analysts, such as Robert H. Frank in *Luxury Fever* and Ed McCaffery in *Fair Not Flat: How to Make the Tax System Better and Simpler*, have recommended a VAT because it taxes spending, not work or saving.

verall, a voucher system would certainly cost no more than the present system. And, over time, it would actually cost less, as it would hold down health care inflation. Since the VAT money would be "dedicated," the amount collected from the VAT would set a hard limit on the cost of the basic benefits package--and, ultimately, the services that insurance coverage could purchase. The amount collected would rise as the economy grew. But, if Americans wanted health care spending to grow even more rapidly, they would have to agree to a higher VAT rate. In other words, there would be no open-ended entitlement leading to open-ended inflation, as there is today.

The voucher system would also foster competition among health plans. Because health plans would get a fixed payment per enrollee in exchange for providing a defined set of benefits, they would have to compete for enrollees based on quality and service. They would have a strong incentive to be efficient and to collaborate with their doctors and hospitals to cut down on waste and marginal medical services. Americans who wanted additional services could still get them. But, to do so, they'd have to spend their own after-tax dollars--giving them an incentive to spend judiciously and get value for their money.

To further cut down on costs, we propose using a small portion of the VAT to fund a new, independent Institute of Technology and Outcomes Assessment that would evaluate the effectiveness, cost, and value of new technologies and new applications of existing technologies. The data developed by the Institute would ensure that technologies added to the basic benefit package by the federal health board would be cost-effective. These reports, in turn, would send a signal to drug and device companies to focus their research and development on cost-effective interventions.

These steps would amount to an ambitious overhaul of U.S. health care. But an ambitious overhaul is exactly what U.S. health care needs. Pushing for lesser solutions is the policy equivalent of prescribing aspirin and Band-Aids for cancer--in other words, a form of malpractice.

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