

# A Comprehensive Cure: Universal Health Care Vouchers

## HEALTH CARE RECONSIDERED

### Options For Change

This proposal is one of four alternative approaches to achieving universal coverage that will be released by The Hamilton Project

THE FUNDAMENTAL STRUCTURES of the U.S. health care system are increasingly unsustainable. The growth of health care spending exceeds GDP growth by an average of 2.5 percentage points annually, and tens of millions of Americans are uninsured or underinsured. Stark inequities exist between those with traditional employer-sponsored health insurance and those without. In addition, the quality of health services can be haphazard. Studies have revealed wide variations in medical practices. For example, only 55 percent of proven-effective therapies are administered to patients who need them, and fewer than 25 percent of doctors and hospitals have installed electronic medical records, despite their demonstrated advantages for quality and efficiency.

In a discussion paper for The Hamilton Project, Ezekiel Emanuel of the National Institutes of Health and Victor Fuchs of Stanford University propose a major health care reform that ensures universal and continuous coverage, controls costs, and improves the quality of care. Their universal health care voucher proposal would guarantee every American a comprehensive package of benefits through private health plans, establish quality control and independent oversight, and curb burgeoning malpractice premiums. They propose funding their system through a value-added tax (VAT) that would replace the premiums currently paid by employers and families. Taking into account savings from administrative efficiency and the phasing out of public insurance, Emanuel and Fuchs argue that universal vouchers would be more effective and equitable than the current system without increasing total health care spending.

## THE CHALLENGE

Of the thirty OECD countries, the United States is by far the most profligate in health care spending. In 2004, the United States outspent Switzerland, its closest competitor, by more than 30 percent in terms of health care expenditures per dollar of economic production. For every dollar that its fellow OECD members spent, the United States spent \$1.75. Yet nearly 45 million Americans—more than 15 percent of the population—went without health coverage in 2005, amounting to one of the highest uninsured rates in the OECD.

This paradox brings into focus the challenge of U.S. health care reform: to expand coverage and improve quality while slowing the growth of health care spending. Many proposals attempt to address this challenge, including individual mandates to purchase insurance, “single-payer” plans that are centrally administered and government funded, and incremental reforms that expand current structures. Emanuel and Fuchs argue that most proposals leave at least one of the following issues unaddressed:

**Insufficient coverage.** Emanuel and Fuchs believe that incremental expansion of government programs is unlikely to achieve true universality. They also argue that a mandate on individuals to purchase health insurance might only guarantee universal coverage in theory, while in practice many individuals may never enroll.

**Soaring spending.** In 2005, U.S. health care spending rose by 6.9 percent to \$2 trillion, or 16 percent of GDP. By 2015, spending is expected to soar to 20 percent of GDP. Some proposals, such as government-financed single-payer plans, eliminate many administrative and marketing costs, resulting in one-time savings. However, Emanuel and Fuchs argue that these policies provide few incentives for cost effectiveness and no solution for the unsustainable escalation of health spending.

**Inconsistent quality.** Few incentives within the existing system encourage insurance companies or health care providers to improve the consistency and quality of care. Patients often lack the information and the means to make their health care decisions on the basis of quality. On the other end, health care providers lack the infrastructure or incentives to assess the effectiveness of various health technologies. Many proposals leave these flawed aspects of the health care system untouched.

## A NEW APPROACH

Emanuel and Fuchs propose a universal health care voucher system based on the three priorities of universality, quality, and cost effectiveness. In their system, a government-provided voucher would entitle everyone in America, regardless of citizenship status, to a comprehensive package of health insurance from qualified private insurers. The benefit package would be modeled on high-end coverage currently received by federal employees, including members of Congress. Private firms could not deny coverage or insurance renewal to anyone for any reason. In return, the federal government would pay firms a risk-adjusted amount per individual, paying higher amounts for enrollees with greater health risks. Under the standard benefit, individuals would have no deductibles and low co-payments, but they could purchase extra features in addition to the standard package with their after-tax dollars.

The growth of health care spending exceeds GDP growth by an average of 2.5 percentage points annually.

Emanuel and Fuchs’s universal health care voucher proposal harnesses the efficiency produced by competition in the private health insurance market. In their system, health plans would compete for enrollees through their packages, not their prices, because all plans would need to provide the standard benefits for the value of the voucher. Health plans would therefore have to cut costs and enhance efficiency in order to boost their profits, and they would have to differentiate themselves through such measures as how they arrange their physician and hospital networks, determine their drug formularies, and organize their disease management programs. Providers would also have an incentive to compete for customers on the basis of quality, which would inject a fundamentally new motivation for improving effectiveness into the U.S. health care system. To participate, plans and companies would have to provide data on patient satisfaction, hospitalization and mortality rates, and other quality measures. Finally, with the risk-adjusted premiums and standard benefits package, insurance companies would no longer compete with each other by trying to attract healthier people and avoid sicker people.

The universal health care voucher proposal includes a variety of other elements to achieve its goals of ensuring universal and continuous coverage, controlling costs, and improving the quality of care.

**Freedom of choice.** Americans in most regions would be able to choose their own physician, hospital, and health plan. There would be an insurance exchange in each region to facilitate enrollment in the health plan chosen by each individual or family. Emanuel and Fuchs anticipate five to eight qualified health plans or insurance companies competing in any given region. Individuals could change plans each year or select a three-year enrollment option with some additional benefits, but they would have sole discretion over these decisions. Insurance providers could not deny renewal to any of their

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customers. In addition, individuals could purchase benefits beyond the core—for example, a broader network of doctors, a wider choice of dentists, or a more comprehensive set of mental health benefits. To keep costs to the federal government low, payments for these additional benefits would not be tax deductible.

**Dedicated funding.** Emanuel and Fuchs propose an initial 10 to 12 percent value-added tax (VAT) to fund the voucher system. As a dedicated source of funding, revenues from the VAT could not be siphoned away to pay for other programs or expenditures. In addition, the VAT would create a transparent choice for citizens: if they wanted to expand benefits, they would have to raise the VAT to pay for these added benefits.

**National Health Board.** The plan also proposes a National Health Board to administer the voucher system with relative freedom from political pressure. Modeled on the Federal Reserve Board and funded by the VAT, the National Health Board and twelve regional boards would define and adjust the standard benefits provided by the voucher system, handle premium payments, and manage the insurance exchange. The regional boards would also certify eligible insurance companies and determine the amount of the risk-adjusted premiums paid to these companies. To guarantee truly universal coverage, the regional boards would assign health plans to families who do not enroll on their own. Finally,

## Key Highlights

### The Challenge

The authors identify three unsustainable failures of the current health care system of the United States:

- **Soaring spending.** The rate of health care spending in the United States exceeds that of GDP growth by 2.5 percentage points annually.
- **Insufficient coverage.** Nearly 45 million Americans—15 percent of the population, including many children and full-time workers—went without health insurance in 2005.
- **Inconsistent quality.** A lack of coordination and research has created vast differences in the delivery of proven therapies and best practices.

### A New Approach

To address these three failures, Emanuel and Fuchs propose a universal health care voucher system with the following attributes:

- **Universality.** All Americans would receive a voucher to purchase a comprehensive benefit package through private insurance. The set of standard benefits would be modeled on a high-end plan currently available to federal employees.
- **Freedom of choice.** Private insurance companies would administer the program, and Americans would be able to choose their own physicians, hospitals, and health plans.
- **National Health Board.** The authors propose an independent National Health Board to define and adjust standard benefits, calculate premiums paid by the government, and sponsor research on quality and performance outcomes.
- **Cost control.** The voucher system would be funded through a dedicated value-added tax of 10 to 12 percent. It would establish an institute to evaluate the cost and effectiveness of drugs, medical devices, tests, and medical procedures; and another institute to resolve malpractice disputes.

the Board would sponsor research on outcomes and performance of health systems to promote quality and control costs.

**Dispute resolution.** In each of the twelve regions, a Center for Patient Safety and Dispute Resolution would be created to mediate malpractice disputes between patients and health care providers. Currently, soaring malpractice premiums encourage the expensive practice of defensive medicine, in which physicians order costly and often unnecessary tests and treatments to avoid the possibility of being sued. Under the proposal, the Centers would compensate patients whose injuries were caused by medical error and discipline physicians who accrued serious malpractice records. By paying for the malpractice investigations, adjudication, and compensation, the Centers would reduce the high malpractice insurance premiums faced by physicians today. Emanuel and Fuchs estimate that funding these centers would require 2.5 percent of revenues generated by the VAT. Issues not resolved through the centers could still be pursued through the legal system.

**Quality improvements.** Emanuel and Fuchs propose the establishment of an Institute for Technology and Outcomes Assessment, which would assess the value of new drugs, medical devices, and tests; and would evaluate patient outcomes. Its findings would be publicly disseminated and used to ensure that only cost-effective technologies are added to the package of core benefits. The Institute's funding would come from a fixed 0.5 percent of the dedicated VAT revenues.

**Transition management.** Those enrolled in Medicare, Medicaid, the State Children's Health Insurance Program (SCHIP), or another government program could elect to stay with that program or switch to the new voucher program. However, these public insurance programs would not accept any new enrollees, and therefore would be phased out over time.

## Costs and Benefits

In the face of the nation's impending health care crisis, Emanuel and Fuchs outline a financially sustainable plan that ensures universality and emphasizes quality without increasing the total national cost of health care. In 2005, the cost of insurance for the non-Medicare population was \$954 billion. The Emanuel and Fuchs proposal would provide insurance to an additional 45 million people who are currently uninsured while still managing to produce an estimated \$126 billion in national savings—for a total national cost of \$828 billion.

The authors arrive at this calculation by assuming a premium cost of \$4,728 per individual and \$10,824 per family (equivalent to the high-end Blue Cross–Blue Shield plan on which the voucher's core benefit is based). These costs translate to \$778 billion for the entire non-Medicare population. To this figure, the authors add \$50 billion to take into account that the uninsured population would likely have greater health care expenses than the population at large.

How can high-quality universal coverage be cheaper than our current limited system, especially after counting the added costs of insurance for the currently uninsured? Emanuel and Fuchs first point out that today's health care system is remarkably inefficient. The voucher system would create large savings in reduced insurance underwriting, sales, and marketing costs. Moreover, it has administrative cost advantages over other health care reform plans that require complicated income-contingent subsidies. Even accounting for the costs of oversight and dispute resolution, Emanuel and Fuchs estimate that administrative savings would exceed \$100 billion. Second, savings would arise because there would be no need to have a safety net for the uninsured. State spending on health care would decline with reduced need for county hospitals, community clinics, and

The voucher proposal's price tag is \$126 billion less than the United States currently spends on health care—even while providing insurance to an additional 45 million people.

public insurance. The authors also expect significant savings from the phase-out of Medicare, Medicaid, and SCHIP.

Under the voucher proposal, employer-based health insurance would disappear immediately, and with it all of the concurrent inefficiencies. The current employer-sponsored system hurts labor markets because employees are reluctant to give up jobs with good health benefits, and employers are compelled to factor health risks into hiring decisions. Employers would also no longer be responsible for covering the health costs of retirees or administering a complex system of benefits. Employees would likely achieve wage increases that reflect their employers' savings on health care compensation. In addition, the 2.9 percent Medicare payroll tax would eventually be eliminated. The VAT would also replace the costs of Medicaid and other government benefits, enabling substantial reductions in federal and state taxes.

Savings would also arise on other dimensions. The cost containment strategies embedded in the proposal would lead to reduced health spending. The VAT would serve as a hard backstop on how much could be spent on the standard benefits. Private sector competition and risk-adjustment subsidies would keep the administrative costs of insurance providers



“Patients and providers would have better information, quality incentives would be ingrained into the system, and medical malpractice would impose less of a strain on health care providers.”

low. The Institute of Technology and Outcomes would ensure that health technologies covered by insurance are cost-effective, while also encouraging drug and medical device companies to focus their research efforts on cost-effective interventions. In addition, because Americans would be paying for their additional health care services out of pocket with after-tax dollars, there would be greater cost consciousness in health care spending at the individual level.

### The New Landscape

Universal health care vouchers would fundamentally alter the dynamics of the U.S. health care system. Americans would no longer have to change health plans along with changes in jobs, marital status, or other major life events. Because every American would have continuous coverage, the vouchers would promote consistent preventative care over more costly emergency care. The universal health care voucher system would also bring everyone into the insurance market, mitigating problems of adverse selection wherein the sickest people enroll in insurance and drive up premiums. The new system would also facilitate the development of broad insurance groups for pooling insurance risks. Through Emanuel and Fuchs's other proposed measures, pa-

tients and providers would have better information on practices and outcomes, quality incentives would be ingrained in the health care infrastructure, and medical malpractice would impose less of a strain on health care providers.

### Questions and Concerns

**Is a 10 to 12 percent VAT feasible?** The proposed VAT is not trivial, although the experience of dozens of other countries shows that it would be administratively feasible. Overall, the voucher system would not cost Americans more than they are currently paying for health care. This dedicated VAT prevents costs from ballooning into an unfunded entitlement deficit. In addition, no one would have to pay premiums or deductibles, and the typical American would see rising wages (as employer-sponsored coverage is replaced by the voucher system), lower taxes (as Medicare, Medicaid, and SCHIP are phased out), and better cost containment in health care. The VAT would also be flexible to meet the public's demands. If people wanted more comprehensive benefits, they could lobby their political leaders through the democratic process to increase the VAT accordingly.

**Would the VAT be regressive?** Taken as a whole, the proposal is progressive. It would provide a new health benefit that is worth more than \$11,000 a year for family coverage—an amount that considerably exceeds what any low- to moderate-income family would pay through the VAT. In contrast to the current system—where everyone essentially pays the same amount for insurance—this proposal would effectively charge high-income families more because they spend substantially more overall than low-income families. The VAT funding system is also more equitable than the current system in its tax treatment of health insurance. The rich would no longer be excessively favored over the poor, which is the case under today's system where the wealthy—who generally spend the most on health care and pay

taxes in the highest bracket—receive the biggest tax subsidies. In addition, the authors suggest that the proposal could be accompanied by other progressive tax changes that would further protect low-income families.

### Will health plans avoid high-cost patients?

Currently, private insurers have the incentive to design benefit packages to avoid the most costly enrollees while attracting healthy, low-cost enrollees. Emanuel and Fuchs address this problem with risk-adjusted premiums, proposing that the government pay insurance companies more for enrolling patients with higher health risks. In addition, they suggest the possibility of “stop-gap coverage,” in which the government would cover medical costs over \$100,000 per patient, further buffering health plans from the risks of especially high-cost patients.

### CONCLUSION

The current health care system fails to provide adequate coverage to the American people. Aside from the millions who remain uninsured, the system is unsuccessful in containing spiraling costs to employers and inconsistent in its quality and service to the insured. The universal voucher system proposed by Emanuel and Fuchs would rehabilitate this struggling U.S. health care system by goals of establishing universal coverage, controlling costs, and improving quality of care. By correcting the incentives facing private insurers, the voucher system would harness the efficiency of the market while advancing the core American values of simplicity, equality of opportunity, and individual freedom of choice.

## Learn More About This Proposal

This policy brief is based on The Hamilton Project discussion paper, *A Comprehensive Cure: Universal Health Care Vouchers*, which was authored by:

### EZEKIEL J. EMANUEL

**Chair, Dept. of Bioethics, National Institutes of Health**

Emanuel is a breast oncologist whose research has encompassed the quality and cost of end of life care, the physician-patient relationship, and the ethics of research with human beings.

### VICTOR R. FUCHS

**Professor Emeritus, Stanford University**

Fuchs uses economics to analyze the determinants of health and the cost of care, applying analytical results to make recommendations for health care reform.

## Alternative Approaches to Universal Coverage

**This proposal is one of four alternative approaches to achieving universal coverage that will be released by The Hamilton Project**

- **Gerard Anderson and Hugh Waters** propose extending Medicare to all firms and individuals wishing to buy into it. The reform, which includes individual and employer mandates and income-based subsidies, is designed to expand affordable coverage to everyone.
- **Stuart Butler** proposes creating state-chartered health insurance exchanges as alternatives to employment-based pooling, using employers to facilitate (rather than fully sponsor) health coverage, and reforming the tax treatment of health care.
- **Ezekiel Emanuel and Victor Fuchs** propose giving vouchers to every American for comprehensive health insurance. They argue the vouchers, funded by a value-added tax, would provide portability and promote cost effectiveness.
- **Forthcoming: Jonathan Gruber** examines the feasibility, costs, and benefits of extending nationwide the “Massachusetts model,” which provides universal coverage through a combination of mandates, subsidies, and alternative insurance risk pools for purchasing insurance.

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