

HEALTH CARE RECONSIDERED
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A Comprehensive Cure:
Universal Health Care
Vouchers

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A Comprehensive Cure: Universal Health Care Vouchers

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This discussion paper is a proposal from the authors. As emphasized in The Hamilton Project's original strategy paper, the Project was designed in part to provide a forum for leading thinkers across the nation to put forward innovative and potentially important economic policy ideas that share the Project's broad goals of promoting economic growth, broad-based participation in growth, and economic security. The authors are invited to express their own ideas in discussion papers, whether or not the Project's staff or advisory council agrees with the specific proposals. This discussion paper is offered in that spirit.

The opinions expressed are the authors' own. They do not represent any position or policy of the National Institutes of Health, the Public Health Service, or the Department of Health and Human Services.

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Abstract

The Universal Healthcare Voucher System (UHV) achieves universal health coverage by entitling all Americans to a standard package of benefits comparable to that received by federal employees. Enrollment and renewal are guaranteed regardless of health status, as is the individual's right to buy additional services beyond the standard benefits with after-tax dollars. Health plans would receive a risk-adjusted payment based on their enrollment. UHV is funded entirely by a dedicated value-added tax (VAT) with the rate set by Congress. A VAT of approximately 10 to 12 percent would insure all Americans under age 65 at a cost no greater than current public and private health care expenditures.

UHV offers true universality, individual choice, effective cost control, and competition based on quality of care and service. To foster accountability and efficient administration, the voucher system creates a National Health Board and twelve regional boards with a governance structure and reporting requirements similar to the Federal Reserve system. The National Board establishes the overall rules and procedures and sponsors an independent Institute for Technology and Outcomes Assessment, which will slow the rate of growth of expenditures by encouraging cost-effective innovations. In each region a Center for Patient Safety and Dispute Resolution replaces the dysfunctional malpractice system. UHV is relatively simple compared with other reforms that have similar objectives. Most importantly, it is congruent with basic American values: equality of opportunity and freedom to pursue personal goals.

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1. Introduction

The American health care system is a dysfunctional mess. The problems are well known. There are coverage problems: tens of millions are uninsured, others have poor coverage, and millions receive Medicaid, which looks comprehensive on paper but, because of extremely low reimbursement, is served by few providers. In addition, as costs rise there has been—and will continue to be—a steady drop in employer-based insurance. There are cost problems: the rise in health care costs exceeds the economy’s rate of growth by 2.5 to 4 percentage points each year (Catlin et al. 2007, Kaiser 2006). Economists predict that health care will consume one of every five dollars of output in the entire economy by 2016 (CMS 2005). Medicare is going bankrupt. Given present trends, it will consume all taxes collected under current law in slightly more than fifty years (Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds 2007). There are serious quality problems: it has become part of the conventional wisdom that 100,000 Americans die each year from medical errors, that only 55 percent of proven-effective therapies are administered to patients who need them, and that fewer than 25 percent of doctors and hospitals have installed electronic medical records, despite their advantages for quality and efficiency (Corrigan, Donaldson, and Kohn 2000, McGlynn et al. 2003, Wachter and Shojania 2004). Paradoxically, the huge amount of money the United States is currently spending on health care should be sufficient to provide high-quality care for all Americans.

Myriad reforms of the health care system have been proposed; they can be grouped into three broad categories (Pauly 2001, Palmisano, Emmons, and Wozniak 2004, and Butler 2001). First are incremental reforms, such as expanding the existing State Children’s Health Insurance Program (SCHIP) to cover all uninsured children, expanding Medicare to cover people between fifty-five and sixty-five, or

providing tax breaks to individuals to buy health coverage. These reforms do not try to solve any single problem entirely, much less seek to change the fundamentals of the health care system. Rather, they try to make headway mainly by expanding coverage.

Second are individual mandates. Having been enacted in Massachusetts and proposed in California and Pennsylvania, this is the health care reform of the moment (Gruber 2006). It is a “fill-in-the-cracks” approach. It aims for nearly 100 percent coverage by requiring that individuals buy insurance. To enable them to do so, these plans typically expand Medicaid, create new health-purchasing mechanisms such as Massachusetts’s Health Care Connector or some other form of insurance exchange, and provide income-linked subsidies so that all can afford health insurance (Enthoven and Kronick 1989). Like incremental reforms, individual mandates aim at extending coverage but, because they keep the current health care financing and delivery systems in place, do not address the problems of cost and quality.

Single-payer plans have long been proposed (Physicians for a National Health Program 2003, Krugman and Wells 2006). *Single payer* is a capacious term that could refer to any plan that relies on tax revenue to finance health care, but in the U.S. context the term is associated with a distinctive approach to reform modeled on Medicare or on the Canadian health care system. Advocates of a single-payer plan would eliminate private insurance and for-profit providers and would use the expected large savings from reduced sales and administrative costs to achieve universal coverage and expand the range of services provided. Most of the single-payer plans currently proposed enshrine fee-for-service payment for physicians and call for negotiated budgets with hospitals.

Although incremental reforms, individual mandates, and single-payer plans all address some of the key problems of the American health care system, all have important operational and political flaws (Fuchs and Emanuel 2005). To address the problems of coverage, cost, and quality in a sustainable, plausible manner, we offer a fourth alternative: universal health care vouchers. But before considering this alternative, it is worth asking what, if anything, can be learned from these other proposals.

It is hard to see what can be learned from proposals for incremental reform. These proposals would not achieve universal coverage, they would increase rather than decrease health care expenditures, and they would leave the current dysfunctional system essentially unchanged.

Individual mandates stress the value of the insurance exchange. If we as a nation decide to retain private health care delivery financed by health plans and insurance companies, then using such arrangements to create extremely large purchasing pools can reduce insurance underwriting, sales, and marketing costs. It can also permit community rating, in which premiums are the same for everyone rather than being adjusted for age, health risk, or other factors. But *voluntary* exchanges such as Massachusetts's Health Care Connector are inherently unstable. As the experience of the now defunct PacAdvantage in California and other voluntary in-

urance exchanges has shown, they lead to adverse selection: the enrollees are disproportionately the sicker patients whose higher costs set off a vicious cycle of ever-higher premiums and reductions in enrollment (PacAdvantage 2006). This suggests that any workable system needs to have *mandatory* enrollment and risk adjustment of premiums so that an insurance company will be fairly compensated if its average enrollees are in particularly poor health. Moreover, because individual mandates by themselves do not fundamentally change the health care delivery system, they can do little to stem cost increases or improve quality of care.

Advocates of single-payer plans argue that a central financing mechanism can achieve tremendous administrative savings and, by removing employers from the business of providing health insurance for their employees, can generate substantial labor efficiencies, thus stimulating the economy. But these savings change only the level of expenditures—they do not affect the rate of increase over time. Lowering the steep slope of the upward curve of health care spending can only be achieved by changing the delivery system to provide incentives, information, and infrastructure for more integrated and cost-effective delivery of care. This reform is impossible within a single-payer system bent on minimizing administrative costs while leaving the fee-for-service reimbursement system in place.

2. The Essential Elements of Universal Health Care Vouchers

How can we integrate central financing of health care with large purchasing pools to gain the advantages of single-payer plans and individual mandates while avoiding their disadvantages? We propose universal health care vouchers as the comprehensive cure for the ailing American health care system (Emanuel and Fuchs 2005). Universal health care vouchers involve a ten-step therapy (see also Table 1).

1. Guaranteed health care for all Americans.

All U.S. residents would receive a voucher good for the acquisition of health coverage through a qualified health plan or insurance company. At first, those who currently receive coverage through Medicare, Medicaid, SCHIP, or another government program would choose whether to stay with their current program or join the voucher system. Unlike a health savings account, the voucher would not provide a specified dollar amount to be used to buy individual medical services over the year, but instead would convey the right to enroll in a health plan that covers a set of standard benefits. In other words, it would be an insurance voucher, not a cash voucher. The recipient would pay nothing directly for the voucher itself or for the benefits that it covers; financing would be accomplished through a dedicated value-added tax (VAT) described below. There would be no deductibles and minimal copayments.

2. Comprehensive benefits. The voucher would cover a set of comprehensive benefits modeled on the generous benefits that federal employees, including members of Congress, receive today through the Federal Employees Health Benefits (FEHB) program.¹ To qualify for participation in

the voucher program, health plans and insurance companies would have to agree to provide these standard benefits for the value of the voucher. Those that qualify, however, would otherwise be free, for the most part, to structure their businesses as they see fit. They could shrink (within limits) or expand their physician and hospital networks. They could offer different drug formularies, more disease management programs, or a larger or smaller choice of specialists or specialty hospitals, or make other modifications. They could even offer, at an additional charge, benefits not covered by the voucher. But, other than copayments, they could not charge voucher holders for coverage of the standard benefits.

3. Freedom of choice. Like today's programs with individual mandates, the voucher system would establish an insurance exchange in each region of the country to facilitate enrollment by individuals and families in the health care plan of their choice. All Americans except those who prefer to remain in Medicare, Medicaid, or SCHIP would receive their coverage by enrolling through the insurance exchange. Participating health plans and insurance companies would be private and would not be run by the government. In most regions, consumers would have freedom of choice among several qualified health plans or insurance companies; probably five to eight, but as many as twenty or more in some locales. They would be free to change plans each year or to select a three-year enrollment option that would provide them with some additional benefits. Americans who fail to enroll themselves in a health plan or insurance program would be assigned to one, on an equitable basis, by the exchange in their region.

1. FEHB program includes coverage for preventative screenings, brand name and generic prescription drugs, dental care, home and office visits, physical and occupational therapy, and mental health inpatient and outpatient care. The plan also allows patients to choose their own doctors and hospitals, requires no referral for specialist visits, and charges low copayments. See FEHB 2007 for a full set of benefits.

TABLE 1

Ten Main Features of the Proposed Universal Health Care Voucher System

Feature	Description
Guaranteed health care for all	Each household would receive a voucher for coverage through a qualified health plan or insurance company. The voucher would not be a cash voucher denominated in dollars to buy health services, but rather would be an insurance voucher entitling the holder to enrollment in a health plan of the holder's choice.
Standard health benefits	Standard benefits would be generous, modeled on services currently received by members of Congress and other federal employees through the Federal Employees Health Benefits program.
Freedom of choice	Voucher holders would be able to choose from among several health plans. Plans would be required to accept any enrollee without exclusions for preexisting conditions and with guaranteed renewability.
Freedom to purchase additional services	Voucher holders could choose to buy, with after-tax dollars, additional services and amenities such as wider selection of physicians, coverage of complementary medicines, or additional mental health benefits.
Funding through a dedicated value-added tax (VAT)	Financing for the vouchers would come from a dedicated VAT of about 10 to 12 percent on purchases of goods and services. Revenue from the tax could not be diverted to other uses such as defense or Social Security.
End of employer-based insurance	The tax exemption for employer-based health insurance would be eliminated. Employers would probably stop offering health insurance, and wages would rise in line with the current cost of health insurance.
Phasing out of Medicare, Medicaid, SCHIP, and other government health programs	No one receiving benefits from Medicare, Medicaid, SCHIP, or any other government program would be forced out, but there would be no new enrollees. Current enrollees would have the option of joining the voucher system. Over about fifteen years these programs would shrink in size and eventually disappear.
Independent oversight	A National Health Board and twelve regional health boards would be created on the model of the Federal Reserve System. Members of the National Board and chairs of the regional boards would be nominated by the President and confirmed by the Senate for long (e.g., ten-year) terms; the other regional board members would be named by the National Health Board. Dedicated funding would make the boards independent of annual congressional appropriations and help insulate them from political lobbying.
Cost and quality control measures	A new Institute for Technology and Outcomes Assessment would assess the effectiveness and cost of new drugs, medical devices, diagnostic tests, and other interventions on the basis of both existing research and new studies commissioned by the Institute. The Institute would also assess the outcomes of patients in the different health plans. Results of the assessments would be publicly disseminated in ways that protect patient confidentiality. To ensure objectivity and independence, the Institute would be funded by a dedicated share of the VAT revenue, estimated at 0.5 percent.
Patient safety and dispute resolution measures	Each regional health board would create a regional Center for Patient Safety and Dispute Resolution to receive and evaluate claims of injury by patients; compensate those patients found to have been injured by medical error; and, when appropriate, discipline or disqualify from practice physicians providing poor-quality care. The regional centers would also evaluate interventions to enhance patient safety and would coordinate and fund implementation of valuable interventions by health plans, hospitals, physicians, and others. Physicians would likely pay greatly reduced premiums to cover those (probably rare) malpractice awards in cases that go to court. The centers would be funded by a dedicated 2.5 percent of the VAT revenue.

To participate in the voucher system, health plans and insurance companies would have to guarantee enrollment and renewability every year for all applicants without consideration of their medical history: they could not turn anyone away for any reason and could not refuse to cover preexisting conditions. They would have to provide aggregate data on their own past performance, including patient satisfaction, disenrollment rates, hospitalization and mortality rates for various conditions (such as diabetes, emphysema, and heart attacks), patient outcomes for various conditions, and other quality measures.

Regional health boards would certify that each health plan and insurance company has a sufficient network of hospitals and physicians and adequate financial reserves, and that the plan or company is in fact providing the standard benefits. The regional boards would pay each plan and company a risk-adjusted premium for each person or family enrolled. To minimize the financial incentive for plans and companies to cherry-pick the healthiest patients and avoid enrolling sicker ones, the government would adjust the premium for age, sex, smoking status, preexisting conditions, and other factors, as determined by the National Health Board.

4. Freedom to purchase additional services.

Individuals and families would be free to purchase additional health care services or amenities that are not part of the standard health benefits. These might include greater choice of physicians and hospitals, access to a wider range of drugs or more brand name drugs, wider choice of eyeglasses, more mental health benefits, or even a “concierge medicine” package that eliminates time limits on office visits and provides for physicians to make house calls. However, payments for this additional coverage would not be tax deductible; they would be paid for with after-tax dollars, as is the case for food, clothing, and other consumer goods.

5. Funding by a dedicated VAT. Funding for the vouchers would come entirely from a dedicated value-added tax (VAT), similar to a sales tax on

purchases of goods and services. Initially the VAT would be about 10 to 12 percent on all purchases subject to the tax. All the money raised, and only that money, would be used to support the voucher system. Thus there would be a direct connection between the VAT rate and the level of services included in the core benefits—the more generous the benefits, the higher the tax rate would have to be. Congress would have the power to set and adjust the VAT rate.

6. An end to employer-based insurance. The current tax benefit for employer-based health insurance would be eliminated. Since all workers would now receive vouchers for the standard health benefits, they would no longer look to their employers for health insurance and would likely demand higher wages instead. Employer competition for workers would push up wages in those firms that previously provided insurance. Some employers might still provide extended coverage for services not included in the standard benefits as a fringe benefit to attract or reward workers. This could be done in either of two ways: the employer could offer a specific dollar amount to its workers to pay for certain noncovered services (a defined contribution), or the employer could purchase an insurance plan on the workers’ behalf. In either case, these added benefits would be taxed like other compensation rather than being exempt from tax as employer-provided health benefits are today.

7. Phasing out of Medicare, Medicaid, SCHIP, and other government health insurance programs. Americans whose health care is currently paid through Medicare, Medicaid, SCHIP, or another government health insurance program would not be forced to switch to the voucher plan. Initially, the voucher system would cover the 210 million Americans who are insured through their employers, self-insured, or uninsured. The 41 million Americans aged sixty-five and older enrolled in Medicare and the 50 million Americans who receive Medicaid, SCHIP, or other means-tested government health benefits (Kaiser 2006) would have a choice: to remain in their government-funded pro-

gram or to join the voucher system. However, there would be no new enrollees in Medicare, Medicaid, SCHIP, or other current programs. Americans who turn sixty-five after the voucher system goes into effect would remain in the voucher system. Similarly, those now receiving Medicaid or SCHIP would have to switch permanently to the voucher system if they get a job or otherwise become ineligible for their current program. Thus, over time, fewer and fewer people would participate in these government-run health programs. Within essentially fifteen years, all Americans would receive the same standard benefits within the same health care delivery system. There would be one universal health care voucher system—a public guarantee with private provision of services—for all Americans regardless of age, income, employment, health, or marital status.

8. Independent oversight. To reduce political interference and allow tough administrative choices to be made, a National Health Board and twelve regional health boards would be established, modeled on the Federal Reserve System. Members of the National Health Board and the chairs of each regional health board would be nominated by the president and confirmed by the Senate for a long fixed term (say, ten years), which could be renewed only once. The terms of the National Health Board members would be staggered, with the term of only one member expiring in any given year. This board would appoint the members of the regional health boards to similarly staggered terms of the same length.

The administrative budgets of the National Health Board and the regional health boards would be funded from the dedicated VAT, not by an annual appropriation by Congress. The National Health Board would have responsibility to

- define and regularly adjust the standard health benefits to reflect changes in standards of care, advances in technology, and fiscal realities;

- conduct research to determine the risk adjustments necessary for the premiums paid to health plans;
- determine payment differences based on geography;
- sponsor research on quality, outcomes, and performance of the health care system;
- oversee and coordinate the regional health boards; and
- report regularly to Congress and the American public on the health care system.

Within their geographic regions, the twelve regional health boards would have responsibility to

- oversee the insurance exchanges;
- certify and oversee the participating health plans and insurance companies and ensure that they have sufficient financial reserves and medical resources to provide the health services offered in the standard benefits package;
- manage the enrollment of individuals and families in health plans and insurance companies and assign to a health plan those who do not enroll on their own;
- pay the health plans and insurance companies the risk-adjusted premiums on their enrollees' behalf; and
- collect, analyze, and disseminate information on the quality of health care delivered by the individual health plans and insurance companies.

9. Cost and quality control mechanisms. An Institute for Technology and Outcomes Assessment would be created to judge the value of new drugs, medical devices, tests, and other interventions and

to assess patient outcomes under the system. This Institute would be responsible for

- systematic review of research studies and other data on the effectiveness of different drugs, devices, new technologies, and other interventions;
- comparison of the effectiveness and costs of drugs, devices, diagnostic tests, and other interventions;
- commissioning of research studies to compare drugs, devices, diagnostic tests, and other interventions;
- collecting data from health plans and insurance companies on patient outcomes and on the drugs, medical technologies, and interventions used; and
- disseminating data on technology and outcomes assessments to health plans, physicians, patients, drug and technology manufacturers, and the general public, while respecting patient confidentiality.

To ensure the independence and objectivity of the Institute's work, funding would come from a fixed share (estimated at 0.5 percent) of the total revenues of the dedicated VAT. In addition, its operations would be overseen by an independent board appointed by the National Health Board.

10. Centers for Patient Safety and Dispute Resolution. Each regional health board would create a regional center for patient safety and dispute resolution. These centers would be responsible for

- receipt and adjudication of patient complaints about medical errors and injuries;
- compensation of patients where it is found that their injuries were caused by medical error;
- discipline, disqualification, and prohibition from practice of physicians and other health professionals who injure patients or violate established safety procedures;
- development of programs to promote patient safety; and
- coordination with health plans, hospitals, physicians, visiting nurses, and others to implement interventions proven to enhance patient safety.

Patients who believe they have been injured and are not satisfied by the center's resolution of their complaint would still be able to sue for malpractice.

Funding for the centers and for compensation to injured patients would come from the dedicated VAT. Since the current malpractice system costs about \$20 billion a year (CBO 2004), approximately 2.5 percent of the VAT's total revenues would be required. With the centers paying for initial investigation, adjudication, and compensation, physicians would not have to pay malpractice premiums. They could still retain insurance in case patients are dissatisfied with the resolution by the centers and elect to sue, but only a small amount of insurance should be necessary.

3. Economics of Universal Health Care Vouchers

We believe that any comprehensive health care reform proposal should meet two basic criteria. First, current national health expenditures should not have to increase to cover all Americans. That is, the initial cost of the new health system should not exceed the amount being spent on health care at this time. The system does not need more money—it needs to spend the money more efficiently. Second, the rate of increase in health care spending over time should reflect the growth of the economy and the public’s willingness and ability to pay for health care services.

Would instituting a universal health care voucher system increase or decrease national health care costs at the time it is instituted? In 2005, the annual premium for the FEHB program varied by state, but the premium in the high-end Blue Cross–Blue Shield preferred provider plan that serves as the basis for the voucher system’s proposed standard benefit was \$4,728 for individuals and \$10,824 for families. Table 2 indicates that the total cost (using the 2005 premiums) for all Americans except those in Medicare would be \$778 billion.

TABLE 2

Projected Costs of the Proposed Universal Health Care Voucher System^a Compared to Current System Costs^b

a. Universal Health Care Vouchers			
Group served	Number	Average annual premium	Total annual costs
<i>Individuals</i>	15.2 million	\$4,728	\$71.9 billion
<i>Families</i>	65.2 million ^c	\$10,824	\$705.7 billion
Total non-Medicare population	257.6 million	NA	\$778 billion
<i>Increase for extra use by uninsured and Medicaid populations</i>	25 percent of population	Added costs per person: 26 percent more than the average	\$50 billion
Total non-Medicare	257.6 million	NA	\$828 billion^d

b. Current Employer-Based System	
Type of insurance	Total annual costs
Medicaid	\$260 billion ^e
Private Health Insurance	\$694 billion
Total non-Medicare	\$954 billion

a. 2005 rates and expenditures. Annual premium is based on FEHB Blue Cross–Blue Shield standard national plan. Using Government Employees Health Association (GEHA) high national benefit plan (2005 annual premiums are \$4,728 for individuals and \$10,824 for families) the total non-Medicare costs would be \$778 billion. Adding \$50 billion for extra use by the Medicaid and currently uninsured populations yields \$828 billion.

b. Using estimates from 2005 according to figures cited in Catlin et al. 2007.

c. The average family size is 3.7 persons.

d. See Footnote 2 in the text for the calculation of this figure.

e. Excludes payments for nursing homes.

Many who are currently uninsured are young, healthy individuals—self-defined “invincibles”—who choose not to insure themselves. But others are uninsured because they are unhealthy and cannot obtain insurance, or have low incomes and cannot afford it, or both. The Medicaid population tends to be sicker than the federal employee population, and therefore their costs are likely to be higher. A study by the Urban Institute estimates that, for an equivalent level of coverage, the uninsured and Medicaid populations incur about 26 percent higher costs per person than employed populations with private insurance (Holahan, Bovbjerg, and Hadley 2006). The uninsured and Medicaid populations under age sixty-five account for about 25 percent of the total U.S. population under age sixty-five. Costs under the voucher system would therefore be higher than the \$778 billion calculated based on premium rates for the FEHB program. This increase raises the total estimate to \$828 billion.

This is a large sum, but it needs to be compared with current health spending for the same population. In 2005 (the most recent year for which data are available), federal and state governments spent \$260 billion on Medicaid, not counting what they spent on nursing home care. In 2005, the total expenditure for private health insurance was \$694 billion; this figure excludes out-of-pocket expenses for prescriptions, dental services, and other products (Catlin et al. 2007). These two figures sum to \$954 billion (in 2005 dollars) for the 257.6 million Americans not currently receiving Medicare. This means that universal health care vouchers would not increase total national expenditure on health care, yet would cover everyone with essentially the same plan that covers members of Congress, even taking into account the higher use by the currently uninsured and Medicaid populations.

Much of the \$828 billion would replace existing spending, both private and public. Moving Medicare, Medicaid, and SCHIP beneficiaries into the voucher plan would yield further savings. First, the need for safety-net providers for the uninsured—county hospitals, community clinics, and the like—would be obviated because all Americans would have health coverage. This should reduce the health care expenditures of municipal and state governments. Second, the responsibility of state and municipal governments for funding of health care for their own employees would be eliminated, thus saving these governments even more. For instance, in 2006 almost 3 percent of Maryland’s state budget went to health insurance for state workers (Maryland 2006). This would be saved. Third, as new enrollment in Medicaid and SCHIP stops, and as current beneficiaries get jobs or choose to enroll in the voucher plan and cease to be eligible for these programs, their funding demands should decline. In Maryland in 2006, Medicaid accounted for 17 percent of the state budget and SCHIP for 2 percent.³ Thus the combination of eliminating state responsibility for employee health insurance and phasing out Medicaid and SCHIP would save states about 20 percent of their budgets. Although states and municipalities may choose not to reduce taxes by the full amount they save—they may instead reallocate some of the savings to other activities, such as education—their citizens should see substantial declines in state and municipal taxes along with improvements in services. The federal government would also realize substantial savings from phasing out Medicaid and SCHIP.

The total phasing out of Medicare would constitute yet another important change in taxes. With no new enrollment, the number of Medicare enrollees would decrease by about 5 or 6 percent a year because of mortality, and the program would

2. The uninsured and Medicaid populations are about one-quarter of the insured population, and therefore the fraction of costs attributable to these groups is assumed to be approximately one-quarter of the \$778 billion for the insured population, or \$194 billion, augmented by 26 percent because of the higher cost per person of these populations, for a total of \$245 billion. Adding the extra \$50 billion in costs for this population (\$245 billion minus \$195 billion) to the \$778 billion for the insured population results in a total of \$828 billion.

3. Maryland budget figures according to the Department of Health and Mental Hygiene (Maryland 2006).

draw to a close in a few decades. This would allow Medicare taxes—currently 2.9 percent of payroll—to be phased out. There would also be a decrease in the general federal revenue devoted to Medicare to make up for shortfalls in the trust fund. In short, the phase-out of Medicare would rapidly result in a substantial reduction in Medicare expenditure.

How are the \$126 billion savings possible? First, underwriting, sales, and marketing costs would be significantly lower under the voucher system

than under the current system of employer-based insurance and self-insurance. In addition, employers would save the cost of administration of health benefits. Also, although the FEHB program is generous, some Americans have even more generous benefit packages. They would be entitled to fewer benefits than they currently receive through their employer-based insurance and would have to pay for any additional services. That additional cost is not included in the above figures.

With no restrictions or enrollment requirements, and no exclusions for preexisting health conditions, a universal voucher system would guarantee that every American has health coverage—not 96 or 97 percent, but 100 percent.

4. Comparing Universal Health Care Vouchers with Individual Mandates and Single-Payer Plans

Table 3 summarizes the principal differences between the proposed universal health care voucher system and proposals for individual mandates and single-payer systems. Unlike individual mandates, universal health care vouchers would simply and efficiently achieve universal coverage without the costly administration of income-based subsidies. The poor and the sick would be implicitly subsidized by the difference between the value of the voucher to them and the amount of VAT they pay. Also, unlike mandates, a voucher system would not prop up an inefficient and inequitable employment-based insurance system, nor would it require beneficiaries to change health plans when their in-

One very important difference between a universal voucher system and single-payer systems currently proposed is that the latter promise an open-ended entitlement that is often not tied directly to adequate funding. In the voucher system, by contrast, expenditure and revenue are explicitly connected through the dedicated tax. Also, single-payer systems generally provide only a monetary promise; they do not guarantee access to care. Many Medicare beneficiaries today have difficulty finding a physician to accept them as a patient. In a voucher system, everyone would be enrolled in a plan that is held responsible for providing care to its enrollees.

A universal voucher system would make plans accountable for quality and service by allowing only qualified plans to enroll patients.

come, employment, marital status, or other characteristics change. Finally, because the voucher system would be universal no coverage denial, it would not be subject to the adverse selection problem in which a disproportionate share of higher users of care are drawn into the system while the better insurance risks make other arrangements. Individual mandates by themselves remain subject to this serious problem.

Finally, a crucial difference between a voucher system and the other two models is that neither of the other two models makes a significant effort to improve efficiency in the organization and delivery of care. The projected universal voucher system, by contrast, would make plans accountable for quality and service by allowing only qualified plans to enroll patients. Paying a risk-adjusted fee per enrollee (that is, capitation) creates a strong financial incentive for insurance companies to be efficient in care delivery. In short, the projected universal voucher system would be more than just a funding mechanism. It would create a positive dynamic that moves the entire system toward more efficient use of resources and higher-quality care.

TABLE 3

Comparison of the Proposed Universal Health Care Voucher System with Other Proposals

Criterion	Universal health care vouchers
Universal coverage	True universal coverage of all Americans.
Choice	Every American has a choice of health plan, hospital, and physicians.
Role of employers	Employers are taken completely out of the health care system. Consequently, wages increase and strikes over health care disappear. Neither workers nor employers any longer make job decisions based on health insurance considerations.
Cost control	Controls costs through several mechanisms: a dedicated tax that limits what can be spent; competition between health plans; greater cost-consciousness on the part of individuals buying additional services; systematic technology assessment that eliminates practices of marginal or no value; and incentives that shift R&D by drug and medical device companies toward more cost-effective interventions.
Administrative efficiency	Administrative costs are about 10 percent of total health care spending. Administrative savings are achieved by reducing insurance underwriting, sales, and marketing, and through administration cuts by employers. The elimination of the administrative burden of Medicaid, and of the income-linked determination of subsidies would also create administrative efficiencies.
Technology and outcomes assessment	Creates an Institute for Technology and Outcomes Assessment to evaluate the effectiveness and cost of drugs, devices, and new technologies and to evaluate patient outcomes and the quality performance of health plans and insurance companies.
Delivery system	Provides strong incentives, through financing and data collection by the regional health boards, for health plans to integrate care across hospitals, physicians, and other providers.

Individual mandates

Falls short of universal coverage.

Requires everyone to have insurance coverage through an employer, government, or self-purchase, but some people will evade mandates and others will be exempted because coverage is unaffordable.

Many people insured through their employer continue to have no choice of health plan. People insured through Medicaid still have very limited choice.

Employers remain involved in health care as they are now. Employers who drop insurance coverage for their workers may pay a penalty.

No cost control mechanism.

Administrative costs exceed 15 or 20 percent, with no administrative savings. The need to determine incomes and the level of subsidies provided to individuals to buy health insurance would increase costs.

No systematic effort to assess technology or outcomes.

Same health care delivery system as at present. No financial or other incentive to create accountable health plans or integrate care.

Single-payer plans

True universal coverage of all Americans.

Every American has a choice of hospital and physicians but is enrolled in a single nationwide plan.

Employers are taken completely out of the health care system.

Controls costs through negotiation of fees, prices, and budgets with physicians, hospitals, drug companies, and other providers; and through restrictions on the supply of medical technologies.

Administrative costs of about 3 to 4 percent. Administrative savings are achieved by removing employers as well as all insurance companies and for-profit providers from the health care system.

No systematic effort to assess technology or outcomes.

Same health care delivery system as at present. No financial or other incentive to create accountable health plans or integrate care.

5. What Would the Health Care Experience Be Like Under a Universal Voucher System?

Initially, all Americans who are not in Medicare, Medicaid, or SCHIP would be notified by their regional health board that they can now choose their health plan or health insurance company through the insurance exchange. Through mailings, the Internet, and other mechanisms, potential enrollees would be informed about the different plans available in their geographic area. Charts would identify the similarities and differences in the various plans: what local hospitals each plan uses, the physicians participating in the plan, the copayments required, and other relevant information. Americans would also be instructed on how to enroll. People with coverage today would be able to keep their current doctor, and many aspects of their plan would remain the same.

As stated above, Medicare, Medicaid, SCHIP, and other government health programs would initially remain in place, but participants in these programs would be notified that they could now switch to the voucher system. Those who prefer not to switch would just stay in their current program.

For most Americans, enrollment in a health plan under the universal health care voucher system would feel much like what they currently experience through their employer-based coverage, with four important differences. First, they would have a wider choice of health plans. Today most Americans who are covered by their employer have no choice of health plan (Kaiser 2006). They are told who will provide their coverage and what will be covered. Those currently uninsured would experience a new freedom to choose a health plan.

Second, Americans would no longer have to be screened to determine their premiums or to determine what will be excluded from coverage for the first year. No health plan or insurance company would be allowed to subject Americans to pretesting or to deny coverage on the basis of preexisting

conditions. No one could be denied enrollment or renewal of coverage for any reason. Instead of health plans choosing their enrollees, as is effectively the case today, enrollees would be allowed to choose their health plan.

Third, enrollees would pay nothing directly for the set of standard health benefits. The universal health care voucher would cover the full cost. There would be no premiums deducted from paychecks or paid for out of pocket. There would be no deductibles, and many people would find their copayments to be less than what they are currently paying.

Finally, enrollees could decide whether they want to buy additional services or insurance coverage, and how much they are willing to pay for them.

Workers who currently receive health coverage through their employer—whether they work in a factory, an office, or a government agency—would see more money in their paycheck as employers compete for their labor by offering higher wages instead of health benefits. Fringe benefits such as health coverage are, after all, just another form of compensation (Gruber 2000). When employers stop offering health insurance, the money that before went into health insurance premiums would be offered instead to workers as higher salaries to induce them to stay with the company. How much would workers' pay rise? It would primarily depend on how much of current workers' compensation is in the form of health insurance.

Conversely, Americans would for the first time pay a VAT. Over time, as Medicare and Medicaid are phased out and their beneficiaries are enrolled in the voucher system, it would increase from the initial 10 to 12 percent to approximately 15 percent. The new tax would be offset by the higher wages mentioned above, however, and by reductions in other taxes. Each year the federal govern-

ment would pay less and less for Medicare, Medicaid, SCHIP, and other programs, reducing the strain on federal finances. Similarly, states would pay less and less for Medicaid, SCHIP, and other need-based programs, and payments for state workers' health insurance would be eliminated; as calculated above, elimination of state expenditures devoted to these programs would reduce total state government spending by about 20 percent. Finally, as mentioned above, state and local funding of safety-net providers—including county hospitals, community health clinics, and other programs—could be phased out, clearing the way for further tax reductions. These safety-net providers would be integrated into the health plan packages approved by the regional health boards.

People with diabetes, emphysema, and other chronic conditions would probably experience much better coordination of care: more home visits from nurses to be sure they are taking their medicine and following the treatment plan, and more telephone calls and other reminders to check on their diet and their use of medications and vaccines. They also would probably observe a greater effort to involve them in exercise, smoking cessation programs, and other preventive activities. Capitation payment to the health plans leads them to emphasize keeping enrollees well.

Potential Concerns About Universal Health Care Vouchers

Three main obstacles stand in the way of enacting a universal health care voucher system. First is the perception on the part of many that a VAT would be regressive and would hurt the poor. Although this contention is widely repeated, it is simplistic at best, and simply bad economics at worst. The fairness of any tax proposal cannot be properly evaluated by considering only the tax. The benefits that the tax would pay for must also be considered—as well as the costs and benefits of alternative policies, or of doing nothing. The current system, is structured largely around the generous tax benefits, worth about \$200 billion in 2007, given to

employer-based insurance. The system is heavily biased toward the rich and against the less well off (Sheils and Haught 2004). Not only do the rich receive a bigger tax break, but the working poor often pay Medicare and other taxes yet receive no health coverage in return. Under the universal health care voucher system, everyone would pay the VAT in proportion to their consumption.

The essential point, however, is that less-well-off Americans—as well as all those who are sick and therefore need more health care services—would generally receive much more in benefits than they would pay in taxes. Health coverage for a family today costs about \$11,000 a year. The poor, the near poor, and many other people earning less than the median income would not pay anywhere near that much in value-added taxes. Consequently, the value of the health coverage they receive would greatly exceed what they pay in tax for that coverage. That is the hallmark of progressivity.

A second obstacle is the danger that insurance companies and health plan sponsors might find ways to cherry-pick (or lemon-drop) prospective customers in a system that allows all Americans to choose among competing health plans. It could be profitable for a health plan or insurance company to avoid sick patients and attract young, healthy ones. Sick patients might be discouraged from signing up, for example, if a hospital network failed to include a cancer center, offered only second-rate mental health services, or did not contract with the best diabetes doctors.

Fortunately, there are ways of preventing this outcome. The key is risk adjustment. The regional health boards would pay health plans more per patient if they enroll older, sicker patients on average, and less if they enroll young, healthy people. Some health care systems in the United States and health authorities in some other countries, such as the Netherlands and Israel, already have relevant experience with what does and does not work. This experience could be applied to the voucher system. Admittedly, risk adjustment is still an imperfect

science. The National Health Board would need to conduct research into improving adjustment methods. In the meantime, however, there could be some form of reinsurance. For instance, regional health boards could provide “stop-loss” coverage, so that any plan that spends more than \$100,000 on a single patient is not held liable for the full cost; the regional health board would pick up the excess. But however it is accomplished, some form of risk adjustment is critical to a stable, efficient, and fair program and to ensuring that the system focuses resources on providing the best health care for people who are sick, not on coddling the worried well.

The final hurdle that universal health care vouchers must overcome is political. The voucher program constitutes a comprehensive reform of the U.S. health care system. It would mean change in the way health care insurance is financed, change in the role of employers, change in the way the system is administered, change in the way Americans enroll, change in the way the system delivers care, and change in the way technology is developed and evaluated. Such far-reaching change is sure to create uncertainty, and uncertainty makes people cautious. Overcoming such inertia and innate risk aversion is a challenge facing any serious health care reform. What ultimately emerges will depend on a balance of factors: how bad the system has become, how willing people are to try something new, and how much comfort they can be given that what is being proposed has a good chance of being better.

Advantages of Universal Health Care Vouchers

Compared with the current health care system, the universal health care voucher system offers advantages in almost every area: coverage and choice, administrative efficiency, cost control, quality, and impact on the economy.

Coverage and Choice. With no restrictions or enrollment requirements, and no exclusions for preexisting health conditions, a universal voucher

system would guarantee that every American has health coverage—not 96 or 97 or even 99 percent of Americans, but 100 percent. Even those who fail to sign up for a health plan would be assigned a plan and would be covered. There would be no gaps.

Americans would enjoy both continuity of coverage and choice. As long as they wanted to stay in a health plan or with a particular physician, they could do so. They could not be denied coverage or denied renewal of their plan. Their employer could not switch plans or force them to change physicians or hospitals. Each individual would decide whether and when to switch health plans, physicians, or hospitals and whether or not to buy additional services beyond those in the standard health benefit. Each household would be allowed to weigh whether a wider choice of physicians or coverage for complementary medicine is worth the money that could otherwise be spent on, say, sending their children to a private college or buying a new car.

Administrative Efficiency. Eliminating the employer from health coverage and removing the burden of Medicaid administration on states would create significant administrative savings and efficiencies, as described above. Putting all Americans—initially everyone except those who choose to remain in Medicare, Medicaid, SCHIP, or another government program—into the insurance exchange would save tens of billions of dollars that are now spent on insurance underwriting, sales, and marketing. Since the voucher system would require no determination of eligibility for participation or for subsidies based on income, its adoption would produce additional billions in administrative savings. Employers also would save billions because they would no longer need such large human resources departments to manage health benefits, track health contributions, and hire consultants to evaluate various insurance options. Once phase-in is complete, states would no longer have to administer Medicaid, and providers would no longer have to bill Medicaid, producing still more efficiency.

The universal voucher system would lead to a reduction in the number of health plans and insurance companies. There are more than one thousand such companies that operate today; these would probably consolidate to fewer than one hundred or so companies nationwide, with many fewer in any one city or region. This would lead to significant savings in billing costs at hospitals and physicians' offices. As Medicare, Medicaid, SCHIP, and other government programs are phased out, hospitals, physicians' offices, home health agencies, and others would realize additional administrative savings because they would be dealing with even fewer billing systems.

The administrative costs of the universal voucher system would not be as low as those of a single-payer system. Expenditures for the Institute for Technology and Outcomes Assessment (an estimated 0.5 percent of costs) and for the Centers for Patient Safety and Dispute Resolution (2.5 percent), as well as for the national and regional health boards, would probably amount to 10 percent of the system's total cost. Even with these costs, however, more than \$100 billion in administrative savings would be realized each year.

Cost Control. Another major advantage of the universal voucher system would be effective cost control, which would ensure the financial sustainability of the entire health care system. This would be achieved without price controls or the centralized management of local spending constitutive of current single-payer proposals. There would be five separate cost-control levers. First, and most effectively, the yield from the VAT would determine how much could be spent on the vouchers. This would provide a hard budget constraint on cost increases. Of course, revenue collected by the VAT would rise as the economy grows; but if the public wanted health care spending to grow even more rapidly because it wanted additional services, it would have to persuade Congress to increase the tax rate. Americans' aversion to tax increases should thus hold health care costs down, but the system would allow Congress to enact increases when the public deems the added expenditure is worth it.

Second, competition among health plans would restrain costs. Currently, competition among health plans is perverse. Plans do not compete to offer a package of services for a fixed price. Instead, all too frequently they compete to avoid sick patients. Under the universal voucher plan, because health plans and insurance companies would have the same risk-adjusted fixed payment per enrollee for a standard set of benefits, with no opportunity to charge enrollees more for those benefits, they would have to compete for enrollees. They would therefore have a strong financial incentive to be efficient. The likely result would be innovations in the management of chronic illnesses, where 70 percent of health care spending occurs (Agency for Healthcare Research 2002). Because hospitalization is so expensive, health plans would probably find ways to keep patients with chronic conditions healthier and out of the hospital. Similarly, they would have a strong incentive to eliminate duplicate testing and expensive medicine that adds little benefit.

Third, those Americans who want additional services would have to pay for them with after-tax dollars. They would therefore have an incentive to spend judiciously to receive value for their money.

Fourth, the independent Institute for Technology and Outcomes Assessment would evaluate the effectiveness, cost, and value of new technologies and new applications of existing technologies. Data developed by the Institute would ensure that any new procedures added to coverage under the standard benefit package would be cost-effective; the data would also provide vital information for health plans and insurance companies as they design more efficient and effective care. Data from the Institute would ensure that any cost cutting that harms patients would be detected. Health plans could also cover only cost-effective, proven care without fear of litigation since the Centers for Patient Safety and Dispute Resolution that adjudicate claims of medical error would not view use of evaluations by the Institute as a medical error. This would provide a safe harbor for actual implementation of cost-effective care by health plans.

Finally, the Institute's reports would send a signal to drug and medical device companies to focus their research and development on cost-effective interventions. Right now the new interventions that these companies develop are typically expected to hit the market in ten years. Companies thus face uncertainty about what interventions will be covered by health insurers ten years hence, and at what price. They therefore try to recoup their costs as fast as possible through high prices. The Institute would provide more reliable and predictable information on future coverage decisions, emphasizing that cost-effective interventions—those that really improve survival or quality of life, or that save money without reducing the quality of care—will be covered. This would lead to a shift in research priorities and hold down costs in the future.

No single cost-control mechanism is likely to be effective in restraining the rise in health care expenditure, but these five different mechanisms all pulling in the same direction should together make a difference.

Improved Quality. The universal voucher system would also improve quality and patient safety, especially through innovation in health care delivery. Today we know two things about quality: that the current system does not consistently deliver high-quality care, and that health plans and current practitioners do not know the best way to deliver high-quality care. Innovation in health care delivery is needed.

Hospitals and health professionals today have few financial or other incentives to implement patient safety measures. The universal voucher system would provide strong incentives for health plans and insurance companies to develop infrastructure that improves quality. Monitoring of outcomes by the Institute for Technology and Outcomes Assessment and monitoring of health plan performance by the National Health Board would provide significant incentives for health plans to invest in information technologies, including computer order entry systems for physicians, electronic medical records,

and other ways to share data. The regional Centers for Patient Safety and Dispute Resolution would develop and finance interventions to improve patient safety.

The voucher system would end the malpractice nightmare in which thousands of patients who are injured are never compensated while a few patients reap outsized rewards, and in which doctors practice defensive medicine while paying large malpractice premiums. To cut through this morass, the voucher system's Centers for Patient Safety and Dispute Resolution would adjudicate all patient claims of injury and compensate quickly and fairly those who have actually suffered harm. The money would come not from malpractice premiums but from the VAT. This would largely free physicians from the malpractice burden, but in exchange they would have to agree that the bad physicians who cause a disproportionate amount of malpractice injury will be drummed out of the profession.

In short, unlike individual mandates or single-payer plans, the universal voucher proposal deals with both malpractice and patient safety more broadly. Many interventions that would improve patient safety have not been implemented, despite substantial evidence that they really reduce infections, reduce complications, and save money and lives. There are many reasons for this inaction, but surely one of them is that no organization exists today with the muscle and money to push for change. The voucher plan would provide both the impetus and the money to develop interventions and implement them.

Economic Improvement. The universal voucher system would help the economy. Most obviously, it would relieve businesses of the burden of financing and administering their employees' health insurance, thus making them more efficient and competitive. Employers would also be relieved of obligations for their retirees' health coverage, and they could reduce spending on human resources departments and consultants, freeing resources to invest in their core business. They would no longer have

to cope with the unpredictability of future health care cost increases, and they could once again base hiring decisions on demand for their output and on worker productivity, not on the basis of future health care costs. This should boost employment.

The voucher system would also be a huge benefit for workers. Their health care coverage would be guaranteed, not tied to their job and possibly lost if they

**Lower-income Americans—
as well as those who are sick and
need more health care—would
receive much more in benefits
than they would pay in taxes.**

are laid off. Strikes over health benefits would disappear. The phenomenon of job-lock, in which workers stay in jobs where they are no longer happy or productive so as not to lose their insurance coverage, would vanish. Although they would pay a new tax, the VAT, workers would at the same time see their Medicare taxes, federal income taxes, and state taxes decline, and they would receive a pay increase. Over time, with effective cost control, pay increases would once again reflect increases in productivity and not be held down by increases in health care premiums.

Other Advantages. Two of the biggest advantages of the universal voucher proposal are implicit rather than explicit. The first is that the plan is comparatively simple. The second is that it coheres with American values.

Nothing that changes the way \$1 out of every \$7 is raised and spent in the U.S. economy is going to be very simple, but the universal voucher program has relatively few moving parts. It envisages one standard benefits plan for all Americans. It involves no income-linked subsidies, and thus none

of the complex administration that such subsidies require. It relies on just one funding source, the VAT, rather than on many different streams—employer contributions, worker premiums, out-of-pocket costs, Medicare taxes, and other state and federal taxes. Each region of the country would have just one insurance exchange. The number of health plans and insurance companies nationwide would be substantially reduced. Employers would be freed of responsibility for financing health care. Administration of the system would be handled by one national board and twelve regional health boards. No other health care proposal that seeks significant improvement is as simple. Such simplicity makes incentives clearer and more effective instead of confusing and counter-productive.

The universal voucher system's biggest advantage, however, may be the way it reflects core American values: equality of opportunity and individual freedom. The United States is different from many other Western countries that emphasize an egalitarian ethos. A universal health care voucher system would promote equality of opportunity: its standard benefits would be provided to everyone, funded by a tax that everyone pays. At the same time, it would let individual freedom flourish: it would use market mechanisms—competition—to foster quality and efficiency in health plans and in hospital and physician delivery of services. It would give people a choice of health plans, physicians, and hospitals operating in the private sector, and the option to spend their own money to buy more coverage for amenities and a wider range of services. This balance of equality of opportunity with market mechanisms and individual freedom is quintessentially American.

If Americans want a health care financing system that can achieve universal coverage, with multiple cost-control mechanisms and incentives to improve quality, and one that can do so in a sustainable way, the universal health care voucher system is the best option.

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