SIX BLOG ENTRIES ON THE AFBF TASK FORCE

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1. *AFBF TASK FORCE*

Last November, I was appointed to an American Farm Bureau Task Force charged with studying the long-term federal deficits. The Task Force absorbed most of my free time between December and July. It was made up of nine farmers from around the U.S. (Iowa, Connecticut, Virginia, Mississippi, Kentucky, Missouri, South Dakota, California, and Oregon) and was set up by the AFBF Board of Directors after they heard a presentation from the "Fiscal Wake-up Tour" about the dangers posed by the large projected federal deficits over the next forty years. The "Fiscal Wake-up Tour" is sponsored by the Concord Coalition and includes both a conservative economist from the Heritage Foundation and a liberal economist from the Brookings Institution --- to show that reducing the deficits isn't a partisan issue. The Task Force had monthly meetings through the spring, mostly in Washington, D.C. We heard interesting presentations from experts on many topics related to the deficits.

The charge for our Task Force was to help Farm Bureau members develop resolutions at their county and state meetings this fall. You can read our background material and view a video featuring the members of the Task Force at

http://deficittaskforce.fb.org/

The video is about 15 minutes long. The AFBF staff did a great job in putting it together and it is well worth watching.

I've learned a lot over the last six months. Before I joined the Task Force, I thought the major obstacles to balancing the federal budget in future years would come from the looming retirement of the baby-boomers and the resulting insolvency of Social Security. I was mostly wrong. Making the Social Security system solvent is politically difficult, but can be accomplished with some relatively simple changes. The real elephants in the room are exploding medical costs that affect the Medicare and Medicaid programs and a structural imbalance that has developed over the last thirty years between federal revenue and expenditures. I will discuss what I've learned about each of these topics in future blog entries.

2. *IS THE U.S. GOING THE WAY OF G.M.*

My first Deficit Task Force meeting took place at the American Farm Bureau headquarters in Washington, D.C. last December 17th --- the day I turned 65 and became eligible for Medicare. I was the oldest Task Force member and the only one close to actually experiencing Social Security and Medicare.

Our first presentation was from the "Fiscal Wake-up Tour" --- three experts on the federal deficit representing the Concord Coalition (non-partisan) , the Heritage Foundation (conservative) and the Brookings Institution (liberal). They were unanimous in their message --- without major changes, the federal deficit would explode and bankrupt our country over the next thirty years (or less). They certainly got our attention.

As I mentioned in the previous post, I came to the meeting with the mistaken belief that the looming retirement of the baby-boomers and the resulting increase in Social Security payments were primarily responsible for the deficits.

Social Security

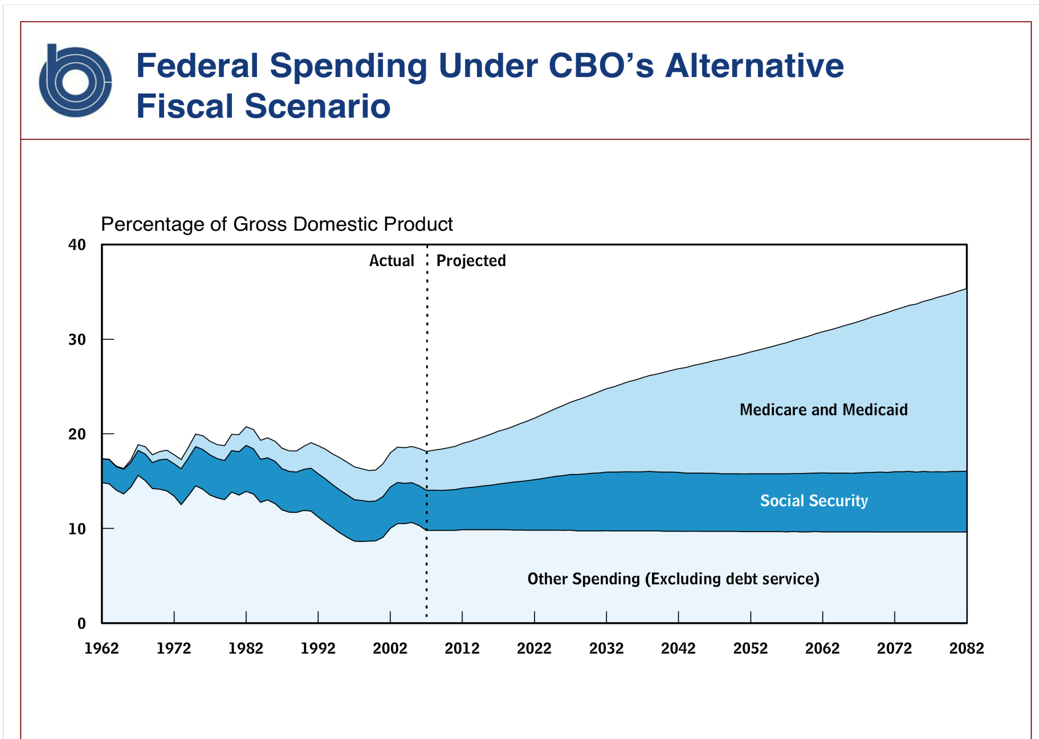
The Social Security Trust Fund is projected to run out of money in 2043. However, Social Security payments are currently equal to 4.4% of GDP and it is taking in payroll tax receipts equal to 4.8% of GDP --- so the Trust Fund is growing and will be for the next decade. If nothing is done, SS payments are projected to grow to 6.1% of GDP in 2033 and then stabilize. A .5% of GDP increase in revenue or a cut in expenditures now would bring SS back into actuarial balance. Increasing the payroll tax from the current 12.4% to 13.7% would achieve actuarial balance. The required increase in the payroll tax would be less if combined with an increase in the "full retirement age" (the Task Force favored automatically increasing the "full retirement age" as longevity increases) and/or a increase in the cap on earnings subject to SS tax ($106,800 in 2009).

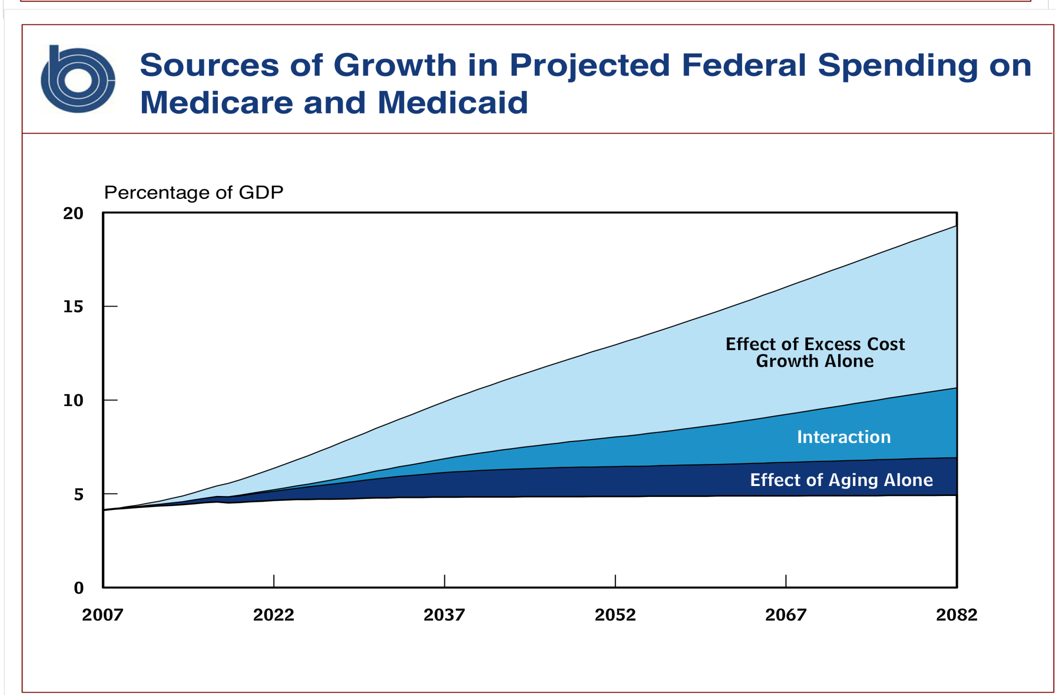
Social Security has a serious long-term funding problem that must be faced soon. However, since Congress controls both the revenue and expenditure sides of the Trust Fund, many options exist that will bring SS back to solvency. Only the political will is lacking.

Medicare and Medicaid

The government now pays directly or indirectly for well over half of U.S. healthcare. The biggest contributors to government costs are the Medicare and Medicaid programs and the tax revenue lost by not taxing employer-provided health insurance. Both government and private healthcare costs are rising much faster than inflation in the rest of the economy. I'll have much more to say about this in future posts.

Unless dramatic action is taken, steadily rising healthcare costs are projected to bankrupt the federal government. The Congressional Budget Office (CBO) has projected that the combined cost of Medicare and Medicaid will increase from 4.9% of GDP in 2010 to 10.6% in 2040 (an increase three times bigger than the increase in SS). During the initial meetings of the Task Force, we saw two graphs from the CBO that dramatically illustrate this point.





Notice the top graph excludes interest payments on the national debt. If nothing is done and interest payments are added, the federal budget is projected to grow to 43% of GDP in 2050 with interest payments on the skyrocketing national debt alone costing 16% of GDP (and these estimates were done before the current recession). Federal tax revenue has averaged about 18% of GDP for the last 30 years. Hence, without a very large increase in taxes, the federal deficit in projected to explode in the near future --- mainly due to rising healthcare costs.

Why worry about the federal Deficit?

We've been hearing dire warnings about federal deficits at least since the 1980's when the Reagan tax cuts caused the yearly federal deficit to jump to unprecedented levels. However, none of the predicted bad effects has materialized yet. Interest rates have stayed low. Buyers have lined up eager to buy our Treasury bonds. Interest payments as a share of federal outlays have actually fallen from 14% in 1985 to a projected 7% in 2009. Why is action so urgent now?

I believe the situation we currently face is different in two fundamental ways. First, the size the projected long-term deficits is much larger than we have ever experienced in peacetime. See the graphs on page 4 and the title page of the CBO's most recent "Long-Term Budget Outlook."

http://www.cbo.gov/ftpdocs/102xx/doc10297/06-25-LTBO.pdf

Second, our government is now selling most of its debt to foreigners. After the waves of currency crises that swept around the world between 1996 and 2001, many countries decided they needed to increase their reserves of U.S. dollar assets. By increasing their purchases of U.S. bonds, foreign governments caused the U.S. dollar to rise in value relative to their currencies and this promoted rapid growth in their exports. Maintaining an undervalued exchange rate turned out to be a spectacularly successful development strategy --- one that China and other developing countries have been reluctant to give up. China now has accumulated over $1.5 trillion in U.S. debt and knows it will suffer large capital losses on this debt as soon as it stop buying dollars and lets the Yuan appreciate.

During the last decade, the U.S. has not experienced rising interest rates and the other negative consequences of its large federal deficits because foreigners have willingly accumulated U.S. dollars. They now have more dollars than they want and may soon start selling rather than buying. Interest rates will soon rise dramatically.

Because more than half of U.S. Treasury debt is now foreign-owned, foreigners have also gained a powerful foreign policy tool they can use against us. Sudden large sales of foreign-owned U.S. Treasury bonds would dramatically raise U.S. interest rates and disrupt our financial system. The U.S. threatened this financial weapon

against the British and French governments and forced them to withdraw from the Suez Canal in the 1950's. The Chinese could now do the same in a conflict with us.

Are we going the way of G.M.?

For sixty years, G.M. was the largest and strongest car company in the world. Because it was so powerful, G.M. could delay facing up to its mounting losses. Neither management nor the unions stepped up to make the painful changes necessary to confront G.M.'s problems and save the company. G.M. ended up bankrupt. Unfortunately, the U.S. faces a similar situation if we don't deal with our looming federal deficits.

A final complication

A federal budget deficit for a year or two is not necessarily bad. During our current severe recession, the federal deficit has ballooned to an unprecedented $1.5 trillion. This deficit is due partly to the additional spending from the stimulus package, but mostly to a decline in tax collections. Both lower taxes and increased government spending are stimulating our economy at a time that stimulus is sorely needed. There is no doubt that the debt we are accumulating is adding to our long-term problem. However, large deficits are necessary until the recession ends. As soon as the economy gets back on it feet, the federal budget must be balanced.

3. SLOWING THE GROWTH IN MEDICARE AND MEDICAID COSTS

Without major changes, the federal deficit will explode and U.S. national debt will reach dangerous levels within the next twenty years. Any realistic plan to balance the federal budget must include two main elements.

1. A significant reduction in the growth rate of federal healthcare costs—primarily Medicare and Medicaid.
2. An increase in taxes.

The more we can slow the growth of Medicare and Medicaid costs, the less we will need to increase taxes.

Medicare and Medicaid cost growth can't be slowed without similar changes in the private healthcare system

Attempts by Congress to slow the growth of federal healthcare costs have been unsuccessful primarily because Medicare and Medicaid are so closely linked to the rest of our healthcare system. All doctors and hospitals treating Medicare and Medicaid patients also have private patients. If Medicare and Medicaid payments are cut much below the standard charges to private patients, healthcare providers will stop seeing the poor and elderly. If the government restricts treatments

available to Medicare and Medicaid patients, Congress will quickly receive complaints that it has created an inferior healthcare system for the poor and old. Consequently, slowing government healthcare costs in the long run is not politically possible without reforms that also apply throughout the U.S. healthcare system.

Slowing the growth of healthcare costs

Between 1975 and 2005, per capita healthcare costs grew much faster than costs in the rest of the U.S. economy --- 2.4% faster for Medicare, 2.2% faster for Medicaid, and 2.1% faster for private patients. Rising costs are now threatening to bankrupt not only the federal government, but also many businesses and private patients. How can the growth of healthcare costs be slowed? That is now the $64,000,000,000,000 question.

There are three main approaches to reducing healthcare costs: reducing the need for treatment, paying less for treatment, and using less treatment.

<u>Needing Less Treatment</u>

The U.S. is currently suffering from an epidemic of obesity and diabetes. Getting Americans to eat better diets and exercise would reduce chronic illnesses now and in the future. However, we all will eventually get old and die, so the main effect of healthier lifestyles is to delay healthcare costs. The studies are inconclusive about long-run savings and, unfortunately, finding ways to motivate people to change their lifestyles is difficult.

<u>Paying Less For Treatment</u>

Congress has passed and rescinded many laws to reduce Medicare and Medicaid payments. Government efforts to pay less have so far been unsuccessful in reducing cost growth. Increasing competition among providers might reduce charges, but is very difficult to implement because of the special characteristics of the doctor-patient relationship (I'll have more on this in a later blog entry.) More competition among insurance companies could reduce costs and this is one of the reasons the Task Force supported a voucher plan. However, unless government takes over the healthcare system, it is unlikely that the growth in payments per treatment can be slowed enough to solve our problem.

<u>Using Less Treatment</u>

This is where the hope (if there is any) lies. Evidence from two sources indicates that about one third of medical treatments have little if any benefit and, in some case, may harm patients. For twenty years, researchers at Dartmouth have been examining Medicare payment records and have published the data in the now famous Dartmouth Atlas of Health Care

http://www.dartmouthatlas.org/

Large variations exist in the cost of healthcare in different parts of the U.S. --- with some areas spending twice as much as other areas. The surprise is that patients in high cost areas don't do any better than those that receive less treatment in low cost areas.

The second source comes from international studies of healthcare. The U.S. spends about a third more of its GDP on healthcare than any other advanced country and other advanced countries usually have as good or better outcomes. See

http://www.whitehouse.gov/assets/documents/CEA_Health_Care_Report.pdf

particularly the discussion starting on page 9.

Our healthcare system seems to be surprisingly inefficient. If we can make better treatment decisions, we should be able to reduce costs without affecting the quality of care. How can this be accomplished? I'll discuss this in the next blog entry.

4. USING LESS TREATMENT

Up to one-third of medical treatment does little or no good for the patient. Several accounts have recently become available illustrating our healthcare system's tendency to overtreat. For example, see the Atul Gawande's article at

http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande

or the radio program available at

http://www.thisamericanlife.org/Radio_Episode.aspx?episode=391

Why do doctors order treatments that don't benefit their patients? There are at least four reasons:

1. **Profit seeking** – Doctors spend their long medical education learning how to treat patients. Our fee-for-service payment system then gives doctors a strong incentive to use this training and provide additional services. Medicine is slowly changing from a healing profession to a business. Read the Gawande article.
2. **Ignorance** – In many cases, doctors don't have adequate knowledge about the cost-effectiveness of different treatment options. Without clear guidelines, they often will, in good conscience, order the procedures they are trained to provide that earn them the most income.
3. **Patient demands** – Patients often ask their doctors to treat ailments for which there is no cost-effective treatment. They sometimes demand treatments

that their doctor knows are not likely to be effective. These requests are more likely when a patient has insurance and doesn't have to bear the cost. Doctors often have a difficult time saying no, especially when their income increases if they give in.

4. **Malpractice lawsuits –** To protect themselves from malpractice lawsuits, doctors may order additional tests and treatments.

The best way to reduce healthcare costs and improve the quality of care in the U.S. is to change doctors' incentives so they will stop ordering ineffective treatments.

I will devote the next blog entry to discussing the last two reasons listed above and will argue that, while they are important, they are not a primary cause of the high cost of healthcare. Profit seeking and ignorance are the primary causes of over treatment.

Actions to reduce ineffective treatments

A. Improving Payment Methods and Encouraging Self-Monitoring by Groups of Doctors

Dr. Arnold Relman has written a book, *A Second Opinion*, and many articles, e.g.,

http://www.nybooks.com/articles/22798

in which he argues that medical costs in the U.S. will be reduced and patient outcomes improved when more doctors start practicing as salaried members of privately-owned, multispecialty groups. The Mayo Clinic is probably the best known such group. The cost of care at the Mayo Clinic during the last six months of life is half the cost of such care at, for example, the UCLA medical school. Several group practices similar to the Mayo Clinic exist around the U.S., including the Cleveland Clinic, Kaiser Permanente, the Billings Clinic and the Health Group in Seattle, and all have been successful in lowering costs. For a video examining these groups, watch

http://www.pbs.org/newshour/bb/health/july-dec09/billings_08-12.html

As a salaried member of a group practice, a doctor's income depends less on ordering unneeded treatments and he has more opportunity to discuss and coordinate care with his colleagues.

Making group medical practice the norm will take many years to accomplish. In the interim, two intermediate steps should be taken now.

1. Accountable Care Organizations

Doctors in an area should organize into "Accountable Care Organizations" (ACO).

ACO's would hold regular meetings at which the member doctors review how medicine is being practiced in the local area and provide feedback to doctors who are either overtreating or undertreating their patients. The ability to review local practice standards would be facilitated by the widespread use of electronic medical records. The formation of ACO's could be encouraged if Medicare and private insurance companies shared part of any cost savings with hospitals and the doctor members of ACO's.

2. Increase the use of "capitated" payments and "bundling" of payments

Medicare and private insurance companies should move away from fee-for-service payments and pay part of a patient's care with a single yearly payment to the group of doctors providing his care ("capitation"). With part of a patient's care covered by the fixed payment, reimbursement for routine tests and procedures could be reduced—reducing the incentive for extra treatments. "Bundling" of payments would provide hospitals and doctors with a lump sum in advance to provide care for a particular medical condition. "Bundling" would encourage doctors and hospitals to improve quality since repeated treatments or readmissions to the hospital would not be reimbursed.

B. Providing Doctors with Better Information about Treatments

For a surprisingly large number of illnesses, doctors currently have inadequate guidelines about the most cost-effective treatments. Prostate cancer is a good example. Many treatments for prostate cancer are available, including radical prostatectomy, several types of external radiation, brachytherapy (radioactive seed implants), and "watchful waiting." The cost of these treatments varies enormously—from very little for "watchful waiting" to over a hundred thousand dollars for newer types of external radiation treatment. For early stage prostrate cancer, no consensus exists on whether one type of treatment is any better than another type.

http://www.nytimes.com/2009/07/08/business/economy/08leonhardt.html

Another example of our failure to provide doctors with adequate information is medical devices (e.g., defibrillators and artificial hip joints).

http://www.nytimes.com/2009/11/05/business/05device.html?scp=3&sq=Barry%20Meier&st=cse

Healthcare costs in the U.S. could be significantly reduced by funding more research on the effectiveness of different treatments and by giving doctors clearer guidelines on which to base their recommendations.

5. MALPRACTICE REFORM AND HIGHER DEDUCTIBLES ARE NOT ENOUGH

When I discuss the rising cost of healthcare with my neighbors, they always bring up the need for tort reform to reduce malpractice insurance costs and the importance of expanding the use of high-deductible health insurance policies in combination with "health savings accounts." Expanding the use of high-deductible policies would give patients added incentives to economize on medical services by forcing them to pay more of their medical costs "out-of-pocket." I strongly support both ideas and both should be part of any reform proposal. However, neither is likely to slow significantly the long-run growth in medical costs.

Medical Tort Reform

Our laws governing medical malpractice are a mess. Less than 3% of patients who are injured by medical negligence ever get their cases heard in court and the desire to avoid frivolous lawsuits causes doctors to order unnecessary tests and treatments—driving up costs. David Leonhardt summarizes the evidence in

http://www.nytimes.com/2009/09/23/business/economy/23leonhardt.html?scp=1&sq=David%20Leonhardt%20Malpractice&st=cse

He writes "[malpractice] jury awards, settlements, and administrative costs … add up to less than $10 billion a year. This equals less than one-half of a percentage point of medical spending." The cost of the "defensive medicine" practiced by doctors because they fear malpractice suits is much greater and has been estimated at up to $60 billion a year. However, this is still only about 3% of healthcare costs in the U.S.

Tort reform that capped excessive jury awards and provided better protection for doctors who follow "best practice" guidelines would reduce the cost of malpractice insurance and the incentives for unnecessary tests and treatments. However, a successful campaign to reform malpractice laws would be unlikely to reduce overall healthcare costs by more than 3 percent.

Higher Deductibles

Increasing the share of medical expenses paid "out of pocket" would cause patients to think more seriously about whether they should seek medical care. They'd be more likely to object if their doctor ordered low-value tests and treatments. In listening to the discussions of my friends on Medicare, I've been surprised by how often even the $30 per visit co-pay causes them to postpone an additional visit to their doctor.

Unfortunately, increasing patients' co-pays is limited as a way to control costs because of the unique characteristics of the doctor-patient relationship. When a consumer goes to purchase a car or refrigerator, he knows what he wants to buy and can determine whether the value of additional features on more expensive

models is worth their higher price. When a patient seeks medical treatment from a doctor, he usually doesn't know what treatment he needs or its value. In at least 70% of doctor visits, patients don't go to buy a medical treatment. They go for advice about what treatment they need. The more serious the illness, the more likely the patient is to rely on his doctor's knowledge and advice. Even with a $5,000 deductible health insurance policy, a patient who receives a cancer diagnosis will usually do what his doctor prescribes, even if the treatment turns out to be very expensive.

Since doctors will be making most of our treatment decisions even when patients are paying the full cost "out of pocket," the focus of any effort to reduce costs must be on doctors and especially on modifying our fee-for-service payment system so doctors have less incentive to prescribe unnecessary tests and treatments.

6. WHY FEDERAL HEALTHCARE VOUCHERS

Our American Farm Bureau Deficit Task Force spent several two-day meetings in Washington, D.C. discussing healthcare reform with leading experts. All the experts agreed costs are rising at an unsustainable pace and action is urgently needed. What disappointed and surprised us was that none of the experts provided us with a solution—a comprehensive approach to reforming our current system.

The Task Force's charge is to find ways to reduce the looming federal deficits. We could not finish our work without recommending a way to deal with the most important cause of future deficits—soaring healthcare costs. After much discussion, we decided the best approach is federal healthcare vouchers:

> … the federal government should provide each citizen with a voucher sufficient to purchase a bare-bones, private health insurance policy. These health care vouchers could be used only for insurance plans that incorporate the reforms necessary to reduce the growth in health care costs. To encourage innovation, the requirements that health insurance plans must meet to be eligible for voucher financing would be determined on a regional basis.

I believe we were all surprised by our vote to support vouchers—I certainly was.

I voted "yes" last May for two main reasons.

<u>1. Vouchers offer the best hope of getting key reforms implemented quickly enough to avoid a government takeover of our healthcare system.</u>

Health insurance premiums in the U.S. more than doubled between 2000 and 2009. According to the Kaiser Family Foundation, the cost of a family health insurance policy now averages $13,375 per year. When out-of-pocket costs are included, the total is close to $16,700. Since median family income in the U.S. is approximately

$60,000, total healthcare costs are now a quarter of family income!

This year, employers paid on average $9,860 of the $13,375 cost of health insurance for a worker and his family. Many workers with employer-provided insurance believe they don't need to worry about rising healthcare costs because their employer is picking up their tab. These workers are suffering from an illusion. Good evidence exists that employers recoup the rising cost of health insurance by reducing future wage increases—so workers do ultimately pay the full cost. Over the last twenty years, output per hour in U.S. businesses has increased by over 150%. Hourly wages in manufacturing (adjusted for inflation) have declined slightly. Productivity growth should cause wages to rise, but rising health insurance costs are siphoning off all the extra income.

If healthcare costs continue to grow at their current rate for nine more years, the average cost of health insurance for a family has been projected to be as high as $38,000 or ½ the family's income. Our current system of private insurance, mostly provided by employers, will self-destruct before that happens.

Our market-based healthcare system has many strengths—including patient choice, rapid innovation, and competition among private insurance companies, hospitals and doctors. As I discussed previously, its inability to control costs stems mainly from an over-reliance on fee-for-service payments. Fee-for-service payments—combined with a physician's dual role as a provider of both diagnoses and of treatments—encourages too much ineffective and costly treatment. How can doctors' and hospitals' incentives be changed quickly without direct government regulation, while still preserving the good features of our current system?

Our recommendation is to have the federal government offer all citizens a voucher redeemable for a bare-bones health insurance policy from one of many competing private insurance companies. Additional coverage could be purchased and added on if desired. The tax deductibility of health insurance would be eliminated. Insurance companies would be required to accept all applicants, but would receive a bigger voucher payment for covering an applicant with a pre-existing condition. Medicaid would disappear. Senior citizens currently on Medicare could stay in the Medicare program. However, younger citizens would stay with vouchers and private insurance when they turned 65 years old. Hence, Medicare would phase out over time and all citizens would eventually finance their basic healthcare with vouchers. **Finally, the most important change—to be eligible to accept vouchers, insurance companies would be required to change the way they pay hospital and doctors. Fee-for-service would be phased out and new methods introduced to encourage better outcomes and discourage costly, ineffective treatments. For example, insurance companies would be required to increase the use of bundled payments, capitated payments, electronic medical records, and self-monitoring by doctors in each local area (Accountable Care Organizations).**

2. Vouchers would establish a national healthcare budget and allow the U.S. to control the growth in healthcare spending.

The AFBF Deficit Task Force didn't make a recommendation on how the healthcare vouchers should be financed. I'm convinced that financing should come from a new dedicated consumption tax—i.e., a value-added tax (VAT) or a national sales tax. The level of the tax would depend on how "bare-bones" is defined. Martin Feldstein recently argued that the federal government could provide everyone with a high-deductible health insurance policy by using only the extra $220 billion in tax revenue gained by eliminating the tax deductibility of employer provided insurance. However, if deductibles are set too high, the poor would still need Medicaid and many low and even middle income Americans would need subsidies to pay their deductibles. One of the great attractions of the voucher idea is that income-based subsidies aren't required. Subsidies that vary with income (such as those included in all the healthcare bills now working their way through Congress) are complicated. They also dramatically increase the marginal tax rate faced by those who receive them and would have bad effects on incentives.

Emanuel and Fuchs provide details on the funding of healthcare vouchers. They estimate that a 15 percent VAT would be needed to provide all Americans, including the elderly who would now be on Medicare, with a voucher for health insurance coverage similar to the plan now covering members of Congress. Adding a 15 percent consumption tax would represent a significant increase in federal taxes. However, healthcare vouchers would provide important other benefits:

1. As Medicare phases out and seniors transition to vouchers, the VAT rate would need to increase from "10 to 12 percent to approximately 15 percent." However, the 2.9% Medicare payroll tax would be eliminated.

2. The federal government currently spends about $220 billon on Medicare above what is collected by the Medicare payroll tax. Medicaid also costs the federal general fund about $200 billion. The tax deduction for employer-provided health insurance reduces federal revenue by about $220 billion. Vouchers would eliminate the need for all three. The federal government would have approximately $600 billion that could be used to reduce the federal deficit.

3. State budgets are currently under severe strain due to the rising cost of Medicaid, SCHIP and employee health insurance premiums. These programs currently take up approximately 20% of state budgets. Vouchers would eliminate these state expenditures and should cause a reduction in state and local taxes.

4. Employer-provided health insurance would be eliminated and individuals would pay only for "add-on" coverage above what their voucher provides. Since an employee must now accept his employer's choice of a health plan, vouchers would give individuals more choice and increase competition in the private insurance market. As employer-provided health insurance phases out, wages should start

rising again in line with productivity growth.

5. Since vouchers would be financed by a dedicated tax, the U.S. would—for the first time—have a national healthcare budget. If healthcare costs increased faster than the growth of the economy, either the VAT tax would be raised or changes would be made in our healthcare delivery system to reduce the growth in costs. Since everyone would bear the cost of a tax increase, our nation would finally have an incentive to deal with the hard choices that we must eventually make—how much to spend on end-of-life care, when to pay for very expensive new medical equipment, how to modify the fee-for-service payment system, etc.

6. Finally, by replacing Medicare and Medicaid with vouchers funded by a new, dedicated tax, the U.S. would eliminate almost all of the federal deficits projected to be such a problem over the next fifty years. Vouchers would also eliminate the need for large future income tax increases**. Vouchers funded by a dedicated tax would, by themselves, solve the problem that caused our Deficit Task Force to be created.**

References about vouchers:

Ezekiel J. Emanuel and Victor R. Fuchs, "A Comprehensive Cure: Universal Health Care Vouchers," The Hamilton Project, The Brookings Institution, July 2007.

Laurence J. Kotlikoff, *The Healthcare Fix—Universal Insurance for All Americans*, 2007