SOUNDING BOARD

Health Care Vouchers — A Proposal for Universal Coverage

Ezekiel J. Emanuel, M.D., Ph.D., and Victor R. Fuchs, Ph.D.

Dissatisfaction with the financing of U.S. health care is widespread. The system is inefficient, inequitable, and increasingly perceived to be unaffordable.[1-4] Because only incremental reform is deemed politically feasible, inordinate attention is devoted to treating the institutional symptoms rather than diagnosing systemic problems that require major surgery. As an alternative, we propose a voucher system for universal health care, an efficient, fair, and relatively simple approach that might elicit broad support. We recognize that change is not imminent, but such a proposal can stimulate discussion and provide a readily available model when the political climate becomes hospitable for endorsing meaningful reform.

FLAWS IN THE CURRENT HEALTH CARE FINANCING SYSTEM

Most Americans obtain their health care through employer-based insurance, Medicaid and other means-tested programs, or Medicare.[1] Each component of this 40-year-old financing system is deeply and irreparably flawed.

Employer-based insurance, which now covers 55 percent of Americans, is inefficient and inequitable.[1,5] It distorts labor markets,[6] has high administrative costs, and generates discontinuous coverage. Because it is paid through pretax dollars, it is inequitable, since it provides a greater subsidy to high-income people.[7] Medicaid and other means-tested programs cover about one in six Americans.[1] These programs require costly determinations of eligibility, impose high marginal tax rates on recipients because the subsidies fall as income rises, and encourage evasion of reported income.[8] Many people who are eligible do not apply — some to avoid the administrative hassle or stigma and others because they expect their incomes to improve.[9] The programs also generate discontinuous coverage as people move in and out of eligibility. Medicare, which covers about one in eight Americans, is a popular open-ended entitlement but has fundamental flaws. It does not consider the cost of technologies relative to their benefits. In an era of rapid technological change, that is a recipe for financial disaster.[4,10,11] Despite the availability of these programs, 15 percent of Americans have no health insurance; they either cannot afford to acquire it or are unwilling to do so.[1,2]

Incremental reforms have been tried, but despite some successes, such as the State Children's Health Insurance Program, the system as a whole is getting worse, not better. Major reform is needed but will not happen immediately. As problems mount, however, the demand for change will intensify. In anticipation of that demand, we propose a voucher system with 10 fundamental features.

FEATURES OF THE VOUCHER SYSTEM

UNIVERSALITY

At the start, every American under 65 years of age would receive a voucher that would guarantee and pay for basic health services from a qualified insurance company or health plan. Participating health plans would have to offer guaranteed enrollment and renewal for the risk-adjusted value of the voucher, regardless of the patient's medical history. People who failed to enroll would be assigned to a health plan.

FREE CHOICE OF HEALTH PLAN

Individuals and families would choose which basic insurance program or health plan they wanted among several alternatives.

FREEDOM TO PURCHASE ADDITIONAL SERVICES

People who wanted to purchase additional services or amenities, such as a wider choice of hospitals and specialists or more comprehensive mental health services, could do so with their own after-tax dollars.

FUNDING BY AN EARMARKED VALUE-ADDED TAX

The funding for the vouchers would come from an earmarked value-added tax. Earmarking creates a

direct connection between benefit levels and the tax level, serving as a cost control "rheostat." If people want more services to be covered in the basic plan, they must be willing to support a tax increase. A value-added tax is administratively efficient and cannot be easily evaded. The tax is based on personal consumption, which is closely related to long-term financial well-being, regardless of the source of income or wealth.

RELIANCE ON A PRIVATE DELIVERY SYSTEM

This proposal does not call for government health care and would not legislate changes in the current private delivery system.

END OF EMPLOYER-BASED INSURANCE

By providing basic care for all Americans and eliminating tax benefits for health insurance premiums, employer-based insurance would probably fade away. Critics throughout the political spectrum have noted the many shortcomings of employer-based insurance; few would mourn its passing.[10,12-14]

ELIMINATION OF MEDICAID AND OTHER MEANS-TESTED PROGRAMS

Since every individual and family would receive a voucher, there would be no need for Medicaid (except for nursing home coverage), the State Children's Health Insurance Program, or other means-tested programs. People who are covered by such programs would be incorporated into the mainstream health care system without means testing. Funding for long-term care, currently provided by Medicaid, would need to be continued.

PHASING OUT OF MEDICARE

Although no one who is already enrolled in Medicare would be forced to change to the voucher system, Medicare would be phased out over time. People turning 65 would continue to be enrolled in the voucher system; there would be no new enrollees in Medicare. It is important to note that current Medicare benefits would be supplemented by a tiered pharmacy benefit modeled on that provided as part of the basic benefits package of the voucher system.

ADMINISTRATION

Management and oversight would be the responsibility of a Federal Health Board (modeled on the structure of the Federal Reserve System), with regional boards to manage and oversee various geographic regions. The Federal Health Board would define and periodically modify the basic benefits package and through its regional boards would be an active contractor with health plans, informing Americans about their health care options, reimbursing health plans, and collecting data related to patient satisfaction, the quality of care, and risk and geographic adjustments for payments. The Federal Health Board would regularly report to Congress on the health care system.

ASSESSMENT OF TECHNOLOGY AND OUTCOMES

An independent Institute for Technology and Outcomes Assessment would be established. Its research and database would focus on assessing the effectiveness and value of various interventions and treatment strategies and disseminate information concerning outcomes of treatments delivered in regular practice. Funding for the institute would come from a dedicated portion of the financing tax, such as 0.5 percent of the total.

These 10 features address fundamental flaws in the current U.S. health care financing system (Table 1).[14] Previous reform proposals have incorporated several of these features, such as providing people with choice among several plans that offer similar benefits at the same price, retaining private insurance and health plans, and removing the tax subsidy for the purchase of additional care.[15-24] This proposal, however, is a unique package marked by the use of vouchers to simplify administration, the creation of a financing system through an earmarked value-added tax, the elimination of Medicaid and other means-tested programs and employer-based insurance, a beginning to the phase-out of Medicare, oversight through a Federal Health Board, and the creation of an Institute of Technology and Outcomes Assessment.[15,17,18,24]

UNIVERSAL BENEFITS PACKAGE

The universal benefits package covered by the voucher should be sufficiently comprehensive to provide most Americans with most of their care most of the time. It should not be designed as a safety net to serve only the poor.[25] The benefits provided should be those typically offered by large employers, including inpatient and outpatient hospital services, visits to physicians' offices, well-child care and other preventive measures, mental health care, and tiered pharmaceutical benefits, typically with dollar limits. We suggest only modest deduct-

Table 1. Problems in the Current Health Care System and Their Resolution by a Universal Voucher System.

Problem	Current System	Universal Health Care Voucher System
Lack of insurance coverage	More than 40 million Americans are uninsured because they are too young for Medicare, not poor enough for Medicaid, unable to acquire insurance at an affordable price, or unwilling to purchase insurance.	Every American is guaranteed basic health care coverage without means testing or exclusions of any kind.
Increases in health care expenditures	Health care expenditures have increased by nearly 10% annually for the past 3 years and by nearly 75% in the past decade. There are no firm cost-control mechanisms. Medicare is an open-ended entitlement that ignores costs relative to benefits. Employer-based insurance typically provides greater subsidies for more expensive plans and insulates patients from consideration of costs.	An earmarked tax directly links the expansion of the cost of a basic benefits package with the public's willingness to increase taxes. Services beyond basic care are paid with after-tax income, which ensures that users weigh costs against benefits. A systematic assessment of technology and outcomes limits the use of services that have high costs relative to their benefit.
Discontinuity of coverage	There is substantial discontinuity of coverage because of job loss or change, retirement, changes in employer-based health plans, or changes in means-tested eligibility.	There is complete continuity of coverage, since users stay in the same plan as long as they wish, regardless of changes in employment, income, health status, or other circumstances.
Inefficient labor markets	Employer-based insurance distorts decisions of employers and employees about such things as outsourcing, hiring, retirement, and job changes. Means-tested programs, such as Medicaid, discourage the poor from working because they might lose their insurance eligibility.	There is no distortion of employment decisions, since employers and employees are free to make decisions independently of any considerations regarding health insurance. The poor do not lose coverage if their income rises.
Haphazard and unfair subsidies	Tax treatment of employer-based insurance provides greater subsidies to high-income workers. Many low-income workers are ineligible for means-tested programs, and many people who are eligible do not apply.	Users contribute to the support of basic care in proportion to their consumption of goods and services. There are no free riders.

ibles and copayments to minimize access barriers for the poor. In 2004, the average annual premium for such coverage in an employer-based program was $9,950 for families and $3,695 for individuals.[2]

Ultimately, the Federal Health Board would structure the benefits package after wide consultation with experts and involvement of the public through various mechanisms.[26-28] The process would be iterative, with modifications reflecting a balance between the public's desire for more health care services and its willingness to pay the valued-added tax.

ECONOMIC FEASIBILITY

The economic feasibility of the voucher system depends on the cost of the publicly funded universal benefits package, as compared with the cost of employer-based insurance, Medicaid, the State Children's Health Insurance Program, and other programs being replaced. In 2004, excluding Medicare and nursing home coverage, the cost of personal health care coverage for Americans under the age of 65 years was estimated to exceed $800 billion, including more than $600 billion in premiums for employer-based insurance and $200 billion for Medicaid and other means-tested programs (Levit K: personal communication).[2,3] These costs have been increasing by 8 to 10 percent annually for the past few years.[2,3]

How much would the voucher plan cost? Because the cost would depend on precisely which services, deductibles, and copayment levels would be incorporated into the universal benefit, the voucher proposal has not been "scored." Nevertheless, educated estimates are possible. Through charity and other mechanisms, the 15 percent of Americans

who are currently uninsured do get some care; the voucher benefit package would probably increase this group's use of services by about one third.[14] This would raise overall use of health care by about 5 percent. Some additional use might be expected from those currently insured with policies less generous than the voucher system's provisions. Conversely, people with more generous policies would probably reduce their use of the system. In addition, some resources would be needed to eliminate deductibles and copayments for the very poor. Overall, it is reasonable to expect use to rise by approximately 5 percent. However, expenditures need not increase.

With the voucher system, administrative costs would decrease markedly. Physicians know all too well that the current system is an administrative nightmare; the voucher system would simplify it substantially. For instance, the cost of screening and determining eligibility for each child enrolled in a State Children's Health Insurance Program is the equivalent of more than two months of health care premiums, and the enrollment of adults is even more complex and costly.[8] Moreover, much of the $100 billion spent on the sales and administrative costs of private insurance would also be saved.[2,29] Over time, the voucher system would foster a more rational approach to the delivery of services. For instance, more rational prescribing of drugs could save 1 to 2 percent of health care expenditures. A combination of lower administrative costs and more efficient delivery should offset some or all of the 5 percent increase in use.

POLITICAL FEASIBILITY

We recognize that the voucher system is not politically feasible at this time. Neither is any other major reform in health care. Obstacles to major reform arise from multiple sources — cultural, social, economic, and political.[10,11,14,30,31] Normally, the American political system resists change; it tends to enact major social programs only during times of war, economic depression, or civil unrest. Even without such traumas, there will come a time when the inequities, inefficiencies, and costs of the current methods of financing health care will be so intolerable that the public will not only accept but demand comprehensive reform.

At that time, the political feasibility of the voucher system will be compelling. It is more congruent with American values than are the alternatives of employer or individual mandates with explicit subsidies or a single-payer plan. By providing publicly funded basic care for all, with free choice of a plan and freedom to buy additional services, the voucher system reconciles the distinctively American tension between equality and individual freedom more directly and efficiently than do any of the alternatives.[32]

The voucher system will appeal to both large and small employers, who are straining under increasing costs and looking for an end to employer-based insurance. The growing demands of Medicaid are overwhelming state coffers, forcing choices between tax increases and cuts in education and other services. State governments will welcome relief from the financial and administrative burdens imposed by means-tested programs.

Opposition to universal health care vouchers may come from employers with mostly young workers, who use little care, and from high-wage workers, who receive munificent benefit packages tax-free. Among the 1300 health insurers, the small ones that rely on select market niches will find universal health care vouchers a threat, as will health-benefits consultants, who will lose business.

The reaction of health care professionals is uncertain. There will doubtless be a concern that any universal-coverage system with a fixed budget will inevitably threaten their income and freedom, and some practitioners will want to maintain the status quo — which is an impossible dream. However, when reform comes, many physicians will support a voucher system because it will provide the opportunity, the information, and the incentive to deliver cost-effective care to all Americans.

Ironically, the strongest resistance to the voucher system may come from people, who embrace universality but might object to the elimination of Medicaid, the imposition of a value-added tax, or the use of vouchers. Such opposition would be misplaced. Although Medicaid provides vital services for some people, it is grossly inequitable, offering no coverage for many uninsured low-wage workers. Means testing is demeaning, an invitation to evasion, and administratively complex.[8,9] Benefits vary greatly by state and are widely perceived to constitute second-class medicine. Most important, Medicaid is draining resources from other state services, such as public education, that are vital to the overall well-being of poor people. The provision of

uniform benefits to both the middle class and the poor — even if some people forsake special benefits — seems a fair trade-off.

Some people reflexively reject a value-added tax as regressive. However, the distributional impact of the voucher proposal requires looking at the benefits as well as the tax burden. All things considered, the program is progressive, since it implicitly subsidizes the poor. It is not an accident that countries such as Norway and Sweden, which provide universal health coverage, make substantial use of value-added taxes to fund social programs. Furthermore, value-added taxes can be made more progressive by excluding from the taxable base items such as food, which account for a declining proportion of consumption as income rises.[32,33] Finally, people often reject voucher proposals as a threat to the universality of social programs. Medical care, however, is different. It has never been universally guaranteed in the United States, and segmentation of the market is currently widespread. The health care voucher would guarantee Americans universal coverage for the first time, and without means testing or exclusion for medical conditions.

Today, comprehensive reform seems politically unrealistic. During the next few years, however, as employers continue to cut benefits or eliminate coverage entirely, as states reduce Medicaid services to avoid deficits, and as increases in Medicare costs lead to higher payroll taxes, higher Part B premiums, and cuts in reimbursements to hospitals and physicians, there will be increasing recognition that the system is irreparably broken. Support for major reform will grow, and the combination of efficiency and equity offered by universal health care vouchers should make it the system of choice.

ISSUES REQUIRING ADDITIONAL STUDY

This is a broad outline of the proposal for a system of universal health care vouchers; myriad details need careful study before such a system is implemented. Economic and financial issues include developing more precise estimates of the cost of universal vouchers, the control of costs over time, and the financing of special services. There will be a need to develop reimbursement methods that encourage efficiency while minimizing the opportunity for health plans to enroll only healthy patients. In a similar way, geographic variations in practice patterns, and thus costs, that are unjustified by differences in wages, other prices, or the quality of care will need to be addressed. Additional study will be required of plan operations and other medical care issues, including the definition of the universal benefit, the development of procedures for participation in the plan and enrollment of beneficiaries, the establishment of the Institute for Technology and Outcomes Assessment, and a strategy for dealing with the effects of health care vouchers on medical education and research. Methods for calibrating the degree of flexibility in modifying the basic benefits package will also need to be developed. Limited flexibility enhances comparability among plans, whereas greater flexibility fosters innovation in the delivery of care and choice.

Numerous legal and regulatory issues must also be investigated, including the establishment of the national and regional offices of the Federal Health Board and a definition of the relationship between the purview of such boards and that of numerous state laws covering malpractice and mandatory medical practice. Finally, considerable thought and study must be given to the problem of the transition from the current system to the voucher system.

All these issues must be addressed with data, analysis, and the balancing of competing values. Questions about the details of health care vouchers are inevitable, but they are not imminently vexing. While pressure builds for comprehensive change, there is time to deliberate about them.

As problems mount with the current health care system, publicly funded social insurance combined with substantial market elements would provide a middle ground that could galvanize broad support from businesses and states and from the uninsured and the general public. By making the financing of health care in the United States considerably more efficient, fair, and simple, universal health care vouchers would also provide a framework for improving the delivery of care.

We are indebted to Kenneth Arrow, David Druker, Alain Enthoven, John Etchemendy, Amy Finkelstein, Alan Garber, Lee Goldman, Mary Goldstein, Hank Greeley, Judy Miller Jones, Sharon Levine, Hal Luft, Philip Pizzo, Antonio Rangel, Deborah Satz, Steven Schroeder, and John Shoven for helpful comments and suggestions; and to Steven Coulter, Andrea Voytko, Greg Scully, Anne Rosone-Franco, Gary Claxton, Ben Finder, and Kate Levit for assistance with data on coverage and rates of various health care plans and health expenditures.

From the Posterity Project, Chicago (E.J.E.); and the Department of Economics, Stanford University, Stanford, Calif. (V.R.F.).

1. Census Bureau. Health insurance coverage in the United States: 2002. (Accessed February 23, 2005, at http://www.census.gov/prod/2003pubs/p60-223.pdf.)
2. Gabel J, Claxton G, Gil I, et al. Health benefits in 2004: four

years of double-digit premiums increases take their toll on coverage. Health Aff (Millwood) 2004;23(5):200-9.
3. Levit K, Smith C, Cowan C, Sensenig A, Catlin A, Health Accounts Team. Health spending rebound continues in 2002. Health Aff (Millwood) 2004;23(1):147-59.
4. Centers for Medicare & Medicaid Services. 2004 Annual report of the board of trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance trust funds. (Accessed February 23, 2005, at http://www.cms.hhs.gov/publications/trusteesreport/2004.)
5. Enthoven AC. Consumer-centered vs. job-centered health insurance. Harv Bus Rev 1979;57:141-52.
6. Gruber J, Madrian BC. Health insurance, labor supply, and job mobility: a critical review of the literature. In: McLaughlin CG, ed. Health policy and the uninsured. Washington, D.C.: Urban Institute Press, 2004:97-178.
7. Shiels J, Haught R. The cost of tax-exempt health benefits in 2004. Health Affairs Web Exclusive. February 25, 2004. (Accessed February 23, 2005, at http://content.healthaffairs.org/cgi/content/full/hlthaff.w4.106v1/DC1.)
8. Fairbrother G, Dutton MJ, Bachrach D, Newell KA, Boozang P, Cooper R. Costs of enrolling children in Medicaid and SCHIP. Health Aff (Millwood) 2004;23(1):237-43.
9. Remler DK, Glied SA. What other programs can teach us: increasing participation in health insurance programs. Am J Public Health 2003;93:67-74.
10. Aaron HJ. Serious and unstable condition: financing America's health care. Washington, D.C.: Brookings Institution, 1991.
11. Peterson PG. Will America grow up before it grows old? New York: Random House, 1996.
12. Thomas B. Vision for health care. Presented at the National Press Club, February 12, 2004. (Accessed February 23, 2005, at http://www.ncpa.org/prs/tst/20040331bttst.htm.)
13. Clinton HR. Now can we talk about health care? The New York Times Magazine. April 28, 2004:26-31, 46, 47.
14. Institute of Medicine. Insuring America's health: principles and recommendations. Washington, D.C.: National Academies Press, 2004.
15. Fuchs VR. Let's make Volkswagen medicine compulsory. Med Econ 1969:110-9.
16. Enthoven A, Kronick R. A consumer-choice health plan for the 1990s: universal health insurance in a system designed to promote quality. N Engl J Med 1989;320:29-37, 94-101.
17. Emanuel EJ. The ends of human life: medical ethics in a liberal polity. Cambridge, Mass: Harvard University Press, 1991:155-233.
18. Fuchs VR. Health system reform: a different approach. JAMA 1994;272:560-3.
19. Davis K, Schoen C, Schoenbaum SC. A 2020 vision for American health care. Arch Intern Med 2000;160:3357-62.
20. Feder J, Levitt L, O'Brien E, Rowland D. Assessing the combination of public programs and tax credits. In: Meyer JE, Wicks EK, eds. Covering America: real remedies for the uninsured. Washington, D.C.: Economic and Social Research Institute, 2001:43-56.
21. Gruber J. A private/public partnership for national health insurance. In: Meyer JE, Wicks EK, eds. Covering America: real remedies for the uninsured. Washington, D.C.: Economic and Social Research Institute, 2001:57-72.
22. Singer SJ, Garber AM, Enthoven AC. Near-universal coverage through health plan competition. In: Meyer JE, Wicks EK, eds. Covering America: real remedies for the uninsured. Washington, D.C.: Economic and Social Research Institute, 2001:153-72.
23. Wicks EK, Meyer JA, Silow-Caroll S. A plan for achieving universal health coverage: combining the new with the best of the past. In: Meyer JE, Wicks EK, eds. Covering America: real remedies for the uninsured. Washington, D.C.: Economic and Social Research Institute, 2001:193-206.
24. Emanuel E. Health care reform: still possible. Hastings Cent Rep 2002;32:32-4.
25. Pear R. Frist expects Congress to try to expand health coverage, but says universal insurance is impossible. New York Times. February 7, 2004:A7.
26. Eddy DM. What care is 'essential'? What services are 'basic'? JAMA 1991;265:782, 786-8.
27. National Advisory Committee on Core Health and Disability Support Services. Core services for 1995/96. Wellington, New Zealand: Ministry of Health,1994.
28. Danis M, Biddle AK, Goold SD. Insurance benefit preferences of the low-income uninsured. J Gen Intern Med 2002;17:125-33.
29. Centers for Medicare and Medicaid Services. Health accounts. (Accessed February 23, 2005, at http://www.cms.hhs.gov/statistics/nhe/.)
30. Fein R. Medical care, medical costs. Cambridge, Mass.: Harvard University Press, 1986.
31. Fuchs VR. National health insurance revisited. Health Affairs (Millwood) 1991;10(4):7-17.
32. Tax reform for fairness, simplicity, and economic growth: the Treasury Department report to the President. Vol. 3. Value-added tax. Washington, D.C.: Government Printing Office, 1984. (Accessed February 23, 2005, at http://www.treas.gov/offices/tax-policy/library/tax-reform/tres84v3All.pdf.)
33. McLure C. The value-added tax: key to deficit reduction. Washington, D.C.: American Enterprise Institute, 1987.

Do We Really Want Broad Access to Health Care?

James J. Mongan, M.D., and Thomas H. Lee, M.D.

Now that the presidential election is over, the real work on the issue of access to health care should begin. The work will be difficult — and probably impossible to accomplish unless the health care profession helps the U.S. public to confront some unpleasant truths.

One might have thought that an election that hinged on "moral values" would generate serious discussion of one of our most fundamental "values" issues — that is, whether we really believe that broader health insurance coverage should be a high priority. The candidates were asked to debate on the basis of their values on issues such as abortion, stem-cell research, and same-sex marriage. But their rather marked disagreement on how to increase access to health care was never treated as a "values" issue, perhaps because voters were unwilling to have their own values tested on this topic.

Americans may say they believe that instituting broader coverage is the right thing to do, yet every-