UNIVERSAL HEALTHCARE VOUCHERS:
Securing Equity and Efficiency in Health Care Finance

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Dissatisfaction with the financing of U.S. health care is widespread.\textsuperscript{1} It is inefficient, inequitable, and increasingly perceived to be unaffordable.\textsuperscript{2,3,4,5} Because only incremental reform is deemed politically feasible, inordinate attention is devoted to treating symptoms rather than diagnosing systemic problems that require major surgery.

As an alternative, we propose universal healthcare vouchers (UHV), 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 become hospitable for endorsing meaningful
reform.

THE FLAWED AMERICAN SYSTEM OF HEALTH CARE FINANCE

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

Employment-based insurance, which now covers 55% of Americans, is inefficient
and inequitable. It distorts labor markets, has high administrative costs, and generates
discontinuous coverage. Because it is paid through pre-tax dollars it is inequitable,
providing a greater subsidy to high income individuals. Medicaid and other means tested
programs cover about one in six Americans. These programs require costly
determinations of eligibility, impose high marginal tax rates on recipients because the
subsidies fall as income rises, and encourages evasion or avoidance of reported income.\textsuperscript{9} Many who are eligible do not apply—some to avoid the administrative hassle or stigma, and others because they expect their incomes to improve.\textsuperscript{10} The programs also generate discontinuous coverage as individuals move in and out of eligibility. Medicare, which covers about one in eight Americans, while popular, has fundamental flaws. It is an open-ended entitlement that 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.\textsuperscript{5,11,12} Despite these programs, 15\% of Americans have no health insurance; they either cannot afford to acquire it or are unwilling to do so.\textsuperscript{2,3}

Incremental reforms have been tried, but despite some successes such as S-CHIPs, the system as a whole is getting worse, not better. Major reform is needed, but will not happen immediately. As problems mount, however, demand for change will intensify. In anticipation of that demand, we propose a universal healthcare voucher system (UHV) with ten fundamental features.
TEN FUNDAMENTAL FEATURES

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 medical history. Americans 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: Americans who wanted to purchase additional services or amenities, such as wider choices of hospitals and specialists, or more comprehensive mental health services, could do so with their own after-tax dollars.

Funding by an Ear-Marked Value-Added Tax: The funding for the vouchers would come from an ear-marked value added tax (VAT). Ear-marking creates a direct connection between benefit levels and the tax level, serving as a cost control “rheostat”: if the public wants more services to be covered in the basic plan, they must be willing to
support a tax increase. A VAT is administratively efficient, cannot be easily evaded, and approximates personal consumption that is closely related to long term financial well-being, regardless of source of income or wealth.

*Reliance on Private Delivery System:* This proposal does not call for government health care and would not legislate changes to the current private delivery system.

*Ending Employment-based Insurance:* By providing basic care for all Americans and eliminating tax benefits for health insurance premiums, employment based insurance would probably fade away. Critics throughout the political spectrum have noted the many shortcomings of employment-based insurance; few would mourn its passing.\textsuperscript{11,13,14,15}

*Eliminating 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 (S-CHIPs), or other means tested programs. Those covered by such programs would be incorporated into the main stream health care system without means testing. Funding for long term care, currently provided by Medicaid, would need to be continued.
Phasing Out of Medicare: While no existing beneficiary would be forced to change to the voucher system, Medicare would be phased out over time. Individuals turning 65 would continue to be enrolled in UHV; there would be no new enrollees in Medicare. Importantly, current Medicare benefits would be supplemented by a tiered pharmacy benefit modeled on that provided as part of the UHV basic benefits package.

Administration: Modeled on the Federal Reserve System, management and oversight would be the responsibility of a Federal Health Board (FHB) with multiple regional boards to provide administration and oversight in different geographic regions. The FHB would define and periodically modify the basic benefits package, and through its regional boards would be active contractor with health plans, informing Americans about their health care options, reimbursing health plans, and undertaking data collection and research related to patient satisfaction, quality of care, and risk and geographic adjustments for payments. The FHB would regularly report to Congress on the health care system.

Technology and Outcomes Assessment: An independent Institute for Technology
and Outcomes Assessment would be established. Its research and database would focus on assessing the effectiveness and value of different 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% of the total.

These ten features address fundamental flaws of the current U.S. health care financing system (Table). Previous reform proposals incorporate several of these features, such as providing individuals 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 purchase of additional care. This proposal, however, is a unique package marked by the use of vouchers to simplify administration, financing through an ear-marked value added tax, the elimination of Medicaid and other means tested programs, elimination of employment based insurance, phasing out of Medicare, oversight through a Federal Health Board to oversee the health system, and creation of an Institute of Technology and Outcomes Assessment.
THE 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. The outlines of such a benefits package can be defined by the benefit packages typically offered by large employers, including in-patient and out-patient hospital services, physician office visits, well-child care and preventive measures, mental health care, and tiered pharmaceutical benefits, typically with dollar limits. We suggest only modest deductibles and co-payments to minimize access barriers for the poor. In 2004, the average annual employer premium for such coverage is $9,950 for families and $3,695 for individuals.

Ultimately, the FHB would structure the benefits package after wide consultation with experts and involvement of the public through various mechanisms. The process would be iterative, with modifications reflecting the public’s desire for more health care services balanced by its willingness to pay the VAT.
ECONOMIC FEASIBILITY

Economic feasibility of UHV depends upon the cost of the publicly funded universal benefits package compared to the cost of employment-based insurance, Medicaid, S-CHIPs, and other programs being replaced. In 2004, excluding Medicare and nursing home coverage, the cost for personal health coverage for Americans under 65 is estimated to exceed $800 billion, including over $600 billion in premiums for employment-based insurance and $200 billion for Medicaid and other means-tested programs (K. Levit personal communications). These costs have been increasing 8-10% per year for the last few years.

How much would the voucher plan cost? Because the cost would depend on what precise services, deductibles, and co-payment levels would be incorporated into the universal benefit, the voucher proposal has not been “scored”. Nevertheless, educated estimates are possible. Through charity and other mechanism, the 15% of Americans who are currently uninsured do get some care; the UHV universal benefit package would
probably increase their use of services by about one-third. This would raise overall health care utilization about 5%. Some additional utilization might be expected from those currently insured with policies less generous than UHV. Conversely, Americans with more generous policies would probably reduce utilization. In addition, some resources would be needed to eliminate deductibles and co-payments for the very poor. Overall, it is reasonable to expect utilization to rise by approximately 5%. However, expenditures need not increase.

With UHV, 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 “equivalent to more than two months’ health care premiums [while] enrolling adults is even more complex” and costly. Moreover, much of the $100 billion spent on the sales and administrative costs of private insurance would also be saved. Over time, UHV would foster a more rational delivery system. For instance, more rational prescribing of
prescription drugs could save 1-2% of health care expenditures. The combination of lower administrative costs and more efficient delivery should offset some or all of the 5% increase in utilization. Therefore, while we lack definitive projections, compared to the current system, additional costs of the universal healthcare voucher proposal would range from 0% to 5%.

**POLITICAL FEASIBILITY**

We recognize that the universal healthcare voucher proposal is not politically feasible at this time. Neither is any other major health care reform. Obstacles to major reform arise from multiple sources: cultural, social, economic and political. Normally, the American political system resists change; it tends to enact major social programs only during war, depression, or civil unrest. Even absent such traumas, there will come a time when the inequities, inefficiencies, and costs of current methods of financing health care will be so intolerable that the public is likely not only to accept but demand comprehensive reform.
At that time, the political feasibility of UHV will be compelling. It is more congruent with American values than 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 plan and freedom to buy additional services, UHV reconciles the distinctively American tension between equality and individual freedom more directly and efficiently than any of the alternatives.\textsuperscript{33}

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

Opposition to UHV may come from some employers with young workforces who use little care, and from high wage workers, who receive munificent benefit packages tax-free. Among the 1300 health insurers, the smaller ones that rely on select market niches will find UHV a threat, as will health benefit consultants who will lose business.
The reaction of health care professionals is uncertain. Doubtless, worrying that any universal coverage system with a fixed budget will inevitably threaten their incomes and freedom, some would prefer the status quo, but that is an impossible dream.

However, when reform comes, many physicians will support UHV because it will create the opportunity, the information, and the incentive to deliver cost-effective care to all Americans.

Ironically, the strongest resistance may come from liberals, who, while embracing universality might object to elimination of Medicaid, a VAT, or the use of vouchers. Such opposition is misplaced. While Medicaid provides vital services for some, it is grossly inequitable. Benefits to some recipients come at the cost of many uninsured working poor. Means-testing is demeaning, an invitation to evasion, and administratively complex.9,10 Benefits vary greatly by state, and are widely perceived to constitute second class medicine. Most importantly, Medicaid is draining resources from other state services, such as public education, vital to the poor’s overall well-being. Providing uniform benefits comparable to those of the middle class for all the poor—even if some
forsake special benefits—seems a fair trade-off.

Some liberals reflexively reject a VAT 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, implicitly subsidizing the poor. It is not an accident that countries, such as those in Scandinavia, that provide universal health coverage, make substantial use of VAT to fund social programs. Furthermore, VAT can be made more progressive by excluding from the taxable base items, such as food, that account for a declining proportion of consumption as income rises.\textsuperscript{33,34} Finally, liberals 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 U.S., and segmentation of the market is currently widespread. The healthcare 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. Over the next few years, however, as employers continue to cut benefits or eliminate coverage entirely, as
states reduce Medicaid services to avoid deficits, as cost increases for Medicare 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 UHV should make it the system of choice.

**ISSUES REQUIRING ADDITIONAL STUDY**

This is a broad outline of the UHV proposal; myriad details need careful study prior to implementation. Economic and financial issues include developing more precise estimates of the cost of the universal voucher, the control of costs over time, and the financing of special services. Importantly, creating reimbursement methods to encourage efficiency while minimizing adverse selection will need to be developed. Similarly, geographic variation in practice patterns and thus costs that are unjustified by differences in labor or other prices or quality of care will need to be addressed.

Plan operations and other medical care issues, including defining the universal
benefit, developing procedures for plan participation and enrollment of beneficiaries,

establishing the Institute for Technology and Outcomes Assessment, and dealing with the
effects of UHV on medical education and research will need study. Calibrating the
degree of flexibility in modifying the basic benefits package will also need study.

Limited flexibility enhances comparability among plans while 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 Health Boards, and defining the relation
between their power and responsibilities and 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 UHV.

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

The present approach to financing health care in the United States is inefficient, inequitable, and increasingly unaffordable. The irreparable flaws of employment-based insurance, Medicaid, and Medicare are increasingly becoming recognized. We propose a universal healthcare voucher system financed by an ear-marked VAT that would facilitate the end of employment-based health insurance, Medicaid and other means tested programs, and eventually Medicare. Such a proposal may not seem politically tenable today, but as problems mount, publicly funded social insurance combined with significant market elements would provide a middle ground that can galvanize broad support from businesses and states, from the uninsured and general public. By making the financing of health care in the United States significantly more efficient, fair, and simple, UHV would also provide a framework for improving the delivery of care.
We thank Kenneth Arrow, David Drucker, 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. We thank 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.
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<th>The Problem</th>
<th>Current System</th>
<th>Universal Healthcare Voucher System</th>
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<td>Uninsured</td>
<td>Over 40 million Americans are uninsured because they are 1) too young for Medicare, 2) not poor enough for Medicaid, 3) unable to acquire insurance at an affordable price, or 4) are unwilling to purchase insurance.</td>
<td>Every American is guaranteed basic health care coverage without means testing or exclusions of any kind.</td>
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<td>Health cost inflation</td>
<td>Health care expenditures have increased by nearly 10% per year for the last 3 years and nearly 75% in the last decade. There are no firm cost control mechanisms. Medicare is an open-ended entitlement that ignores costs relative to benefits. Employment-based insurance typically provides greater subsidies for more expensive plans and insulates patients from consideration of costs.</td>
<td>Use of an ear-marked tax to directly link expansion of cost of basic benefits package with the public's willingness to increase taxes. Services beyond basic care will be paid with after tax income ensuring people weigh costs against benefits. Systematic technology and outcomes assessment will limit use of services only when proven beneficial.</td>
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<td>Discontinuity of coverage</td>
<td>Substantial discontinuity of coverage because of 1) job loss, 2) job changes, 3) retirement, 4) employer changes in health plans, or 5) changes in means-tested eligibility.</td>
<td>Complete continuity of coverage since individuals can stay in the same plan as long as they wish regardless of changes in employment, income, health status, or other circumstances.</td>
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<td>Inefficient labor markets</td>
<td>Employment-based insurance distorts decisions of employers and employees about outsourcing, hiring, retirement, job changes, etc. Means-tested programs, such as Medicaid, discourage the poor from working because they might end insurance eligibility.</td>
<td>No distortion of employment decisions since employers and employees are free to make decisions independent of any health insurance considerations. The poor do not lose coverage if their income rises.</td>
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<td>Haphazard and unfair subsidies</td>
<td>Tax treatment of employment-based insurance provides greater subsidies to high income individuals. Many lower income and working individuals are ineligible for means-tested programs, and many eligible do not apply.</td>
<td>Everyone contributes to support of basic care in proportion to their consumption of goods and services. There are no free riders.</td>
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**TABLE 1: Problems in the Current System and Their Resolution by a Universal Healthcare Voucher (UHV) Plan**


27 Eddy DM. What care is ‘essential’? what services are ‘basic’? JAMA 1991;265:782-788.

29 Danis M, Biddle AK, Goold SD. Insurance benefit preferences of the low-income uninsured. JGIM 2002;17:125-133.

30 www.cms.hhs.gov/statistics/nhe/


