

Virtual Mentor

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Journal Discussion

The Emanuel-Fuchs Voucher Plan for Health System Reform

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[A single-payer health care system] is no more politically feasible today than it was when President Clinton rejected it as a model for reform. Sure, a compelling case can be made that the Canadian or French system serves those countries' citizens better than the American system does ours. But an equally compelling case can be made that we'd be better off with an extra dollar-per-gallon tax on gasoline. These are, in the end, liberal sugarplum visions. If progressives want to use this moment to achieve universal health care, they will need to put forward a proposal that makes the most of what's good about the current system and reflects America's basic values [1].

These words, written by Ezekiel Emanuel and Victor Fuchs, capture a rare event in American political history: the interest—and the opportunity—for a marriage of two fundamental and often opposed values, namely, social equality and individual free choice, in the interest of achieving substantial health care reform. If ever effective policy was needed, it is now: about 45 million Americans lack any health coverage; the vast majority of them are working but cannot (or will not) purchase health insurance. Those who lack coverage are more likely to live sicker and die younger. The Institute of Medicine estimates that each year 18 000 people without health insurance die prematurely, and the total annual loss in human capital is upwards of \$130 billion [2,3]. Emanuel, a physician-philosopher, and Fuchs, an economist, believe that any plan to successfully avert what has become a catastrophe-in-waiting must concurrently maintain the freedom of choice Americans so value while expanding health coverage for everyone [4].

The Health Care Voucher Proposal

Emanuel and Fuchs propose a 10-component voucher plan for universal health coverage, summarized in 4 key concepts [4]:

Sufficiently Comprehensive Benefits

According to their plan for guaranteeing basic, universal health coverage, every American under 65 years of age will receive a voucher for purchase of a sufficiently comprehensive health plan from a private insurer of their own choosing; participation in the voucher system will be mandatory. Insurers who want to compete for vouchers

will be required by law to provide a plan with predetermined, minimum “universal benefits,” that include inpatient and outpatient hospital care, physician office visits, preventive services, mental health care, and tiered prescription drug benefits. Voucher holders will still be responsible for “modest” deductibles and copayments. Persons in existing publicly provided health insurance (such as Medicaid or SCHIP) will be rolled into the new voucher program. Medicare enrollees (people aged 65 or older) will continue to be covered through existing programs, but those newly eligible for Medicare will enroll into the voucher program, thus phasing out Medicare over time.

Privately Delivered Coverage and Care

All Americans will choose a basic health plan from a private insurer whose plans meet the government standard for universal benefits. A person who desires services not covered by the basic plan will be able to purchase supplemental services and pay for them with after-tax, out-of-pocket dollars. Employers will no longer offer health insurance as part of an employee's compensation.

Publicly Financed

The voucher system would be publicly financed through a dedicated, value-added tax (VAT). The level of the VAT would be legislatively determined, and the amount of money brought in by the tax would govern the level of coverage. Public demand for more services would mean a higher tax; conversely, if the public desired a lower tax, they would have to settle for fewer services.

Federally Administered

In a structure similar to the Federal Reserve System, a Federal Health Board, supported by regional health boards, would manage and oversee the voucher system and be directly accountable to Congress. An independent Institute for Technology and Outcomes Assessment would be established to research and assess cost-effectiveness in the health care system.

Eliminating Financial Barriers to Health Care

The principle advantages of the Emanuel-Fuchs voucher plan over other health-care financing proposals that cede administrative powers to a government—namely single-payer systems—are that it preserves market competition among insurance companies and health plans while eliminating the financial barriers to obtaining health care coverage. Private delivery of health care services would remain; so too would private reimbursement and its provider, the health insurance industry, a sector that contributes hundreds of billions of dollars a year to the US economy and employs hundreds of thousands of workers. The seeming simplicity of single-payer proposals ignores the indirect, macroeconomic consequences of eliminating an entire sector of the United States' economy, including the challenge of finding jobs for displaced workers and means for injecting new money into our economy.

Because participation in the voucher plan is mandatory, health care becomes, in effect, a public good, paid for and provided to all citizens. This eliminates the so-called “free riders” who receive health care without paying for services and pass on the costs to taxpayers. Without free riders, emergency room waits would decline, the need for a

health care safety net would eventually disappear, and money would be freed for more equitable distribution among all citizens.

Political Feasibility

Despite maintaining the individual's ability to choose his or her health care coverage, something Americans so value, the voucher plan faces significant obstacles to adoption. Emanuel and Fuchs astutely point out,

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 [problems] of the current [health care financing system] will be so intolerable the public will not only accept but demand comprehensive reform [5].

Since most Americans currently receive decent health care without having to wait for it, they will be generally reluctant to accept sweeping reform, especially if it puts their health or pocketbooks at risk. Moreover, if health care stakeholders (eg, managed care groups, insurance companies, and even physicians groups) perceive that reform will reduce their influence or financial gain, they could stymie change by sowing doubts and fears about government-financing of health care among the public. This happened in 1993, when many health care stakeholders claimed that President Clinton's proposed Health Security Act would turn the United States into a single-payer health system. The resulting public pressure contributed heavily to the proposal's collapse [6].

Financing

The authors do not offer a firm idea of what the voucher program would cost, although they project that sharp reductions in current administrative costs would greatly offset new costs generated by increased use of health care services by the previously uninsured.

What makes the proposed VAT an attractive source of funding for health care? VAT is levied on sales of all goods and services at every stage of production, unlike retail sales tax which is collected only at the point of sale from the final customer. Advocates say that a VAT is fair because it distributes tax burden more evenly throughout an economic system; businesses would be unable to pass their full VAT-related increases on to the consumer because they would still have to compete in the marketplace. Emanuel and Fuchs call their financing plan "progressive" because it provides the poor with a good in the form of health care, while the cost is shared by all taxpayers. Critics, however, say a VAT will be "regressive" if it taxes basic, needed goods because the poor spend a far greater percentage of their income on necessities than do middle- and upper-income earners. An effective VAT-financing system will have to distribute cost equitably at all points of production, put controls in place to protect consumers from unjust price increases, and protect basic goods like groceries, electricity, and pharmaceuticals from being unfairly taxed.

Impacts on Cost of Care

The most important criterion when judging the validity of a health care financing

reform proposal is its ability to expand coverage for the uninsured. Emanuel and Fuchs believe their plan will achieve this goal. At the same time, they admit that issues of quality and cost of care need to be studied. First, the taxpaying, voting public will only accept a universal health plan if it is both financially sound and provides even better coverage than the current system. It is unclear whether this voucher plan can satisfy these demands. The authors believe that the combination of more efficient delivery with a marked decrease in administrative costs would offset a projected 5 percent increase in services [5], but these claims seem undersupported by the studies they cite [2]. Additionally, any plan that creates a centralized oversight body to make decisions regarding the value of a voucher (ie, the Federal Health Board) should include basic protections to shield policymakers from lobbying practices by insurers intending to pad their profits.

Emanuel and Fuchs argue that much of the \$100 billion now spent on administration and sales by private insurers would be saved [5]. However, it seems unlikely that an insurer would reduce such costs. Persons previously eligible under public insurance programs (like Medicare and Medicaid) would now be absorbed by insurers, creating a greater administrative burden. In fact, insurers would be likely to hire new workers to handle increased administration and to serve as sales staff to compete for the newly voucher-eligible—both the previously uninsured and those previously insured under public programs. Thus, administrative and sales costs may actually go up under the voucher system. Nor is it clear that physicians' administrative duties would decline: instead of justifying a procedure to Medicare or Medicaid administrators, physicians would now deal exclusively with insurers, but with no net savings in time for more patient contact. A single-payer system, of course, does significantly streamline administrative overhead, but at the macroeconomic costs mentioned earlier.

Finally, the cost of providing health care services and the price consumers pay for such services will be stable at best and will possibly increase under a voucher system. Roughly 10 percent of those who use health care services account for 70 percent of usage [7]. If it turns out that the previously uninsured, newly-covered individuals are using a disproportionate share of services (ie, if many new users have chronic health conditions that require long-term care), the Federal Health board will have to raise the value of the voucher, reduce the universal benefits package, or put insurers at risk of losing money. Nothing in the voucher system operates to squelch cost increases, so it leaves patients potentially susceptible to increases in health care costs.

Conclusion

Health care reform has been under discussion for years. Economic, ethical, political, and cultural shifts may be pushing us towards significant reform. The Emanuel-Fuchs voucher system plan weaves ideas of freedom, choice, and social obligation together to remove financial barriers and open access to health care for all Americans. Many of the authors' claims regarding improving efficiency in the system, reducing administrative overhead, and improving the cost-efficiency of delivery remain undersupported. The authors concede, however, that further study is needed to clear up questions of the plan's impact on cost, efficiency, and quality of health care before

determining whether such a sweeping reform will be beneficial to the overall health of the United States.

Questions for Discussion

1. The authors admit that the current political climate makes adoption of universal health care nearly impossible. Could the voucher plan be implemented incrementally? For instance, could a pilot voucher program (eg, a plan covering currently Medicaid- and SCHIP-eligible persons along with the uninsured) produce data that allowed policymakers to make more accurate economic predictions, helping sell the plan on a wider scale to taxpayers? How would such a pilot plan be funded? Beyond the primary benefit of removing financial barriers to health care access, would there be secondary benefits of access to and quality of care (for instance, would giving current Medicaid enrollees a voucher encourage them to seek better care or improve the quality of care they receive because of reduced stigmatization)?

2. Although the voucher plan removes financial barriers to health care access, other obstacles to entering the health care system persist. Examples of such barriers may include one's proximity to health care facilities, the location of medical specialists, the availability of certain medical procedures, and language and cultural barriers. Should the voucher plan include policies to overcome the remaining challenges to accessing care, and, if so, what might those policies look like?

3. The authors speculate that overall use of health care services would rise by about 5 percent; mostly from one third of the previously uninsured persons becoming new users. They argue that increased use by those currently insured with policies less generous than the voucher system's universal benefits package would be balanced by decreased use among those who currently have more generous policies. Do you think this is an accurate prediction? Under what conditions might previously insured persons increase their use of services? Decrease their use of services?

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