On the Use of Vouchers for Medicare

HAROLD S. LUFT

Institute for Health Policy Studies,
University of California, San Francisco

ONE APPROACH TO THE PROBLEM OF RISING medical care expenditures is the encouragement of increased competition among various types of health care delivery systems. Alain Enthoven (1980) is one of the original proponents of a major method of enhancing the role of market forces, the use of vouchers to encourage cost-effective consumer choice of health plans. Others have offered variations on the voucher theme (Friedman, LaTour, and Hughes 1983). The basic idea is that consumers would make periodic choices (e.g., once a year) among alternative systems, such as local health maintenance organizations (HMOs), conventional insurance plans offering various copayment provisions, and other innovative systems. These choices would typically occur with the provision by the plans of substantial information and, more important, in the context of choosing a delivery system rather than bargaining with a surgeon during an illness episode. The government or other external agency would monitor the marketing practices of the health plans to assure truth in advertising.

A key aspect of this system is the notion of a voucher. Rather than covering the cost of a plan regardless of its efficiency, as is the case with many employers and the current Medicare and Medicaid programs,

Milbank Memorial Fund Quarterly/*Health and Society*, Vol. 62, No. 2, 1984

the voucher would be set at a level that would substantially cover only the cost of an efficient health care plan. If a consumer wishes to enroll in a less efficient plan, he or she would pay the full incremental cost associated with that decision. The vouchers themselves could be provided by employers in place of their current health benefit systems (or could be paid for by governments, replacing the current Medicare and Medicaid systems). In fact, some employers, such as the Federal Employees' Health Benefits Program, already offer close approximations to a voucher system, and there are some experiments offering public program beneficiaries a choice of health plans.

The notion of using vouchers to encourage choice and competition among alternative providers of medical care is attractive for several reasons. Providing consumers with a choice of plans is better likely to meet individual differences in preferences. Some types of medical care delivery systems, such as HMOs, seem substantially more efficient. Vouchers can be designed with incentives to encourage consumers to join such efficient plans, and if consumers still wish to enroll in less efficient systems, then, many would argue, they should bear the additional cost rather than be subsidized by others who choose less profligate providers. One can also predict that if currently inefficient providers were faced with the loss of enrollees and patients, they would institute their own cost-containment efforts. Such efforts are likely to be far more effective than those forced upon providers by government bureaucracies. It is therefore anticipated that the competition resulting from a voucher system will help lower the rate of growth in medical care expenditures.

Vouchers offer additional advantages from the government's perspective. Currently, Medicare and Medicaid expenditures are open-ended in that price inflation or utilization increases directly increase budgetary outlays. Vouchers would put a fixed limit on government costs for the year, with the only uncertainty being the number of eligibles. A second major attraction is that a voucher system would extricate the government from involvement and responsibility for medical care costs. Once the value of the voucher has been set, the government need only monitor the operation of the market in order to assure reasonable fair trade practices; it can be removed from its current adversarial role with providers.

Enthoven's original proposal to introduce a voucher-based system was designed to enroll all U.S. residents. It was intended as an alternative to the widely discussed national health insurance proposals

of the 1970s. Now, in the mid-1980s, we hear little about national health insurance. Instead, there is a clamoring for health care cost-containment, with particular attention being paid to reducing federal expenditures for Medicare and Medicaid. At a recent conference sponsored by the House Ways and Means Committee, the Congressional Budget Office, and the Congressional Research Service, Bernard Friedman, Stephen LaTour, and Edward F. X. Hughes (1983) offered a proposal for a Medicare voucher system. In contrast to Enthoven, who felt that a competitive system should begin with the private sector and slowly add Medicare beneficiaries, this new proposal focuses on Medicare only. One of the immediate objections to such a strategy is that a separate system will quickly become unequal. However, even if a Medicare voucher plan is designed as a precursor to a national system, there are important implementation issues that must be examined and equity questions that should be raised.

These comments are intended to help policy makers think about the desirability of a voucher system and the modifications necessary to make such a system work well. As has Enthoven (1980), Friedman, LaTour, and Hughes (1983) make a strong case in favor of vouchers, and I agree that such proposals have many merits. However, there are also specific weaknesses that should be considered by voucher advocates in order to strengthen the proposals. The first part of the discussion focuses on whether a voucher system will work as well as its advocates suggest. The second part asks whether such a system would be desirable even if it worked as advertised.

Implementation Issues

There are several issues that bring into question the feasibility of a voucher system as one attempts to move from the economist's drawing board to the reality of the marketplace. These implementation issues include (1) adverse selection, (2) attractiveness of alternative health plans, (3) administrative problems in a multiple-option system, (4) regulation, and (5) implementation costs.

Adverse Selection

The most important threat to the successful operation of a voucher-based system is adverse selection. Adverse selection is the situation

in which those people who are above-average users of medical care are concentrated in certain plans, causing premiums to reflect not just differences in efficiency but also differences in enrollee mix. There is evidence that selection bias is a substantial problem in the Federal Employees' Health Benefits Program and in several Medicare demonstration projects (Office of Technology Assessment 1982; Eggers 1980; Eggers and Prihoda 1982). Numerous private employers are finding selection bias to be an increasingly important problem (Luft, Trauner, and Maerki 1983; Jackson-Beeck and Kleinman 1983). Moreover, in most employment-related situations there is a crucial difference with the proposed voucher system. If adverse selection occurs, the employer may cross-subsidize through the contribution or premium so that the extra costs of the plan with higher risk employees are borne at least partly by either the employer or the other options. (These internal adustments often occur when high and low options are offered. The premiums quoted may reflect the actuarial value of the plan, not the actual experience.) Cross-subsidization dampens the adverse-selection problem because the plan with a disproportionate share of high-risk enrollees does not have to reflect all their costs in the premium. Thus, lower risk enrollees are not driven out of the plan. The proposed voucher system, however, does not include such transfers among plans, and cross-subsidization would be difficult to implement with any voucher system using different carriers.

In principle, establishing premiums and vouchers according to risk classifications is an attractive solution to the adverse selection problem, but in practice it may run into difficulties. Age and sex categories are rather crude measures, and evidence from the Medicare capitation-demonstration projects indicates that even a fairly complex classification system accounts for only a small fraction of the variation in utilization. Furthermore, the best predictor of future use is past use, and even its inclusion leaves substantial room for selection (Beebe, Lubitz, and Eggers 1983). To the extent that the risk adjustment is incomplete, carriers selectively have incentives to attract potential enrollees whose expected utilization is substantially less than that indicated by their actuarial category. As I have indicated elsewhere, there are numerous devices that might be used by carriers and most of these techniques do not rely upon obvious schemes such as health examinations (Luft 1982).

There are also important policy questions concerning the design of

risk-adjusted vouchers. People in high-risk categories may have premiums that might be ten or more times higher than the premiums of low-risk people. If the voucher does not cover the full cost of the premium, should the enrollee's share be a fixed dollar amount, irrespective of risk, or should it be a fixed proportion of the premium? One can make strong arguments either way. A flat amount irrespective of risk does not penalize the sick for their higher expected utilization. However, while a small premium differential may be enough to deter a relatively healthy person from joining a "Cadillac" plan, especially if the alternatives involve some copayments or inconvenience, small premium differentials will have little or no effect on people with high expected utilization. Thus, the "Cadillac" plans will continue to provide a blank check for the high-cost enrollees and their providers.

Even simple age-rating may be contrary to age-discrimination statutes, and other risk categories may be similarly challenged on the grounds that they merely represent differences in average values and bear little relation to what will be experienced by any one individual. Such arguments are analogous to those raised concerning sex-specific life insurance premiums. While new legislation could circumvent such problems, the issue of political feasibility becomes crucial if it is necessary to move beyond the arena of changes in the medical care system alone.

Adverse selection is likely to be an even more important problem in a voluntary plan in which people have the option of staying in the existing Medicare plan. The basic Medicare plan will probably be left with all the high-cost enrollees because low-risk beneficiaries will be attracted into low-option plans. This will be the case even if shallow coverage plans are prohibited, but active choices are required to join HMOs and other alternative delivery systems. Inertia is an important factor in multiple-option situations; those people currently in treatment are unlikely to want to change providers, and plans will probably not try to attract high-risk enrollees.

A mandatory voucher system does not eliminate the problem of selection, it merely transfers the risk from the federal government to the private sector. If the private carriers are not convinced that the risk adjustments are adequate, they will probably refuse to join the system. Friedman, LaTour, and Hughes (1983) report that quite a few new plans signed up for capitation experiments under a voluntary voucher system. This may be an encouraging example of public spir-

itedness. Alternatively, it may be evidence that the vouchers were set so high that entrepreneurs expected to make a killing.

The crucial point is that if substantial adverse selection occurs and cannot be controlled, a voucher system will quickly fall apart. It is true that the adverse-selection problems experienced by the federal employees' and University of California plans have not resulted in immediate collapse. In each case, however, the administering agency has allowed cross-subsidies or has increased the employer contribution to help offset the problem. Furthermore, both systems have long histories of careful management and "statesmanlike" behavior by the major carriers. A new Medicare voucher system might not have such advantages, unless great care and effort are devoted to its design and development.

Attractiveness of Alternative Health Plans

There is reasonably good evidence that well-managed prepaid group practices deliver comprehensive medical care of good quality at a lower cost than the conventional system. The evidence concerning the performance of individual practice association HMOs, preferred provider plans, and other alternative health plans is either extraordinarily thin or nonexistent (Luft 1981). It is possible that much of the purported savings is due to favorable selection, and it is not appropriate to generalize from the experience of prepaid group practices to the newer types of systems. Yet, prepaid group practices have relatively limited appeal for the elderly who are not already members, and, more important, the establishment of large, well-functioning groups is a difficult and time-consuming process.

Administrative Issues

A thorough analysis of administrative problems in a mandatory voucher system should be based upon the careful evaluation of demonstration projects. However, some of the issues that have arisen in multiple-option health benefit plans and the Arizona Health Care Cost-Containment System are worthy of discussion. One of the most important issues is how one should deal with persons who do not enroll in any plan. (Contrary to economic rationality, this failure to enroll even

occurs when there are no out-of-pocket premium costs.) There should be a default option other than Medicaid and public hospitals, yet who is to choose which plan gets these automatic enrollees? Locating potential enrollees is not a trivial matter either. The monthly Social Security check mailings, even if made available for informational inserts or private advertising, will not help inform those people who have checks deposited directly in their banks.

Friedman, LaTour, and Hughes (1983) propose a clever implementation scheme that would avoid disruption to current enrollees yet offer a substantial enrollment base when vouchers are initiated. If legislation were passed today, they propose that the voucher plan become effective three years from now, in 1987. Everyone becoming eligible for Medicare between now and 1987 would be in the mandatory voucher plan as of 1987. All other current beneficiaries would be offered voluntary vouchers. Of course, such a strategy also reduces the short-run impact on Medicare program costs and, thus, reduces the attraction of vouchers as a source of budgetary savings. Moreover, making voluntary vouchers available to current beneficiaries increases the potential for adverse selection.

Advocates of vouchers generally underestimate the amount of consumer education about health plan options necessary to provide both reasonable choice and consumer protection. A simple listing of copayments and exclusions is far from adequate. Enrollees need to understand fully the benefit coverage and financial incentives to the enrollee in each plan. Even with the same listed coverage, insurers may vary in their determination of medical necessity and in the level of usual and customary fees, which are the base for benefit payment. Thus, mandating a minimum-benefit package is not sufficient to reduce the potential real variability among plans. One might avoid this difficulty by also having all conventional insurance plans require their providers to accept assignments in order to take part in the voucher system. (Such a scheme, of course, reduces the political viability of the proposal.) As one moves from conventional insurance plans to preferred provider organizations, HMOs, and other alternative systems, the structure and performance of the delivery system becomes more complex and correspondingly more difficult to explain. (Friedman, LaTour, and Hughes [1983] note that the Kaiser mailings to Medicare beneficiaries in the demonstration project seem not to have been completely under-

stood.) With an increasing number of options the problems of providing the relevant information to local beneficiaries becomes even more difficult.

Regulation

Advocates of competition often overlook the substantial amount of regulation necessary under a voucher-type system. Conventional insurers are regulated by the states, with varying degrees of effectiveness. The regulatory oversight of HMOs and other alternative delivery systems is split between federal and state authorities, and in some states certain types of plans can avoid regulation (Trauner 1983). Yet regulation is necessary to assure minimum benefit provisions—and thus to protect the Medicaid program from low-option plans seeking to attract low-income beneficiaries with cash rebates. Regulation is also necessary to avoid the types of fraud and abuse that occurred in the early 1970s under California's Prepaid Health Plan program for Medicaid beneficiaries. While consumer sovereignty argues against regulation, consumer ignorance and the political liability of a scandal argue for regulation.

Monitoring plans appropriately is an extraordinarily complex task requiring substantial skill, but there is little incentive and fewer resources for the government to try to do it well. Private employers typically avoid the regulation issue by dealing with a small number of carriers with proven track records. Employers cannot be sued for excluding plans they do not like as long as they are in compliance with the HMO Act. The ability of the Health Care Financing Administration (HCFA) to exclude plans from a voucher market will be substantially more limited because of the public nature of the program. The Office of Personnel Management has substantial leeway in allowing plans to participate in the Federal Employees' Health Benefits Program (FEHBP). In fact, the FEHBP is exempt from many restrictions imposed on private employers (e.g., the HMO Act). Whether a Medicare voucher system would be designed with the flexibility of the current FEHBP rather than the rigidity of most other public programs is an open question.

The issue of regulation is also linked to the adverse-selection problem. It is probably impossible to design an automatically self-correcting risk-adjustment system. Instead, HCFA actuaries must continually monitor enrollment patterns to see if plans have figured out subtle

ways of selecting low-cost enrollees and then design ways to offset those strategies. This monitoring will be even more difficult in the future when one can no longer use as a benchmark the costs of individuals while in a uniform Medicare plan. If this actuarial adjustment is not done, the more clever—not the more efficient—firms may eventually drive out the others.

One might suspect that the potential for short-term profits could even lead to fraudulent behavior that might result in a political reaction against the voucher system, such as occurred in the California Prepaid Health Plan scandals of the early 1970s. Note that fraud and abuse can occur in any system. The concern here is that because a voucher system is so different, there will be more "political enemies" watching for the first mistake. Furthermore, there is a pervasive public bias in favor of more, rather than less, medical care. The outcry when a patient dies, having been denied an operation, is greater than when a patient dies as a result of a probably unnecessary operation.

Implementation Costs

A voucher plan would eliminate the government's ability to command below-market prices because Medicare is such a dominant purchaser of medical care. While it is true that this monopsony power cannot be exercised without limit, a voucher system would probably entail a 10 to 20 percent increase in hospital charges for Medicare beneficiaries. (This assumes that hospitals would charge voucher plans the same rates they charge everyone else.) Startup costs of the system and the regulatory structure must also be included in the budget. This implies that not only will the potential savings that might result from voucher-induced competition be realized several years after implementation, but also that the cost to Medicare may increase substantially in the interim.

Equity Issues

The previous discussion outlined several reasons why a voucher plan may not work as well as one might hope. However, even if all the necessary corrections could be made, there are some important equity issues that must be considered in order to decide whether such a plan

is socially desirable. Equity questions are usually framed in terms of the benefits to different income groups, but in this case the issues are somewhat broader. They will be discussed under four major areas: (1) blaming the victim; (2) regional inequities; (3) educational inequities; and (4) government commitment over time.

Blaming the Victim

One underlying concept of insurance is the notion of risk-pooling, which is associated with the often-held belief that because all members of the community are at risk of medical adversity, all should share in paying for insurance against such events. The shift from community to experience rating is a movement away from such sharing of responsibility. Risk-rated premiums and vouchers—if the enrollee's cost is tied to the risk category—is an additional major step away from the community concept. This experience rating may be explicit, for instance, in establishing a risk class for persons with a history of cancer. Of more concern, however, is the implicit sorting out of risk associated with selection. Suppose that a local fee-for-service plan is the only one to cover hospitalization at a renowned out-of-area cancer center, such as Sloan-Kettering. This plan will attract a disproportionate share of cancer patients, and its premiums will increase. There may be a tendency for HCFA *not* to risk-adjust the vouchers in this case and merely blame the higher premiums on inefficiency. Of course, not adjusting the vouchers to reflect this risk differential merely adds a financial burden to those who are already suffering because of poorer health.

It is important to note that such behavior is not necessarily proof of hard-heartedness. Once a voucher system is underway and people disperse to different plans, there is no way to compare medical utilization across plans to separate individual risk factors from the plans' efficiency incentives. Clearly, this issue is intertwined with the adverse-selection problem. The point here is that not only may the system not work well, but that it will generally be the sick who suffer the most when it does not work well.

Regional Inequities

Friedman, LaTour, and Hughes (1983) point out that one of the problems with a voluntary voucher program is that a national rate

will be too generous in some areas and too low to avoid adverse selection in other areas. While a mandatory voucher eliminates the cost of adverse selection to the government, it does not alter regional cost patterns. In currently high-cost areas the voucher either will require substantial additional enrollee payments or will force people into low-option or restricted-choice plans. Both of these effects will tend to increase adverse-selection problems.

It may be argued that one could allow regional differentials in voucher payments initially that would be eliminated over time, as in the current DRG program. However, there are two important differences between vouchers and diagnosis-related groups (DRGs). Because the voucher program requires the establishment of new competing plans, one could anticipate that few plans would enter those regions in which the projected national rate is "too low." In the DRG case, the hospitals are already in place. The second difference is that the DRG prospective payment system will place the burden of "excess" hospital costs on the hospitals, *not* the patients. The voucher system penalizes all consumers who live in regions where the providers are inefficient or highly paid.

Educational Inequities

As has been discussed above, the evaluation of various health plan options is an extraordinarily complex task. Most large employers do not have the expertise to evaluate adequately the plans they offer. A voucher system, even with substantial regulation of advertising, is likely to be more comprehensible only to the well educated. The less well educated may be easily misled. The problems with Medigap plans are likely to be repeated, but with more serious consequences because victims will find themselves with unusable coverage rather than just inflated costs for supplemental policies.

Government Commitment over Time

A final concern has to do with the determination of voucher levels over time. The current administration is clearly interested in reducing its expenditures for health care. Under the existing Medicare system, the government, as the largest purchaser of medical care, can use its monopsony power to demand price reductions, as under DRG prospective payment, or to introduce other changes, such as altering relative fee levels or constraining coverage of certain technologies. Because under

a voucher system the government's contribution will be divided among many insurers, this negotiating power will be lost and the only control available will be a constraint on the rate of growth in the amount of the voucher. With projections of continuing budget deficits, there will be strong incentives to reduce that rate of growth in vouchers and, thereby, to shift more of the premium cost onto the beneficiaries.

In the past, providers such as physicians and hospitals have had the political power to avoid major threats to their incomes and, as a by-product, to protect Medicare beneficiaries. The passage of prospective payment suggests that a shift in the political balance of power has occurred. Vouchers will further fragment the political power of providers. Moreover, the voucher program itself will no longer have a means of determining costs because of selection problems, so allegations that the voucher should be growing more rapidly may be rejected as efforts to subsidize inefficient providers. The question, then, is whether a voucher scheme will eliminate too many checks and balances in the political process.

Conclusions

Despite some appealing aspects of a voucher program for Medicare, there are important uncertainties about its feasibility and desirability. Adverse selection poses perhaps the largest single question concerning the immediate implementation of vouchers for the whole Medicare program. Unfortunately, theoretical discussions cannot tell us how important a problem adverse selection will be. To get an answer, major demonstration and evaluation projects would have to be undertaken. Such demonstrations also might help to determine whether or not alternative health plans can attract enrollees and whether the administration and regulation of a voucher plan is feasible in the real marketplace. Trying out the system also would provide an estimate of the costs associated with implementation and the loss of monopsony power. It is important to recognize that voluntary vouchers are not a suitable test case. Just as some states have been allowed to experiment with all-payer systems, perhaps others could be induced to experiment with vouchers on a statewide basis. This would also allow a test of whether a voucher system would only work in areas that already have a large number of well-established HMOs. It is surely better to

experiment at the state level than to risk the entire Medicare system in an experiment.

Even if adverse selection is not too great a problem and the implementation of a voucher system is not too difficult, we need to ask whether such a system is desirable. It has the potential for capping federal expenditures, but there is no assurance that this will be done by promoting efficiency rather than by shifting the cost burden to the beneficiaries, especially those who are least able to afford such costs. However, we must also explore whether or not a voucher system—perhaps with modifications so as to minimize its flaws—may still be better than any of the available alternatives. Whether an efficient *and* equitable system can and will be designed is a question that requires political as well as technical judgment.

References

Beebe, J., J. Lubitz, and P. Eggers. 1983. Using Prior Utilization Information to Determine Payments for Medicare Enrollees in HMOs. Baltimore: Health Care Financing Administration, Office of Research and Demonstrations, Office of Research. (Mimeo.)

Eggers, P. 1980. Risk Differential between Beneficiaries Enrolled and Not Enrolled in an HMO. *Health Care Financing Review* 1(Winter):91–99.

Eggers, P., and R. Prihoda. 1982. Pre-Enrollment Reimbursement Patterns of Medicare Beneficiaries Enrolled in "At-Risk" HMOs. *Health Care Financing Review* 4(September):55–73.

Enthoven, A. 1980. *Health Plan: The Only Practical Solution to the Soaring Cost of Medical Care.* Reading, Mass.: Addison-Wesley.

Friedman, B., S. LaTour, and E.F.X. Hughes. 1983. A Medicare Voucher System: What Can It Offer? Presented to the Conference on the Future of Medicare, sponsored by the Committee on Ways and Means, the Congressional Budget Office, and the Congressional Research Service, November 29–30.

Jackson-Beeck, M., and J. Kleinman. 1983. Evidence for Self-Selection among Health Maintenance Organization Enrollees. *Journal of the American Medical Association* 250(November):2826–28.

Luft, H. 1981. *Health Maintenance Organizations: Dimensions of Performance.* New York: Wiley-Interscience.

———. 1982. Health Maintenance Organizations and the Rationing of Medical Care. *Milbank Memorial Fund Quarterly/Health and Society* 60(Spring):268–306.

Luft, H., J. Trauner, and S. Maerki. 1983. Rising Premiums in Multiple Option Health Insurance Plans: Causes and Potential Solutions. Presented at the American Public Health Association Annual Meeting, Dallas, Texas, November 15.

Office of Technology Assessment. 1982. *Medical Technology Under Proposals to Increase Competition in Health Care.* Appendix C: Federal Employees' Health Benefits Program. Washington.

Trauner, J. 1983. *Preferred Provider Organizations: The California Experiment.* San Francisco: Institute for Health Policy Studies, University of California, San Francisco.

Acknowledgments: An earlier version of this paper was prepared for the Conference on the Future of Medicare sponsored by the U.S. House of Representatives, Committee on Ways and Means, the Congressional Budget Office, and the Congressional Research Service of the Library of Congress, Washington, November 29–30, 1983.

Address correspondence to: Harold S. Luft, Ph.D., Professor of Health Economics, Institute for Health Policy Studies, University of California, San Francisco, 1326 Third Avenue, San Francisco, CA 94143.