

The Ethics of Medicare Privatization

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The Empirical and Ethical Arguments Against Medicare Privatization

- History of privatization efforts since 1994. Break up of policy consensus (Oberlander); the role of premium support proposals and managed care
- Privatization provisions in the Medicare Modernization Act (2003); the role of managed care

The Empirical and Ethical Arguments Against Medicare Privatization (cont'd)

- The drug benefit will be administered by private companies rather than through the Medicare program, which will add expensive layers of administration.
- In order to attract or retain participating Medicare HMOs, a federal bonus subsidy of \$1.3 billion will be paid during 2004 and 2005; even before drug coverage starts in 2006, this subsidy will boost the cost of care in Medicare HMOs to about 115% of what Medicare pays for traditional coverage.

The Empirical and Ethical Arguments Against Medicare Privatization (cont'd)

- Overpayment and subsidies for participating private health plans, originally expected by the CBO to cost \$14 billion from 2004–2013, are now projected by White House actuaries to require \$46 billion, more than three times as much.
- The legislation mandates a six-year privatization experiment to begin in 2010 in six metropolitan areas.
- The bill includes a health savings account program that many privatization advocates would like to see imported into the Medicare program as a premium support approach to privatization.

Medicare Managed Care: The Empirical Experience

Cost-containment.

- The data on this criterion are clear; private Medicare plans do not contain costs as well as fee-for-service (FFS) Medicare.
- The cumulative growth in per-enrollee payments for enrollees in Medicare has increased by less than three quarters as much as costs for enrollees in private plans since 1970 (Geyman, 2004).
- Medicare HMO enrollees now cost 107% for what it costs to pay for fee-for-service beneficiaries with similar risk characteristics. As poorly designed as the FFS system is to provide care efficiently, it is less expensive than managed care in the Medicare context.

Medicare Managed Care: The Empirical Experience (cont'd)

Quality of care.

- Although comparative quality of care studies have produced generally mixed results, several well-designed studies have found that older members (age 65+) of HMOs experience less favorable outcomes, especially for chronic conditions, than those receiving care in the fee-for-service system.
- I have followed this research literature carefully since 1993 and I have not found a single study showing that Medicare HMOs achieve better quality-of-care outcomes than the fee-for-service system. HMOs do appear to get better results than fee-for-service systems in terms of reduced paper work, quicker appointments and reduced out-of-pocket costs.

Medicare Managed Care: The Empirical Experience (cont'd)

Choice.

- Managed care is inherently more restrictive than FFS care in terms of the beneficiary's ability to select and retain her own physician.
- The Medicare + Choice program was supposed to expand choice but in her assessment of the program, Marsha Gold (2001) found that, "Existing plans have withdrawn from M+C, few new plans have entered the program from among the newly authorized plan types, and greater choice has not developed in areas that lacked choice. (qtd. in Geyman)."
- Her grade for expanding choice was a D.

Medicare Managed Care: The Empirical Experience (cont'd)

Reliability.

- Medicare HMOs have tended to be substantially less reliable than the regular FFS Medicare program as demonstrated by the 2.4 million people who were left stranded when Medicare HMOs left the market between 1999 and 2003.
- The array of benefits offered by HMOs are often reduced on short notice.

Medicare Managed Care: The Empirical Experience (cont'd)

Efficiency.

- Administrative costs in the regular, FFS Medicare program represent 2 to 3% of total costs compared to between 15% and 20% for private health insurance plans, including HMOs.

Medicare Managed Care: The Empirical Experience (cont'd)

Fraud.

- Fraudulent practices have long been endemic to Medicare.
- Prosecutions and huge settlements, however, have become steadily more common as the number of for-profit fiscal intermediaries, hospitals and HMOs have grown over the past 20 years.

Ethical Framework

- Daniels, Light and Caplan (1996) have developed an ethics of health care based on what they think is a fundamental principle deeply embedded in America culture, public policy and historical experience.
- This is the principle of “fair equality of opportunity” of individuals to flourish as human beings (to achieve their capabilities), which is the foundation for the widely held notion that health care, like education, is a right and not just a privilege.

Ethical Framework (cont'd)

- Drawing on the work of John Rawls, Daniels et al. distinguishes between formal and fair equality. Formal equality means that individual characteristics (accidents of birth) like race, gender, age or disability should not be allowed to determine our opportunities.
- Fair equality goes a qualitative step further by positing a positive obligation “to eliminate residual unfairness in the distribution of capabilities.”

Ethical Framework (cont'd)

- Adherence to the fair equality of opportunity principle requires that, “A commitment to fair equality of opportunity thus recognizes that we should not allow people’s prospects in life to be governed by correctable, morally arbitrary, or irrelevant differences between them, including those that result from disease and disability.
- By designing a health care system that keeps *all* people as close as possible to normal functioning, given reasonable resource constraints, we can in one important way fulfill our moral and legal obligations to protect equality of opportunity.” (Daniels, 1996, p. 20)

Ethical Framework (cont'd)

- The principle also requires that strong efforts be made to prevent inordinate waste, inefficiency and fraud in the health care system in order to preserve as much of the pool of resources as possible for the provision of effective (not wasteful) services.
- Waste, inefficiency and fraud are inherently violations of the fair equality of opportunity principle in that they materially diminish the resources available to ensure access to the level of health care needed to protect normal functioning.

Fairness Benchmarks

- Daniels et al. have developed a set of ten benchmarks of fairness which they use to measure the fit between health care reform proposals and their interpretation of what the fair equality of opportunity principle would require in terms of each of their ten benchmarks.
- They also use the benchmarks to trace the trajectory of the U.S. health care system during the mid- 1990s, finding that the system was tending away from the kinds of destinations consistent with the fair equality principle.

Fairness Benchmarks (cont'd)

Universal access.

- If access to services is not universal, then equality of opportunity is weakened. If access is not universal, other morally irrelevant social contingencies—income and wealth, education level, or geographical location—will determine access to health care, not medical need.

Fairness Benchmarks (cont'd)

Comprehensive and uniform benefits.

- Fairness also requires that the criteria for inclusion of health care services in a benefit package are their effectiveness and relative importance in protecting opportunity through promoting normal functioning.

Fairness Benchmarks (cont'd)

Equitable financing.

- By treating fairness in health care as a special case of promoting equality of opportunity, we emphasize that it is a social obligation we must all share. The benchmarks requiring community-rated premiums and out-of-pocket payments that are means-based specify two aspects of the fair sharing of the burdens of meeting those obligations.
- Community rating means that health status differences among individuals will not determine the cost of health care insurance. Means-based payments assure that all medical bills are proportional to the ability to pay.

Fairness Benchmarks (cont'd)

Value for money.

- The two “value for money” benchmarks emphasize the ways in which a proposal must strive to get rid of wasteful uses of health care dollars.
- If a system is wasteful, and resources are limited, then the needs of some will be sacrificed to wasteful features of the system. Their opportunities will not be as well protected as in a less wasteful system, and they will be wronged.

Fairness Benchmarks (cont'd)

Public accountability.

- Even if all waste were corrected, advances in medical technology demand that hard choices be made about which beneficial uses of medical services are most important.
- This prescribes a benchmark concerning public accountability through fair procedures for making such decisions. Justice quite generally requires that the grounds for making decisions that affect our lives in fundamental ways be accessible to us.

Fairness Benchmarks (cont'd)

Degree of consumer choice.

- This is a complex issue since there are many dimensions to choice: treatments, physicians, insurance plans.
- It may not be possible to maximize choice along all these dimensions at once, and some kinds of choice compromise other benchmarks of fairness. For example, a choice between insurance plans with different levels and ranges of benefits can deeply compromise community rating and equal access.

Protecting Professional Integrity

- The contrasts between business and professional ethics are striking. Business ethics accepts health care as a commodity, its primary principle is non-maleficence, it is investor- or corporate-oriented, its attitude is pragmatic, and its legitimate self-interest, competitive edge, and unequal treatment based on unequal ability to pay.
- Professional ethics, on the other hand, sees health care not as a commodity but as a necessary human good, its primary principle is beneficence, and it is patient-oriented. It requires a certain degree of altruism and even effacement of self-interest.

Applying the Fairness Benchmarks to Medicare Privatization

- The fundamental strategy for the privatization of Medicare since 1994 has been to use incentives designed to increase the number of Medicare beneficiaries in managed care organizations, primarily HMOs.
- Therefore, my use of the Daniels et al. benchmarks to assess the ethics of Medicare privatization will focus on managed care and what we know about the history of HMOs in Medicare.

Applying the Fairness Benchmarks (cont'd)

Universal access.

- Medicare is universally available to those age 65 and older and to disabled persons after a two-year waiting period.
- HMO-oriented privatization initiatives may threaten universal access by making it increasingly difficult for the less healthy beneficiaries who are relatively heavy users of health care services and more dependent on carefully selected providers to remain in the regular fee-for-service Medicare program.

Applying the Fairness Benchmarks (cont'd)

Universal access (cont'd).

- As healthier beneficiaries join HMOs, the cost of the fee-for-service system is likely to be driven up through adverse selection.
- This process could lead to policy makers increasing premiums, copayments and deductible for beneficiaries to the point that FFS becomes increasingly unaffordable for heavy users of health care services.

Applying the Fairness Benchmarks (cont'd)

Comprehensive and uniform benefits.

- The MMA gives large subsidies to HMOs, which will presumably permit them to offer more benefits or reduced costs for similar benefits than are available to beneficiaries who prefer or need to remain in the traditional fee-for-service system.
- HMOs maybe able to offer better, more comprehensive benefits, but at the expense of greater fragmentation and reduced uniformity of benefits coverage across the Medicare program. Furthermore, the history of Medicare HMOs shows that they often reduce coverage and increase costs to beneficiaries after achieving desired levels of market share.

Applying the Fairness Benchmarks (cont'd)

Equitable financing.

- HMOs in Medicare often tend to recruit healthier, less expensive Medicare recipients who, at least initially, benefit from lower out-of-pocket costs and access to more benefits than those who prefer or need to remain in the traditional program.
- This kind of favorable selection clearly violates the fair equality of opportunity principle by allowing health status differences among beneficiaries to determine the cost of health care insurance for both beneficiaries and the federal government

Applying the Fairness Benchmarks (cont'd)

Equitable financing (cont'd).

- This arrangement also violates the principle-related notion that medical bills should be proportional to the ability to pay.
- In fact, this arrangement moves in the opposite direction by allowing healthier beneficiaries to pay less than sicker and disproportionately poorer beneficiaries who must remain in the FFS system to receive the kind of care, in their judgment, that they need.

Applying the Fairness Benchmarks (cont'd)

Public accountability.

- There is little reason to think that public accountability will be maintained at even its currently inadequate level with HMO-led privatization of the Medicare program.
- Effective accountability in privatized programs often falls victim to the power of private firms to gain controlling influence over the contract bidding and monitoring processes. As their stake in the privatization of public programs expands, firms have demonstrated the capacity to use their lobbying and campaign financing resources to guide executive branch decision-making and achieve their legislative agendas.
- The latest example of this capacity is the extent to which drug companies (no price negotiations with the federal government) and HMOs (large subsidies) were able to get their way in the MMA and effectively resist passage of the HMO patients' bill of high legislation.

Applying the Fairness Benchmarks (cont'd)

Public accountability (cont'd).

- The fundamental threat of broad scale privatization in any program is that accountability will become so attenuated and the public so inured to reports of malfeasance that scandalous behavior becomes inseparable from normal practice and impervious to democratic interventions in the public interest.
- The 25-year-old attack on the public sector may finally reach its apotheosis in the disappearance of any effective notion of the public interest and of the public servant working in the public interest under a code of professional ethics.
- The threat to professional ethics in the public sector is similar to the threat experienced by health care workers under managed care where the priority is placed on increasing profitability.

Applying the Fairness Benchmarks (cont'd)

Degree of consumer choice.

- An essential part of the rationale for HMO-led privatization of Medicare is that, in response to the subsidies in the MMA, HMOs will enter the market on an unprecedented scale and give many more beneficiaries the opportunity to choose between FFS providers and managed care plans.
- If, in fact, these expectations are met, however, the longer range impact of significant increases in HMO Medicare enrollees could well reduce the degree of beneficiary choice by making the FFS option increasingly unaffordable for low-income beneficiaries due to adverse selection in the FFS sector.

Applying the Fairness Benchmarks (cont'd)

Professional integrity.

The two main ethical dilemmas are described below.

- *Disrupting the physician's fiduciary relationship with his/her patient*—this relationship is the principal “vehicle of care” for the chronically ill elderly. The physician must know her patient very well and, over an extended period of time, the patient must be able to trust the physician and believe that her best interests are foremost in the physician's mind.
- If financial incentives, intrusive monitoring/approval procedures and frequent switching of physicians and patients or other managed care procedures are allowed to disrupt this relationship, the essential trust between physician and patient may be eroded along with the quality of care that is substantially dependent upon its maintenance.

Applying the Fairness Benchmarks (cont'd)

Professional integrity (cont'd).

- *Undermining accountability for access to care and quality of care*—financial incentives in management mechanisms designed to either directly or indirectly (spin-off effect) limit access to services, especially specialty care, or compromise a commitment to achieving an acceptable quality of care in order to protect profit margins (the interests of stockholders) are not morally defensible.
- Physicians and the organizations that employ them must be accountable first to their patients and all other involved parties second.

Applying the Fairness Benchmarks (cont'd)

- I am far from convinced models of mediation designed to address ethical dilemmas at the physician-patient level are adequate vehicles for addressing the most fundamental ethical issues in the current health care system.
- I do not see how these models can serve as effective, ethically defensible substitutes for direct, undistorted, sincere communication between the physician and her patient, undistorted by cost-containment or profit maximizing imperatives.
- These mediation models may simply increase the bureaucratic interference between the physician and the patient and help subordinate this relationship, however indirectly, to corporate interests.

Conclusion

- According to my assessment, which is based on a set of criteria drawn from the fair equality of opportunity principle, Medicare privatization through the expansion of managed care participation is, at best, ethically questionable on several accounts.
- I consider this assessment to be a preliminary and highly provisional effort to raise ethical issues in the context of Medicare privatization, especially provisions within the Medicare Modernization Act designed to support the expansion of managed care.

Conclusion (cont'd)

- In my view, the ethics of Medicare privatization should receive at least as much attention as the debates over abortion, gay rights, gun control and school prayer.
- Adding Medicare privatization to the list of moral issues, which seems to have had such a substantial impact on how many people voted in the 2004 Presidential election, could contribute to the emergence of a liberal, democratic ethics emphasizing fairness, social justice and servicing as a counterweight to the currently dominate ethics of neo-conservatism and the values of individualism, private property and the unfettered market.