Chapter 6

The Ethics of Medicare Privatization

Larry Polivka

BACKGROUND

Medicare has maintained an exceptional status in the United States health care system since its inception in 1966. Medicare is essentially a publicly funded, single-payer system that is more similar in design to the public health care systems of Europe and Canada than it is to the rest of the American health care system, which is largely privately funded and administered. This exceptional status, however, has been under attack in the Congress since the Republican takeover of the House of Representatives in 1994. Many members of the Republican majority, including the leadership, have made sweeping privatization of the Medicare program a high priority, undertaking several major initiatives since 1995 to move Medicare towards privatization. The principal vehicle for achieving this objective has been the implementation of incentives designed to increase the number of beneficiaries in managed care organizations, primarily health maintenance organizations (HMOs) and, more recently, preferred provider organizations (PPOs). These incentives have essentially failed to achieve the goal of increased beneficiary numbers in HMOs: the percentage of beneficiaries in HMOs fell from 16% in 1999 to 11% in 2004.

This failure, however, has not lessened the enthusiasm of privatization supporters for a greatly expanded HMO role in the Medicare program. The Medicare
Modernization Act of 2003 (often referred to as the prescription drug bill) includes a very large increase in reimbursement levels for HMOs, which supporters hope will induce HMOs to recruit more Medicare members and offer benefits that will attract many more beneficiaries. This is the rationale for making managed care a more expensive option than fee-for-service on a per capita basis. Managed care was once supposed to be less expensive because it was more efficient than fee-for-service care. The goal now, however, appears to be privatization regardless of the cost.

The major Medicare privatization initiatives taken over the last decade include a failed 1996 Balanced Budget Amendment that would have required the complete privatization of the program; the Medicare + Choice program in the 1997 Balanced Budget Act, which was intended to increase HMO coverage to more than 30% of Medicare beneficiaries; the National Bipartisan Commission on the Future of Medicare, whose chairmen (former Senator John Breaux (D-LA) and Senator Bill Frist (R-TN)) became advocates for a “premium support” proposal that would have given beneficiaries a set amount of money to help them purchase private health insurance; and the 2003 Medicare Modernization Act (MMA), which provides several billion dollars for drug companies and HMOs and includes a number of provisions that increase beneficiary cost sharing, support privatization, and provide a drug benefit that has more critics than supporters among beneficiaries.

In the absence of any feasible constraints on drug prices, such as allowing the federal government to negotiate prices with drug companies, the drug benefit will not do much to contain beneficiary out-of-pocket costs for their prescriptions. The benefit will cover only 22% of the projected costs beneficiaries are expected to spend on drugs between 2004 and 2013. Premiums and deductibles will increase by 78% between 2006 and 2013, much higher than beneficiaries’ projected income growth, and catastrophic coverage will rise from $5,100 to $9,066 in 2013. All of this will make the benefit less affordable each year after 2006.

The privatization-related provisions in the MMA include the following:

- 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.
- Overpayment and subsidies for participating private health plans, originally expected by the Congressional Budget Office (CBO) to cost $14 billion from 2004 to 2013, are now projected by White House actuaries to require $46 billion, more than three times as much as the estimate.
The Ethics of Medicare Privatization

- The legislation mandates a 6-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.

MEDIACARE MANAGED CARE: THE EMPIRICAL EXPERIENCE

Before directly addressing the ethical issues associated with efforts to privatize Medicare through the expansion of managed care participation in the program, it may be instructive to review the empirical results of the Medicare HMO experiences over the last 20 years vis-à-vis criteria commonly used to assess health care programs and policies, beginning with cost containment, an essential part of the original rationale for managed care. These results have major implications for any analysis of the ethics of Medicare privatization cost containment.

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, p. 583). Medicare HMO enrollees now cost 107% of 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.

A U.S. General Accounting Office report summarized the impact of the Medicare + Choice program as follows:

The Medicare + Choice program has already been expensive for taxpayers . . . the vast majority of plans have gotten paid more for their Medicare enrollees than the government would have paid had these enrollees remained in the traditional fee-for-service program. Raising payment rates to a level sufficient to retain the plans leaving Medicare would mean increasing the excess that currently exists in payments for plan enrollees, relative to their expected fee-for-services costs. In areas of the country where there are few beneficiaries and providers are in short supply, no reasonable payment rate increase is likely to entice plans to participate in Medicare. . . . In our view, efforts to protect the viability of Medicare + Choice plans come at the expense of ensuring Medicare's financial sustainability in the long term. (as cited in Geyman, p. 588)

The fundamental threat of privatization to the financial sustainability of Medicare emerges from the fact that HMOs have a strong incentive to enroll healthy
beneficiaries. Those who are less healthy have a strong incentive to avoid HMOs, which would limit their access to providers. The interaction of these incentives could generate what has been called a death spiral for the traditional Medicare program. The advantages of sharing risk on a broad basis are lost as risk pools are segmented, with the ultimate threat of demise of the original Medicare program through adverse selection.

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 plus) 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 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 paperwork, quicker appointments, and reduced out-of-pocket costs.

Quality of care and cost containment are two of the most important criteria for assessing the relative value of alternative health-care policies and systems, with quality of care arguably the most important single criterion. Quality of care is critical not only to the instrumental aspects of alternative health care strategies, but also is just as important to the ethical dimension as well. Therefore, it is useful for the purposes of this chapter to take a closer look at the results of several studies of the comparative effects of the managed care versus fee-for-service systems of care for Medicare beneficiaries. These studies were conducted over the last 10 years, from 1993 to 2002, with strikingly similar findings.

Findings from a series of studies by Mathematica, Inc. (Brown, Bergeron, Clement, Hill, & Retchin, 1993) of the Medicare TEFRA (Tax Equity and Fiscal Responsibility Act) HMO2 programs indicated that the HMO enrollees were not as likely to receive as many chronic and long-term-care services (such as home health care and rehabilitative services) as those in the fee-for-service sector; they had fewer visits with their physicians; and they reported somewhat lower satisfaction with the quality of care received. On the other hand, HMO enrollees clearly were pleased with the lower out-of-pocket cost of their care and the reduced paperwork.

A study by Shaughnessy, Schlenker, and Hittle (1994) found that the Medicare HMO enrollees received fewer home visits and had longer intervals between visits than fee-for-service Medicare patients had, and the cost of home services in the HMOs averaged two thirds of the fee-for-service costs. When patient status outcomes (e.g., bathing ability) and service utilization outcomes (e.g., hospitalization) were compared across groups, the fee-for-service patients had significantly better outcomes than the HMO patients did.

A study by Ware, Bayliss, Rogers, Kosinski, and Tarlov (1996) found substantial differences in 4-year outcomes for elderly and poor, chronically ill patients
The Ethics of Medicare Privatization

89

treated in HMOs versus fee-for-service systems in four urban areas. For elderly patients (those aged 65 years and older) treated under Medicare, declines in physical health were more common in HMOs than in FFS plans (54% vs. 28%; p < .001). In one site, mental health outcomes were better (p < .05) for elderly patients in HMOs relative to FFS, but not in two other sites.

The study included 2,235 patients (18 to 97 years of age) with hypertension, non-insulin-dependent diabetes mellitus, recent acute myocardial infarction, congestive heart failure, and depressive disorder sampled from HMO and FFS systems in 1986 and followed up through 1990. Outcome measures were derived from differences between initial and 4-year follow-up scores of summary physical and mental health scales from the Medical Outcomes Study 36-Item Short-Form Health Survey (SF-36) for all patients and practice settings.

Goldzweig et al. (1997) conducted a study comparing rates of cataract extraction in prepaid health settings versus those in fee-for-service settings in southern California. The study included more than 62,000 Medicare managed-care enrollees in a staff model HMO and an Independent Practice Association (IPA), and 47,150 FFS Medicare beneficiaries (a 5% sample of all southern California FFS beneficiaries.) After controlling for age, sex, and diabetes status, FFS beneficiaries were twice as likely to undergo cataract extraction as prepaid beneficiaries were.

Morgan, Virnig, De Vito, and Persily (1997) analyzed HMO enrollment/disenrollment patterns among Medicare beneficiaries by examining enrollment and inpatient billing records for southern Florida from 1990 through 1993. This study was based on an analysis of differences in the use of inpatient medical services by 375,406 beneficiaries in the Medicare fee-for-service system, 48,380 HMO enrollees before enrollment, and 23,870 enrollees after disenrollment. The authors found that the results of this study seem to support the view that many Medicare recipients join and remain members of HMOs when they are healthy but return to the fee-for-service system when they become sick and need to make relatively extensive use of medical services.

The most recent study by Safran, Wilson, Rogers, Montgomery, and Chang (2002) is based on data from 8,828 respondents (Medicare beneficiaries) who were either in Medicare fee-for-service or a Medicare HMO in 13 states with Medicare HMO markets. Their findings show the following:

Overall, the findings reveal that primary care performance favors the traditional FFS Medicare system over Medicare HMOs for 9 of 11 features of care that were examined. A salient advantage of Medicare HMOs was their superior financial access to care (i.e., fewer cost-related barriers to care).

The results did not differ for patients in better or worse health, and the relative performance of the systems was the same in all 13 states, with the exception of one staff/group-model HMO that outperformed FFS and IPA/networks in its area (Arizona) on three aspects of care. The findings are markedly consistent—in both direction and magnitude of effect—with previous comparisons of indemnity and
managed care systems' performance on the defining elements of primary care (Safran et al., 2002, p. 757).

Choice

Managed care is inherently more restrictive than FFS care in terms of beneficiaries' ability to select and retain their own physician. The Medicare + Choice program was supposed to expand choice, but in her 2001 assessment of the program, Marsha Gold found, "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" (cited in Geyman, p. 581). Gold's grade for expanding choice was a 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 benefits offered by HMOs often are reduced on short notice. As Geyman (2004) notes,

Many Medicare + Choice (M+C) HMOs have reduced benefits as they raise premiums, particularly among the two-thirds of HMOs that are for-profit. While almost all M+C plans offered prescription drug coverage initially, by 2002, 29% of their enrollees had no such coverage and 69% of those with coverage had a limit of $750 or less. Between 1999 and 2002, the proportion of M+C programs offering preventive dental benefits dropped from 70% to 14% while those providing hearing benefits fell from 91% to 53%.

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. Even with this lower administrative overhead, the FFS Medicare program has done a better job of constraining costs.

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. For example, Blue Cross/Blue Shield organizations, which have increasingly converted to a for-profit status, paid more than $200 million in settlements to the federal government between 1993 and 1998. The two largest for-profit hospital chains, Hospital Corporation of America and Tenet, have paid more than $2 billion to settle cases of fraud in the Medicare program. This is precisely the pattern one
would expect with the spread of poorly regulated privatization initiatives in Medicare or any other publicly funded program.

AN ETHICAL FRAMEWORK

Daniels, Light, and Caplan (1996) have developed an ethics of health care based on a fundamental principle deeply embedded in American 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.

Drawing on the work of John Rawls, Daniels et al. (1996) distinguish between formal and fair equality. Formal equality means that individual characteristics (accidents of birth) such as race, gender, age, or disability should not be allowed to determine our opportunities. Fair equality goes a qualitative step further by posting a positive obligation “to eliminate residual unfairness in the distribution of capabilities.” Daniels et al. claim fair equality of opportunity requires that

We offer assistance wherever unfair practices regarding race, gender, age, or disabilities have led either to the mis- or underdevelopment of people’s capabilities. Such corrections for the effects of unfair social practices are needed to make sure that competition is truly fair to all and not just fair in name only (p. 20).

Daniels et al. (1996, p. 21) apply the fair equality of opportunity principle to health care policy by noting, “disease or dysfunction restrict access to life’s opportunities.” Health care protects our opportunities by protecting our functional capabilities, including both physical and mental capabilities. The absence of access to adequate health care undermines (creates often insurmountable barriers to) our capacity to use our talents and skills to pursue the range of opportunities available to those able to function normally. According to Daniels et al.:

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 (p. 20).

In support of the notion that fair access to health care is a necessary condition for human flourishing, Pellegrino (1999) notes the following:

A society becomes good if it provides those goods which are most closely linked to being human and health care is surely one of the first of these goods. It is, to be sure, not the only human good (Aristotle, Nicomachean Ethics, 1178b30-34). But other goods, like happiness, wealth, friends, career, etc., are compromised or even impossible without health. (p. 259)
The fair equality of opportunity principle does not require that individuals receive all of the health care they may want or could benefit from, even in some marginal fashion, if it were provided. The principle recognizes the need for reasonable limits on the use of finite resources drawn from a pool of resources that also must be used to ensure the availability of other “common goods” needed to achieve fair equality of opportunity, such as education and public safety. The principle requires, however, that enough resources be provided to ensure that no one is denied access due to discrimination or inability to pay in order to have access to all basic levels of health services sufficient to protect normal physical and mental functioning. For Daniels et al. (1996), a sufficient level of services to protect normal functioning includes mental health services, long-term care, and preventive services, all of which are only partially, if at all, covered in the current Medicare program.

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 inherently are 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.

In describing the effort to create an adequate balance between fair access and resource limitations, Daniels et al. note the following:

The primary social obligation is to assure everyone access to a tier of services that effectively promotes normal functioning and thus protects equality of opportunity. Since health care is not the only important good, resources to be invested in the basic tier are appropriately and reasonably limited, for example, by democratic decisions about how much to invest in education or job training as opposed to health care. Because of their high “opportunity costs,” there will be some beneficial medical services that it will be reasonable not to provide in the basic tier, or to provide only on a limited basis, for example with queueing. To say that these services have “high opportunity costs” means that providing them consumes resources that would produce greater health benefits and protect opportunity more if used in other ways. (p. 27)

This general framework does not by itself, of course, specify precisely the terms of a just and balanced relationship among the objectives of fair equality of opportunity, efficient use of resources, and liberty under reasonable resource constraints. Achieving a just (equitable) balance among these objectives requires that they be supplemented by “an account of fair process to provide those answers in a way that has legitimacy” (Daniels et al., 1996, p.73). A fair process of determining priorities and setting limits must be designed to treat all affected parties as free and equal citizens in a transparent, democratic decision-making process characterized by what Habermas calls “undistorted communication.” No one could credibly claim that we have anything resembling such a process for the development of health care policy in the United States, where the corporate health care sector is virtually unchallenged in its domination of the policy process.
Daniels et al. offer a set of criteria that could be used in assessing alternative health care policies and programs that are consistent with the fair equality of opportunity principle. These criteria, which I will use later to assess the effects of privatization on the Medicare program, could become part of an operational framework for the kind of “fair process” of policy decision-making that Daniels et al. (1996) recommend as a supplement to the broader ethics of health care based on the fair equality principle. The fair equality of opportunity ethics developed by Daniels et al. and its application to health care is fundamentally consistent with the work of several other theorists who have focused on the concepts of human capabilities and human flourishing in the area of human rights (Polivka & Borrayo, in press).

**Fairness Benchmarks**

Daniels et al. (1996) have developed 10 benchmarks of fairness they use to measure the fit between health care reform proposals and their interpretation of what the fair equality of opportunity principle would require. They also use the benchmarks to trace the trajectory of the U.S. health care system during the mid 1990s, finding that the system tended away from the kinds of destinations consistent with the fair equality principle. The 10 benchmarks are described briefly below.

1. a. Universal access—coverage and participation
   1. b. Universal access—minimizing non-financial barriers
      
      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. (p. 32)

2. Comprehensive and uniform benefits

   Fairness, as we have construed it, 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. The benchmark measuring comprehensiveness of benefits employs that criterion, prohibiting, for example, categorical exclusions of preventive or mental health or other types of services without regard for their effect on normal functioning. (p. 32)

3. a. Equitable financing—community-rated contribution
   3. b. Equitable financing—by ability to pay

   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. (p. 33)
4. a. Value for money—clinical efficacy
   4. b. Value for money—financial efficacy

   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. (p. 33)

5. 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. (p. 33)

6. Comparability

   The comparability benchmark reminds us that health care is not the only important social good: other services, like education, have a profound impact on opportunity, and other use of social resources, for national defense and the criminal justice system, promote security and protect our liberties. (p. 33)

7. 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. (p. 34)

The authors note that their 10 benchmarks do not address every aspect of a fully comprehensive assessment of health care policy and practice, including respect for the professional integrity of clinicians. I will include this dimension of health care, along with most of the benchmarks offered by Daniels and his colleagues, in my own assessment of the ethics of privatization in the Medicare program. The maintenance of professional integrity is a very important issue in any discussion of the impact of managed care on the practice of medicine, and to the extent that managed care is the main vehicle for privatization of Medicare, threats to professional integrity must be included in any assessment of privatization. It is no accident that criticism of managed care over the last several years has focused on these threats, which many critics think are unavoidable in the transformation of health care from a professional service with many characteristics of a common good to a commodity in a market-oriented health care economy.

Professional integrity in health care is based on a fundamental distinction between business and professional ethics, as recognized by Pellegrino (1999):
The Ethics of Medicare Privatization

The contrasts between business and professional ethics are striking. Business ethics accepts health care as a commodity, its primary principle is non-maleficeance, 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. (p. 254)

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. (1996) benchmarks to assess the ethics of Medicare privatization will focus on managed care and what we know about the history of HMOs in Medicare. This approach is especially appropriate, in that many of the privatization provisions in the Medicare Modernization Act feature expansion of beneficiary membership in HMOs, PPOs, and other managed care organizations. I do not use all 10 of the benchmarks offered by Daniels and his colleagues, but just those that are most salient in the current context and that we have enough information about to make reasonable judgments.

Universal access. Medicare is universally available to those who are age 65 and older and to disabled persons after a 2-year waiting period. HMO-oriented privatization initiatives may threaten universal access by making it increasingly difficult for 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. 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 deductibles for beneficiaries to the point that FFS becomes increasingly unaffordable for heavy users of health care services.

Comprehensive and uniform benefits. The MMA gives large subsidies to HMOs, which presumably will 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. The Medicare program is far from comprehensive in its coverage of services, even with the new drug benefit, which is much less generous than the benefit often available to younger people in employer-funded plans. Medicare does not cover long-term care and many rehabilitative services that are high priority needs for many elderly people. The steep increases in premiums, copayments, and deductibles over the last 15 years have put benefits beyond the reach of many low-income beneficiaries. HMOs may be 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. It would be more equitable (more consistent with the fair equality of opportunity principle) to cap out-of-pocket costs to beneficiaries, add the missing benefits to the Medicare program, improve the drug benefit, and let HMOs and PPOs compete with the traditional fee-for-service program on the basis of quality of care and patient satisfaction criteria.

Equitable financing. Medicare HMOs 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. The latter is projected to pay up to 115% more for HMO members than similar fee-for-service beneficiaries pay under the Medicare Modernization Act. 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 do sicker and disproportionately poorer beneficiaries, who must remain in the FFS system to receive the kind of care they feel they need.

Value for money. As noted earlier, there is little or no evidence that managed care provides better or even equal care compared to the traditional fee-for-service system. In fact, most of the findings from the available research literature indicate that health care outcomes (clinical efficacy) are better in the traditional program, especially for those with chronic and multiple medical conditions. This is a highly salient difference, in that a far higher percentage of Medicare beneficiaries (30% or more) suffer from chronic diseases and comorbidities than do members of the younger population. These differences in outcomes and patient satisfaction levels have appeared consistently in the literature from the earliest reported research in the early 1990s (Brown et al., 1993) to the latest reported findings (Safran et al., 2002).

In terms of financial efficiency as a measure of “value for money,” Medicare HMOs clearly fail to match the performance of the traditional program. Administrative overhead constitutes only 2% to 3% of the traditional program’s budget, compared to 15% and higher for HMOs. This relatively high administrative expense is a major reason that HMOs currently cost 5% to 7% more than care provided in the FFS system for beneficiaries with similar health status profiles. This difference is expected to exceed 15% as federal managed care subsidies ($45 billion between 2004 and 2013) become available under the MMA, whose supporters appear to have relinquished any notion that HMOs should be expected to help contain costs in the Medicare program. The rationale for privatization now appears to be an ideological faith (no proof required) in private sector efficiency and a deep
commitment to the interests of corporate health care and its view of Medicare as the last frontier for managed care expansion.

Public accountability. There is little reason to think that public accountability will be maintained even at its currently inadequate level with HMO-led privatization of the Medicare program. The accountability track record for privatization initiatives is spotty at best at every level of government and across programs from health and human services to corrections, education, information systems, and the military, and is often characterized by sweeping negligence and malfeasance. 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 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 rights legislation.

Democratic processes of public accountability in the Medicare program are likely to diminish if HMOs gain greater control over Medicare resources by signing up one third of all beneficiaries over the next several years, which is the goal of legislators supporting the HMO subsidies in the MMA. As HMOs gain control of the Medicare program, the traditional FFS Medicare program is likely to shrink to the point that it no longer will be a feasible alternative to managed care. This will leave policy makers without the leverage required to exercise any effective accountability for costs and outcomes in the Medicare program. The only cost-containment leverage left will be over beneficiaries, which policy makers could exercise by reducing appropriations for the program and forcing beneficiaries to pay more out-of-pocket for services.

Public accountability in privatized programs, including health care, is not theoretically impossible. In fact, privatization theory is based on the notion that the public sector retains the power to ensure fair competition through a transparent and rigorously managed competitive bidding process; the collection of accurate and detailed cost and performance (outcomes) information; and unambiguous procedures for preventing conflicts of interest among policy makers and administrators. In practice, however, these mechanisms quickly tend toward entropy with occasional, though mostly brief, resurrections following well-publicized scandals. 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.

Degree of Consumer Choice. An essential part of the rational for HMO-led privatization of Medicare is that in response to the MMA subsidies, HMOs would enter the market on an unprecedented scale and give many more beneficiaries the opportunity to choose between FFS providers and managed care plans. This enhanced ability to choose would be made even more attractive by the additional benefits the plans would be able to offer with the new subsidies. If, in fact, these expectations are met, however, the longer-range impact of significant increases in the number of 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. As healthier beneficiaries are drawn into managed care and the percentage of less healthy beneficiaries in the traditional program increases, the cost of the program to government and beneficiaries is likely to increase substantially and leave a growing number of beneficiaries with no choice but to join an HMO. This would mean, in many cases, that beneficiaries would lose control over providers. For many sicker beneficiaries, their relationship with their doctor and other providers is the most important factor in the decisions they have to make about health care. Choice for these beneficiaries is most meaningful when it comes to selecting specific providers, not in being able to choose between FFS and managed care. This choice of specific providers would be qualitatively curtailed for many sicker and poorer beneficiaries if privatization of Medicare were to unfold as described above—as an affordability crisis in the traditional Medicare program resulting in what some analysts have referred to as a "death spiral" in the traditional program. This threat to the degree of consumer choice now available to most beneficiaries violates the fair equality of opportunity principle in that it would severely disadvantage poorer beneficiaries and those in the greatest need of adequate health care.

PROTECTING PROFESSIONAL INTEGRITY

Beyond the policy level issues related to the fair equality of opportunity benchmarks for health care, managed care creates unique ethical challenges to frontline care providers, especially physicians. The potential of managed care to provide more integrated care to patients who are chronically ill and elderly is seriously threatened by ethical dilemmas inherent in for-profit managed care and in nonprofit managed care organizations that are pushed by competition to limit access to specialty services and to lower their guard when it comes to ensuring an adequate quality of care. The two main ethical dilemmas are described below.

Disrupting the physician's fiduciary relationship with his or her patient. This relationship is the principal vehicle of care for chronically ill and elderly patients. The physician must know the patient very well, and over an extended period of
time, the patient must be able to trust the physician and believe that the patient’s best interests are foremost in the physician’s mind. If financial incentives, intrusive monitoring and 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.

Morreim (1998) has noted that, in the absence of a fundamental commitment to maintaining a close, trusting, long-term relationship between the physician and patient, managed care organizations are likely to adopt a “widget” approach to health care, namely, one

featuring generic, interchangeable providers seeing generic, interchangeable patients for guideline-bound diagnoses and treatments, which may work acceptably in manufacturing and other kinds of business, but it can be disastrously simplistic in medicine. (p. 331)

**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.

According to Nancy Dubler,

managed care has not only exacerbated existing conflicts between patients and providers but has “changed the shape and scope of the healthcare enterprise and introduced an entirely new set of disputes.” Indeed, managed care is by “definition and design” a dispute model, having erected barriers to provider-patient communication, linked physician resource utilization with practitioner evaluation, and created approval prerequisites for diagnostic and therapeutic interventions. So serious are the conflicts and power imbalances that managed care has an “ethical imperative” to create accessible dispute mediation systems. (cited in Fina, 1998, p. 360)

Efforts to implement remedies for this potential threat to the interest of the patient, such as Dubler’s mediation strategies, would be greatly aided by a more comprehensive ethical framework than anyone has offered so far. Managed care has the capacity to improve the quality and availability of care for frail elderly patients through the integration of services, reduced out-of-pocket costs, and increased training in geriatrics. I doubt, however, that these benefits will be achieved without a full-scale debate over the ethics of managed care, which are at least as important as the economics of managed care. In fact, ethics should proceed and determine the economics of managed health care, especially for elderly people in Medicare, who are far more likely to need health care services than are younger people.

Medical ethicists, health policy analysts, and health services researchers have long been aware of the ethical conflicts endemic to proprietary managed care. For
the most part, however, these ethical issues have been overshadowed by corporate and public policy concerns about health care costs and the need to contain them. The media drumbeat about escalating Medicare costs and the approaching bankruptcy of the Medicare Trust Fund with the aging of the baby boomers has obscured the clinical consequences of subordinating the needs of patients to the requirements of cost containment and profit maximization in managed care. It also has become increasingly difficult to raise ethical questions about the effects of pursuing profits on medical decision-making in a culture dominated by a market ideology and the drive to privatize (marketize) public programs. In fact, the market seems to have been granted a prescription of moral neutrality and essentially removed from moral discourse.

I am far from convinced that 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 physician and 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.

If the integrity of the doctor/patient relationship is a primary ethical principle in health care, then the proponents of mediation models must demonstrate how they will work to preserve and enhance this principle. If this ethical principle is not primary, then we are on a slippery slope toward instrumentalizing health care decision making in favor of interests other than those of the patient, including corporate profits. We are already somewhere along this slope and there is no clear evidence that this step has led to any permanent containment of health care costs. It clearly has done little to improve the quality of care.

A substantial effort is being made to develop a comprehensive array of scientifically sound clinical outcome measures that can be used to hold providers accountable in terms of patient-oriented criteria. It will take many years, however, to complete the development of outcome measures for most medical conditions, especially chronic conditions like cancer, diabetes, ant bites, and strokes. We simply do not know enough about how best to treat many of these conditions to establish scientifically sound outcome measures. Even if such measures were available, providers and policy makers still would confront ethical issues that cannot be avoided by further efforts to instrumentalize the medical decision-making process.

Providers and payers would have to decide what threshold levels a procedure must achieve, in terms of measured outcome effectiveness, before its cost-effectiveness was assured and it could be used in a particular case. More information about the relative effectiveness and cost of interventions is as likely as not to make the decision-making process more complicated than the current state of relative ignorance about the effectiveness of many medical procedures. In short, more knowl-
The Ethics of Medicare Privatization

...edge will not allow providers, payers, and society to escape the ethical burdens inherent in health care delivery and financing decisions. Neither science nor procedural processes (like ethics committees) will lift this burden from our collective shoulders. Fundamental, substantive ethical issues are at stake and we cannot avoid them indefinitely by resorting to scientific assessments, mediation procedures, and other techniques of instrumentalizing them away. These unavoidable ethical issues are more acute in an increasingly corporate health care system characterized by a conflict between the interests of shareholders and corporate executives, providers and their patients, and the leakage of resources away from care into profits and administrative overhead.

CONCLUSION

The debate over the efforts to privatize Medicare by increasing the participation of private health plans, mainly HMOs, in the program has focused primarily on issues related to cost-containment. Privatization proponents have argued, until recently at least, that managed care could better contain costs than the traditional Medicare fee-for-service system does. Most of the research on the relative cost-effectiveness of Medicare managed care versus the fee-for-service system does not support this argument. The research literature also shows that Medicare managed care is not as effective as fee-for-service care in terms of most of the outcome measures used in the research conducted over the last several years. These findings tend to support the view that managed care is fine for relatively healthier persons, but highly problematic for less healthy persons, especially the 30% of the Medicare population with chronic conditions and comorbidities.

The empirical shortcomings of Medicare managed care are related to any assessment of the ethics of privatization initiatives based on the use of incentives designed to expand the role of managed care in the Medicare program. In this chapter, I have used assessment criteria based on the Rawlsian-influenced principle of fair equality of opportunity to flourish or achieve one’s capabilities as a human being. The application of this principle to health care policy generally, and Medicare in particular, is based on the perception that health care is one of a limited number of “common goods” that individuals must have at least roughly equal access to as a condition for achieving their capabilities.

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. This assessment is 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. The ethics of Medicare privatization should receive at least as much attention as the public debates over abortion, gay rights, gun control, and school prayer.
Adding Medicare privatization to the list of national 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 that emphasizes fairness, social justice, and servicing as a counterweight to the currently dominant ethics of neoconservatism and the values of individualism, private property, and the unfettered market.

REFERENCES