

What Are Bioethicists *Doing* about Health Care Reform?

by Ezekiel J. Emanuel

Health care reform is once again in the air. Everyone is excited—probably too excited—about the possibility that reform could be enacted next year. As the debate evolves and intensifies, it behooves those of us interested in bioethics to ask ourselves “What are we doing to promote reform?”

Talking about reform and avowing our sincere support for universal coverage are easy. The bigger challenge is to gauge whether the bioethical decisions we make, the advice we offer, and the positions we espouse are furthering or hindering sustainable reform.

It might be good to begin by considering two important lessons that the reform effort in Massachusetts has made clear.



Lesson 1: A Massachusetts-style reform cannot possibly achieve universal coverage. Only comprehensive reform of the financing system can achieve true universal coverage.

Jonathan Gruber, one of the chief architects of the Massachusetts reform, describes it as a “fill in the cracks” plan or, as he put it in another characterization, “incremental universalism.” The Massachusetts plan attempts to come as close to universal coverage with as few changes to the existing health care system as possible. It largely leaves the existing financing and delivery systems in place. The major changes are a mandate to purchase insurance, state subsidization to do so, and the insurance ex-

change—called a Connector in Massachusetts—to standardize insurance offerings and reduce administrative costs (underwriting, sales, and marketing).

Unfortunately, even with a mandate and the most optimal confluence of factors, this incremental mandate reform could never achieve true universal health coverage. At best, it was going to get 97 percent of the population insured. This could be described as “universal coverage” only by economists who also believe 4 percent unemployment is “full employment.” While there are good economic reasons to have a small level of unemployment—it prevents labor shortages that slow economic production and spur inflation and is necessary for people who are transitioning between jobs—there are no comparable arguments for less than 100 percent health care coverage. Having 3 percent of the population uninsured is certainly better than having 15 percent uninsured, but it is still not *universal*. Less than 100 percent coverage is a policy failure because it is neither a political necessity nor an economic imperative.

Why will the Massachusetts plan never achieve universal coverage? Massachusetts mandates the purchase of an insurance package and subsidizes it for families earning up to 300 percent of the federal poverty level—roughly \$61,000 for a family of four. With such a policy, two groups will still lack insurance. The first are the young and healthy who will evade the mandate, calculating that the penalty for not having insurance and needing care is less costly than buying what they think is “unnec-

essary” coverage. More important are the families earning \$60,000 to \$80,000 (300 percent to 400 percent of poverty) whose employers do not provide health insurance. Clearly, these families are not poor—they earn above the median income. But, realistically, a family health insurance policy that costs \$12,000—for them, roughly 15 to 20 percent of pretax income—is unaffordable. Accordingly, in Massachusetts, they are exempted from the mandate. This last category constitutes about 3 percent of the population. This means that even in the best case scenario, only 97 percent of the Massachusetts population will be insured. Obviously, it is theoretically possible for the state to subsidize this group, but subsidizing families up to 400 percent of poverty—roughly 62 percent of the population—would raise the cost for the program enough to make it fiscally impossible.

Those who are dedicated to true universal coverage should not be satisfied with the Massachusetts approach—mandate or no.

True universal coverage—covering 100 percent of the population—requires significantly changing the health care financing system. In particular, it requires disconnecting coverage from employment and any income-indexed eligibility requirements. Without such a separation, some people will refuse to pay, and others will be excluded because they cannot pay. Even in the Netherlands, where the population is more compliant and easier to oversee, a similar mandate with subsidies for two-thirds of the population still leaves 1.5 percent of the population uninsured. In this regard, single-payer plans have it right—true universal coverage requires a single-payer financing system. In the current U.S. health care system, this would mean eliminating employer-based coverage as well as government programs, such as Medicaid and the State Children’s Health Insurance Program, that have income eligibility limits.



Lesson 2: A Massachusetts-style plan is unsustainable. Sustainable reform

must credibly address health care cost control by changing the delivery system.

One of the most important but least emphasized parts of John Rawls's political theory is his emphasis on sustainability—or what he calls “stability.” A key question to ask of any reform is whether it creates a policy dynamic that reinforces its main objectives or, on the contrary, engenders circumstances that are likely to undermine it. The Massachusetts plan is self-defeating and unsustainable.

The goal of the Massachusetts reform was expanding coverage with as few changes to the existing health care system as possible. The reform does nothing about health care costs. Focusing on coverage but ignoring costs ultimately undermines coverage.

There is a health care *cost-coverage trade-off*. As many studies have shown, as the costs of health care rise, coverage shrinks. One recent study by Michael Chernew, David Cutler, and Patricia Keenan suggested that nearly two-thirds of the decline in coverage since 1990 is attributable to increases in health care costs.¹

If health care costs in Massachusetts continue to rise in excess of inflation and increases in household income, the number of uninsured will inevitably also rise. Some employers will eliminate their insurance and pay the paltry penalty of \$295 per employee, forcing the state to subsidize more and more people. This will impose higher costs on the state, forcing a choice—either raise taxes to pay for the expanded health insurance subsidies or declare health insurance “unaffordable,” exempting more people from the mandate.

Is this just a theoretical worry? No. The plan has barely been enacted and health insurance costs in Massachusetts have already risen 10 to 12 percent for 2008. This rise prompted Jon Kingsdale, the executive director of the Commonwealth Health Insurance Connector Authority (the agency that oversees the subsidized insurance market) to say, “We’re going to be very aggressive in trying to get those [increased rates] down to single digits. If we continue with dou-

ble-digit inflation, I don’t think health reform is sustainable.”²



Unless a health care reform deals with increases in health care costs, this dynamic is inescapable. Yet dealing with health care costs over the long term is very, very hard. Proposals to reduce administrative costs, avoid using emergency room care for routine health problems, hold down drug prices, or emphasize preventive care and wellness are “lipstick” cost control. They are painted on for the public to admire, but are not integrated into the structure of the reform and therefore stand no chance of truly reducing health care cost inflation over time.

These proposals fail for three reasons. First, they are only one-time savings, not lasting cost control. Under ideal circumstances, reducing administrative costs would save about \$60 billion. But only once. It does nothing about future cost increases that are largely driven by development and diffusion of medical technology. Second, it is impossible to achieve administrative savings by waving a wand. To achieve administrative savings requires serious reform of employer-based health insurance; only that can eliminate the wasteful underwriting and sales costs. This is not a small or easy change. Finally, as a practical matter, many of these ideas are unproven and unlikely to save a penny. There is no evidence that more preventive care or wellness interventions actually reduce the total health bill. They may delay costs, but that is not the same as *lowering* the inflation rate. Indeed, many preventive and wellness interventions still cost money even if they are cost-effective, and many are on the high end of cost-effectiveness.

Truly controlling costs requires nothing less than changing the dysfunctional health care delivery system. A key is to pay for quality, not quantity, and for outcomes, not activities. This means nothing short of eliminating the fee-for-service reimbursement system, which is purely quantity-driven. It also requires routine monitoring and reporting pa-

tient outcomes. Again, these are hardly easy reforms. A second essential reform is to charge people who want services above the baseline for the incremental costs of those services. If you want brand-name rather than generic drugs, you pay for it, and not just a slightly higher copay, but the full incremental cost. If you want IMRT rather than three-dimensional conformational radiation for early stage prostate cancer treatment, you pay the extra \$25,000. If you want Erbitux for metastatic colorectal cancer, you pay for it. This requires routine technology and outcomes assessment of interventions and patient outcomes, and linking this to coverage decisions. These reforms will require a decade or more to put in place, but they are absolutely necessary if universal coverage is to be sustainable.

For those in bioethics, these lessons mean that if we really care about universal coverage, we have to focus on cost control. And focusing on cost control means committing ourselves to revamping the health care delivery system. Are we as bioethicists helping in this regard? Do we help make it legitimate to consider or to ignore costs when evaluating what interventions people should get? Does our view of confidentiality encourage or inhibit better integration of care and systematic monitoring of outcomes? Do we advocate for single-tier insurance or pharmacy benefit plans, or believe it is ethical for some people to buy additional services? Do we object to the use of clinical care guidelines and disease management on grounds that they intrude into the personalized care of physician-patient relationship? Do we consider how our decisions might impact health care costs?

1. M. Chernew, D. Cutler, and P. Keenan, “Increasing Health Insurance Costs and the Decline in Insurance Coverage,” ERIU Working Paper 8 (Ann Arbor, Mich.: Economic Research Initiative on the Uninsured, 2005).

2. Quoted in K. Sack, “Massachusetts Faces a Test on Health Care,” *New York Times*, November 20, 2007.