

THE KAISER PROJECT ON INCREMENTAL HEALTH REFORM

Incrementalism: Ethical Implications of Policy Choices



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Executive Summary

That 43 million Americans do not have health insurance is perhaps the most frequently cited evidence of the basic unfairness of the American health care system. We currently lack the political will to extend insurance coverage to all 43 million and instead have adopted a course of incremental reform in which insurance options are extended piecemeal to selected populations. Although any consequent reduction in the number of uninsured is, on the face of it, morally desirable, there are real moral differences between the policy options being explored.

Our analysis of the ethics of incremental health care reform leads us to the following conclusions. First, unless those of us who currently benefit from public policies that subsidize the costs of our health insurance are willing to forego these benefits, we are obligated as a matter of basic fairness to extend similar benefits to the currently uninsured. There is simply no acceptable moral justification for the current state of affairs, in which most Americans receive assistance from the federal government with the costs of their health insurance but some do not.

Second, any public policy intended to remedy the basic unfairness of the current system must ensure that all citizens receive equal treatment with respect to access to health insurance as a consequence. Mere extension of existing federal tax policies to include the currently uninsured is not enough. Proposals for tax relief (credits and refunds) that still leave the uninsured with insufficient resources to purchase adequate levels of health insurance may remove the appearance of unfairness from current policy but they still leave unaddressed fundamental concerns about unequal treatment by the government in enabling financial access to health insurance. Such proposals wrap public policy in the language of justice only to mock its meaning.

Third, it is extremely difficult to determine to whom among the uninsured coverage should first be extended. The arguments favoring different criteria for priority-setting within the uninsured are all compelling and demand satisfaction. This is because, as a moral matter, the only truly satisfying outcome is a public policy that ensures all Americans access to an adequate level of health insurance. Currently, however, an incremental approach to the expansion of coverage remains the most viable political strategy. Insofar as choices must be made, no single metric of justice will resolve the question. We believe that the case for expansion of coverage to the most vulnerable members of society is the most morally compelling, although the specific rationale for different groups among the vulnerable differs. The claim of children for societal assistance in securing important goods is generally greater than that of adults in view of the dependency and vulnerability of childhood. Similarly, the claim of those doubly disadvantaged by chronic illness and insufficient financial resources is strengthened by the fact that their special vulnerability is in large part a result of a societal institutional arrangement that makes poor health a limiting factor on the ability to obtain adequate health insurance and inadequacy of insurance coverage a substantial contributor to further financial disadvantage.

Fourth, the question of whether current inequities in federal policy should be addressed “in kind” or “in cash” turn heavily on arguments about the social utility of insurance and the importance of personal choice, as well as on considerations of justice. Those who favor addressing the problem of the uninsured by expansions of Medicare or Medicaid programs, or by policies that condition tax benefits on proof of insurance coverage, place a high value on the social utility of health insurance. By contrast, those who, for example, favor eliminating disparate tax treatment of insurance options through such vehicles as tax refunds and individual medical savings account take the opportunity for individuals to decide how best to meet their health care financing needs as more morally important than social benefits of universal insurance coverage, per se.

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That 43 million Americans do not have health insurance is perhaps the most frequently cited evidence of the basic unfairness of the American health care system. We currently lack the political will to extend insurance coverage to all 43 million and instead have adopted a course of incremental reform in which insurance options are extended piecemeal to selected populations. Although any consequent reduction in the number of uninsured is, on the face of it, morally desirable, there are real moral differences between the policy options being explored. The purpose of this paper is to examine these moral differences by identifying the values and commitments that ground the different policy options.

This paper is divided into three parts. In Part One we discuss the general moral justifications for the public policy goal of extending health insurance coverage to all Americans. We consider, and find at least partially wanting, the argument that health insurance should be provided so as to equalize insofar as possible opportunities for good health, and social opportunities generally. We then examine other important moral reasons for extending health insurance coverage, and we consider how a variety of moral justifications taken together support such extensions as instrumental in achieving the aim of universal health coverage. In Parts Two and Three we turn to the moral issues raised by proposals to incrementally decrease the number of Americans without health insurance. Part Two focuses on priorities for extension of coverage. We examine different moral arguments for what groups should come first, and why. Part Three focuses on the mechanisms through which coverage should be extended, and explores in greater detail the underlying value commitments and assumptions guiding some of the major policy alternatives currently being considered.

PART ONE: WHY WE SHOULD EXTEND HEALTH INSURANCE COVERAGE

Before proceeding to an analysis of the ethics of alternative proposals to expand health insurance coverage, we need to step back and examine why expanding coverage is morally important. We consider here four arguments that, when taken together, constitute a strong moral defense for government policies to expand access to health insurance.

The Good of Health and its Contribution to Equality of Opportunity: Perhaps the most cited justifications for the moral importance of access to medical care is that medical care is necessary to promote health and that good health is important if not essential to equality of opportunity. Contrary to expectation, however, available data suggest that access to health insurance would not have a profound effect on the overall, aggregate health status of the uninsured. There are at least two reasons why this is likely to be the case. First, the uninsured do receive medical care. They generally receive less care than people with insurance, and that care is often provided later than is medically desirable and is of lesser quality, but it is not as if the uninsured are denied all medically necessary interventions.

Second, access to medical care contributes less than one might think towards

aggregate indicators of health such as average life expectancy. Even when access to adequate medical care is guaranteed, substantial differentials in life expectancy by socio-economic status and race or ethnicity persist (HHS 1998). Indeed, it is unlikely that providing health insurance to all is either the best way or the most efficient way to improve the health status or social opportunities of this nation's poor. As many have argued, lack of access to adequate nutrition, shelter, and education, as well as greater than average exposure to environmental and occupational risks, also contribute substantially to poor health.

That said, there are many individuals and groups, such as those in poor health and with chronic illnesses (we will return to the chronically ill shortly), for whom timely and regular access to medical interventions, of the sort generally available only to those with health insurance, is terribly important. Without health insurance, these individuals are likely to experience preventable hospitalizations, more disability and even shortened life spans. Thus, for many individuals, expanding access to health insurance *can* be justified by appeals to promote their health and the equality of opportunity with which good (or at least improved) health is associated.

Preventing Suffering: There are other arguments in justice that apply as well to the "healthy" as to the ill among the uninsured. Those who do not experience serious setbacks to their health because they are uninsured still suffer. Some of this suffering is immediate and direct. The child with an untreated ear infection, for example, may be in pain for several days without necessarily incurring permanent hearing loss. Self-limited pain and physical discomfort are not, however, the only ways in which people suffer because they are uninsured. An additional source of suffering experienced by those who lack timely and predictable access to regular health care services is the worry and anxiety associated with delay in treatment and lack of information about the nature of their illness and its prognosis. Timely access to care provides relief from unnecessary concerns when the condition is determined to be not serious or readily treatable, and in cases of more serious medical conditions, allows patients to adjust and cope with their situation (President's Commission 1983, p. 17).

Non-health-related justifications: There are yet additional arguments for extending health insurance coverage to all citizens that appeal to values ancillary to the inherent good of health itself. When the uninsured do seek care, they may suffer indignities at least as troubling as any threat to their health. Presenting for medical care without an insurance card, like appearing at a border without a passport, marks a person as outside the community and puts her in a potentially demeaning, supplicant posture. Health insurance is thus of significant value to each of us as individuals, even in the absence of any direct impact on our physical well being. An individual's sense of dignity and self-worth is undermined when starkly confronted with the awareness of weakened or attenuated social bonds of empathy and compassion for her plight.

Health insurance, and the access to medical care that insurance ensures, also provides to those who have it a sense of personal security and control. Persons lacking access to goods that so powerfully influence individual life prospects experience an increased degree of vulnerability to harm and a sense of dependence and powerlessness that erodes both

individual autonomy and self respect, especially when they are unable to meet their obligations to care for and provide for their families. Indeed, the burden of such moral obligations to family and loved ones falls more heavily on those without material resources, including health insurance (O'Neill, 1993, pp. 303-304; Nickel, 1986, pp. 71-77). Those lacking health insurance have to live with the fear that if they or a loved one becomes ill or injured, they would not know how to secure or pay for the care that would be required. Without adequate insurance coverage, individuals are not free to make decisions about whether to seek medical care based on concerns about their own or their children's health. They are forced to make such difficult choices burdened by the stress of having to balance their or their children's medical well being against other basic needs, and they bear the added moral burden of knowing that they are unable to discharge the familial obligations which most members of society take to be among the most basic of all moral requirements. In addition to the stress, powerlessness and social disrespect that have been shown to be associated with poorer health status, their awareness of their disadvantaged social status has the potential to undermine self-respect and their sense of themselves as the moral equals of the more fortunate members of society.

The potential developmental impact on children living under such circumstances also cannot be discounted. As Wilhemine Miller has argued, "If needy parents are not equipped with the resources to care adequately for their children, the development of persons with a diminished capacity for self-respect and moral autonomy is virtually guaranteed" (Miller, 1997, p. 31). Such children grows up with an awareness that they and their families lack access to basic social opportunities available to the majority of citizens. This awareness undermines these children's sense of self-worth and capacity for seeing themselves as persons able to exercise a substantial measure of control over their own lives through their own choices.

Moreover, the lack of a comprehensive system of health insurance imposes unfair and largely hidden economic burdens, as well as disproportionate moral burdens, on those who are in the position of responding to the medical needs of the uninsured. Health care professionals and the health care institutions in which they work are forced to adopt whatever strategies they can conceive to meet the demands of uncompensated care. For society to rely on the charity of increasingly financially strapped health professionals to meet these needs is to abandon any commitment to a fairly shared moral burden of beneficence. Insofar as health care administrators shift the costs of treating uninsured patients to private payers or government programs, additional moral concerns are introduced. At the same time, however, keener competitive market forces and enhanced efforts to achieve greater accountability and costs-savings in government programs militate against perpetuation of the traditional hidden system of cost-shifting in American hospitals, and physicians and hospital administrators report increased pressure to adopt strategies designed to curb access by the uninsured (Kilborn, 1998, p. 14).

Basic Fairness: The unfairness of the disproportionate medical and non-medical adverse effects on the uninsured is not the whole of what matters from the perspective of justice. It is fundamentally unjust for the federal government to fail to assist the uninsured to obtain coverage when most citizens who do have health insurance benefit from federal

subsidies, either in the form of favorable tax policies or through Medicare and Medicaid. The current system of subsidies is morally incoherent. While there may be powerful reasons to give some priority to the medically and financially worst-off citizens in designing government subsidies, there are no morally relevant reasons why the federal government should subsidize the financing of health insurance for those who are employed by others but not for the self-employed. Similarly, there are no morally relevant reasons why the greatest subsidy (in the form of the largest tax benefit) should go to the wealthiest employees with the most generous employment-based insurance plans (Butler, p.1).

Perhaps most foundationally, there are no morally relevant reasons why the federal government should subsidize the costs of health insurance for the nation's upper and middle income citizens, and for the nation's poorest, but not for the nation's near-poor. However, the remedy for this injustice may be not be as simple as extending comparable tax treatment to those not currently eligible for the tax subsidies. As pointed out in the Introduction, concentrating on reform of the tax code may not be the most efficient way to expand insurance coverage, or even the morally most pressing inequity for policy makers to address. The real test of fairness requires more than merely eliminating an incoherence in the way income is treated in the tax code, but a genuine commitment to ensuring that those left out of the insurance scheme as a result of low income have comparable opportunities to secure insurance coverage. Indeed, it could be argued that in expanding coverage to the currently uninsured the nation is not creating a new entitlement but rather is redressing a wrong, an existing unfairness, in the current system of subsidies and entitlements.

The above arguments, taken together, support the case for viewing the ultimate end of incremental or more wholesale reforms to be a system of universal access. These arguments thus far are silent about the morally most appropriate means (discussed in Part III) or the most pressing priorities guiding the steps undertaken to achieve the end of universal access (discussed in Part II). They do, however, point to the moral inadequacy of any strategy of incremental reform not shaped by a vision of universal access as the overriding policy goal.

PART TWO: TO WHOM SHOULD COVERAGE BE EXPANDED?

Alternative proposals to incrementally expand health insurance coverage differ on at least two dimensions-- the populations they target and the mechanisms they use to finance the expansion (Glied, 4/24/98 version, p. 1). Each of these dimensions raises moral concerns.

Consider the question of how to select priorities for target expansions. Should we go first:

- where the greatest reduction in uninsureds can be obtained for dollar invested
- where the health effects of not being insured are the greatest
- where inability to pay for insurance is greatest
- where the uninsured are not competent adults
- where barriers to insurance access are medical as well as financial
- where the most uncompensated care occurs and thus where the current distribution of the costs of medical care is the most problematic

These criteria are not in all cases mutually exclusive, but they represent different moral commitments and values.

Where the greatest reduction in uninsureds can be obtained for dollar invested: A nation's failing to ensure health insurance for all is viewed by many as a fundamental social unfairness. If the goal of incremental health care reform is to reduce that unfairness, then, all other things being equal, an incremental proposal that reduces the numbers of uninsureds by 10 million is morally preferable to a proposal that reduces the numbers of uninsureds by 2 million. This position assumes that there are no relevant moral differences between groups of uninsureds and thus that fairness does not require that we expand coverage first to some groups over others.

Although there is currently a surplus in the federal budget, competition for programmatic funding remains intense and we can assume that any new incremental program will have limited resources. If the relevant objective is to achieve the greatest possible decrease in the rolls of the uninsured, than considerations of efficiency require that we expand coverage first to those groups who are actuarially and administratively cheapest to insure, thus maximizing the numbers of newly insured we can obtain with the given resources.

An efficiency-based policy may have the effect, however, of expanding coverage first to the healthiest among the uninsured as the healthy (and those likely to remain so, such as the young) are generally inexpensive to insure. This government equivalent of "cherry picking" may leave to fend for themselves in the medical marketplace precisely those among the uninsured, the ill and the near-elderly, who are likely to find private insurance most out of reach. A strict commitment to the objective of achieving the greatest reduction of uninsureds per federal dollar invested also prohibits any policy that would produce "crowd out," in which individuals who already have private or workplace insurance substitute the new federal program for their existing coverage.

Where the health effects of not being insured are the greatest: While access to health insurance may be valued in its own right, health insurance increases in social and personal value insofar as it is associated with improved health outcomes. It is unjust for a society to treat its citizens unequally with respect to financial assistance with health insurance. It is also unjust for a wealthy society to fail to provide its citizens with all the important benefits that health insurance entails. However, the injustice is arguably deepest where significant effects on health and well being are at stake. It is particularly unjust that opportunities to preserve or improve health should be conditioned even in part on having health insurance. Insofar as health is among the most important ends served by proposals to expand health insurance coverage, these proposals should be directed first towards those persons or groups whose health is most negatively affected by the lack of insurance. These are the "medically worst off" amongst the uninsured.

Although data specifically on this point are not available, it seems plausible that people with chronic medical conditions are most likely to have their health negatively

affected by not having insurance. Securing optimal health outcomes for people with chronic illnesses requires regular, high quality medical management of the sort generally not available to the uninsured. How exactly to craft a policy that effectively targets those in poor health and with chronic illnesses is, however, difficult, and current policies guided, in part, by considerations of greatest perceived medical need reveal some familiar drawbacks. For example, criteria for establishing disability eligibility under Medicaid are problematic at best. Often a showing of “total disability” is required, and such a requirement can be overly burdensome for persons with chronic medical conditions, such as Lupus and Chron’s Disease that produce intermittent disabilities. Persons with such conditions may be in particularly great need of insurance for many years prior to a definitive medical conclusion that the patient is permanently unable to function in the workforce.

Another strategy is to design disease-specific insurance expansions, for example, for all children with asthma or all children with diabetes, modeled after the Ryan White CARE Act of 1996. This disease-specific approach could also be directed towards adults as, for example, was the case with the End Stage Renal Dialysis program. A major problem with the disease-specific approach, however, is that chronic illnesses are often asymptomatic in their early stages yet in some cases intervention during these early stages is necessary to maximize health outcomes. In one study of breast cancer, for example, uninsured women were more likely to be diagnosed with more advanced disease than woman who had health insurance; four to seven years after their initial diagnosis, they were 49% more likely to have died (Ayanian). A policy that extended eligibility for health insurance based on existing disease could not address such an inequality.

In short, neither a “degree of disability” approach nor a disease-specific approach to identifying the medically worst-off is wholly adequate. It is especially difficult to construct targeted public policies that are both sufficiently inclusive of all the relevant chronically ill and still administratively efficient to implement for groups who are generally healthy, such as children and young adults. Because both approaches are narrowly tailored to meet the needs of those clearly identifiable as among the medically worst off at a particular point in time, they risk missing those, who, without continuous access to medical care in periods of lesser, or less obvious, medical need, nonetheless qualify as among the medically worst off over the course of their lifetimes. To the extent that health insurance coverage is not extended to include those who, at any point in time appear relatively healthy, but who may ultimately have the greatest long-term unmet medical needs, such narrowly tailored policies may undermine the goal of giving priority to those people who in retrospect may be among the truly medically worst off.

Where inability to pay for insurance is greatest: Many people without insurance cannot reasonably afford it. About one third of the uninsured have incomes below the poverty line and another one third have incomes between 100-200% of the federal poverty level (Glied, this volume). It is undeniably more difficult for persons of such limited funds to pay for insurance, particularly if they do not have workplace-based insurance options, than it is for those who have greater incomes. The near-poor are the “financially worst off” amongst the uninsured. Insofar as they have a greater claim in justice for public assistance than those uninsured with higher incomes, proposals to expand insurance coverage should be directed first towards those least able to pay for insurance on their own.

Where the uninsured are not competent adults: Competing conceptions of social justice differ, however, on the extent to which a just society should concern itself with inequalities in income or in the distribution of important goods. That some, lower-income Americans do not have health insurance is not viewed by all as an injustice. In some cases, it is argued that those who “cannot afford” health insurance are simply not working hard enough; in other cases, it is argued that health insurance is indeed “affordable” but individuals are choosing to spend their limited incomes on other goods. Neither of these arguments apply to children (or other incompetent persons).

Children can in no respect be understood as responsible for not having health insurance. Even those who believe that adults without health insurance are irresponsible or make imprudent choices generally agree that is morally unacceptable to let their children suffer as a consequence. As a general class, many believe that children (and other persons of diminished cognitive capacity) have the strongest and most widely accepted claim on society for assistance. For this reason alone, it could be argued that proposals to expand insurance coverage should be directed first towards the young.

There is a related moral reason why children should be given priority in incremental expansion policies. A major expression of this nation’s commitment to equality of opportunity is the universal entitlement of all children to education. There is an intimate connection between good health and learning, and between both health and education in childhood, and social and employment opportunities later in life. Although, with the notable exception of infant mortality, data suggest that access to regular medical care may have only limited impact on the overall health status of otherwise healthy children, the impact on particular children can be huge. The early identification of chronic illness in childhood can, for example, have a profound effect on the subsequent life prospects of those affected. Although it is no doubt true that continuing education and good health in adulthood also contribute significantly to life prospects, it is arguably the case that education and health in one’s early years are of disproportionate importance with respect to equality of opportunity. Moreover, the aforementioned general claim of children for societal assistance provides a rationale for ensuring all children an adequate level of education and health care before ensuring such for adults.

Where barriers to insurance are medical as well as financial: Americans with pre-existing medical conditions - disease or illness that developed prior to application for health insurance coverage - are doubly disadvantaged in their efforts to obtain health insurance. Because they have a serious, often chronic medical condition, their need for medical care is great. Individuals with pre-existing medical conditions constitute a significant proportion of what we referred to earlier as those for whom the health effects of not being insured are the greatest. Moreover, because of the increased costs associated with an increase in the need for care, the economic as well as the health burden of uninsurance falls heaviest on those with pre-existing medical conditions who have the least economic resources. Yet the fact that their medical and economic needs for insurance are greater is the reason that, from the insurer’s perspective, they are the least desirable enrollees.

The double disadvantage experienced by those who are among both the medically and financially worst off manifests itself in two familiar ways.

First, among those who lack employment-related group health insurance, their demonstrated need for more medical care - and potentially at greater than average costs - denies them access to insurance at an affordable premium. Until recently, in many states, persons with pre-existing conditions have been unable to qualify for any of the individual health insurance plans available in their geographic market. Health insurance for those with preexisting medical conditions outside the workplace is now more readily available in many states, but at premiums that may be as much as 140% to 600% higher than ordinary non-group rates (GAO 1998, p. 11). At these high prices, health insurance is unaffordable for even middle-income Americans.

Second, although recent federal legislation (popularly known as the Kennedy-Kassebaum Act) provides persons with employer-sponsored insurance some legal protection against exclusion from health plans on the basis of their medical condition, they continue to face significant burdens. The most obvious burden is financial; federal legislation prohibits exclusion but does not regulate the premiums charged.

Those with chronic medical conditions also can be burdened in ways other than exclusion from coverage or being charged a higher premium. Kennedy-Kassebaum still leaves employers and insurers the option of tailoring group health plans, often on an annual basis with an eye to the most costly benefits, to limit the expense associated with covering the biggest users of services. Cost-limiting solutions include lifetime caps on the amounts paid for specific services or diseases, higher co-payment requirements for some treatments, and outright exclusion of coverage for some diseases or specific medical procedures. Thus, cost-limiting strategies within group health plans shift (often invisibly) the cost of illness back to individual plan members, creating among the “underinsured” a subset of individuals who are effectively *uninsured* with respect to their pre-existing medical condition.

The difficulties that older Americans face in obtaining health insurance outside the workplace may be an instance of the same “pre-existing medical condition” phenomenon. Age itself is used as a proxy for estimating the likelihood that a potential enrollee will develop a costly medical condition in the near future. Because of the higher probability of greater illness, or the fear of such illness, the near-old purchase individual (i.e., non-group) insurance at substantially higher rates than the other non-elderly adults (Chollet and Kirk 1998, p. 7). For example, Kaiser Foundation Health Plan of the Mid-Atlantic States announced in October, 1998 that its premiums for residents of the District of Columbia will increase in 1999 for individuals ages 60-64 by 97.8% to \$356 a month. By contrast, premiums for individuals ages 40-44 will *decrease* by 9.6% to \$141 a month. (Hilzenrath 1998, pp. A1, A4.)

Although many of the near old earn more than their younger counterparts in the workforce, their increased vulnerability to illness, and the consequent financial ruin it may produce, place the near old in a morally similar position to others who count among the ranks of the medically and financially less well off. For example, rates of employer-based

insurance are lowest for persons between the ages of 55-64, second only to 18-25 year olds in their lack of access to employer-sponsored insurance. In addition, about half of the uninsured population between the ages of 62 and 64 are retired. Recent efforts of several major U.S. employers to terminate unilaterally those retiree benefits call into question the historical expectation that former employers will continue to pay for insurance coverage for their retirees.

Several lawmakers, policy analysts, and members of the executive branch have responded to the moral case for aiding the near-old, particularly those with chronic illnesses who are caught in the bind of having to remain in the workforce to retain affordable health insurance while being too ill to continue working. However, recent proposals to address the inequities experienced by the near-old founder on much the same grounds as efforts to prevent employer-based health insurance coverage discrimination: the common problem is that it is the lack of economic resources that undermines the chances that such efforts will succeed. Current projections suggest that if the Medicare program was expanded to allow persons between the ages of 62-64 to buy into Medicare coverage at the estimated \$300 per month necessary for the option to remain budget-neutral, only about 10% of that population could afford it.

For those who believe that medical care should be distributed on the basis of need and not ability to pay, the plight of those with pre-existing medical conditions and limited financial means is viewed as particularly unjust. Many are amongst both the medically and the financially worst off, or in the case of many of the near-old, they are especially vulnerable to joining the ranks of the medically and the financially worst off because of both biology and the fragility of the current social safety net. Even among those who see a relevant role for ability to pay in a medical market, the plight of the uninsured, chronically ill may be viewed as sufficiently morally problematic to warrant their being among the first groups to whom health insurance coverage should be extended.

Where the most uncompensated care occurs: People without health insurance continue to receive medical care. Some of this care is paid for directly by uninsured individuals, much of it is not. These services are commonly referred to as “uncompensated care” but, in fact, their associated costs are frequently subsidized through indirect mechanisms by other payers including state and federal government and the privately insured (through higher premiums). Although the changing health care market may profoundly alter these patterns of subsidy and thus the availability of such “uncompensated care,” it is likely that the cost of providing at least some medical services to the uninsured will continue to be passed on to others. Because these patterns of subsidy are not generally known or understood, they are not available to public scrutiny and run afoul of moral requirements of openness and just procedure in public policy. Depending on who bears the cost and how, these patterns may be substantively unjust as well. Insofar as the achievement of a fair system of health care financing is the goal served by proposals to expand health insurance coverage, these proposals should be directed first towards those persons or groups, or those services, that account for the most uncompensated care.

Complex Implications for Public Policy: These six criteria do not by any means exhaust all the candidates for prioritization, anymore than they are in all cases mutually exclusive. Nor would public policy ever be crafted strictly along such lines. They do, however, illuminate underlying moral commitments and point to potential moral conflicts. Consider one of these criteria-- to go first where the greatest reduction in uninsureds can be obtained for dollar invested. This criterion is silent on an important underlying issue. Assuming a fixed appropriation, is it morally preferable to provide less complete coverage to more people or more complete coverage to fewer people? According to some accounts of justice, assuming everyone is equally entitled to a scarce resource and that resource is meaningfully divisible, it is fairer that all get something (everyone wins, but wins something less valuable) than for some to get nothing at all. On the other hand, if at some point the coverage package that “everyone wins” becomes so poor that it is of little social and individual value, in what sense, other than symbolic, is justice served?

Because costly medical interventions such as hospitalizations occur relatively infrequently and may well be provided as “uncompensated care,” it seems plausible that the uninsured would place greater values on coverage that would allow them to obtain preventive and acute care services. This suggests that, if the decision is made to “underinsure” more people rather than more adequately insure fewer people, then what is to be eliminated from the insurance package is coverage for in-patient services. This policy could run afoul, however, of the criterion concerning “uncompensated care” which calls for extending health insurance first where there is the most implicit cost-shifting. In this case, a decision would have to be made as to which values are the most important, equality of access to health insurance and respecting the preferences of those to whom the insurance is extended, or achieving a fair system for distributing health care costs.

The question of whether to insure fewer people with better coverage or more people with less adequate coverage is hardly an abstract matter. Some states such as New York and Massachusetts have in fact elected to expand coverage to more children by restricting coverage to only out-patient services. Much of the current tension between federal and state government concerning the federal government’s prerogative to determine the basic benefits covered under Medicaid also turns on just this question. The decision by the federal government in July, 1998 to require states to cover Viagra, the impotence drug, under their Medicaid programs is only one of many cases in point. It is estimated that Viagra will add from \$100 million to \$200 million nationwide to states’ Medicaid expenses (Washington Post, 1998, p. A21). At least some states perceived this new cost as coming at the expense of efforts to extend health insurance to some among the currently uninsured, particularly children.

Recent trends in American public policy have generally favored those who already have health coverage over those still uninsured. The plight of the uninsured has today been almost entirely eclipsed by the public’s intense concern with the potential excesses of managed care which, although clearly important, affect only those among us fortunate enough to have health insurance. For decades now, the American health care system has been strongly criticized for “rationing people, not services.” This is a powerful moral critique that speaks to what many see as the fundamental injustice of the American system of

which the uninsured is a chief symptom. This critique does suggest that, as in the Viagra example, expanding benefits for those already insured at the expense of those still uninsured is deeply morally problematic. It does not necessarily follow, however, that, in the current piecemeal approach to the problem, the morally preferable strategy is to stretch whatever resources are allocated for expanding coverage to include as many people as possible.

As we have already suggested, to take this position is to assume, at minimum, that the values that make access to health insurance important are equally relevant to all the uninsured, and also that these different values are themselves equally important. Security, dignity and empowerment are arguably of equal value to all the uninsured, although these issues may be of most acute concern to the poorest amongst the uninsured and those who are minorities as these groups are already relatively disadvantaged with respect to these values. What is most clear, however, is, as we have already noted, that people with poor health and chronic illnesses differ from the rest of the uninsured in the extent to which access to health insurance serves the values of optimizing health and social opportunity. The extent to which this difference matters morally depends at least in part on the importance placed on health and social opportunity relative to health insurance and also the extent to which inequalities with respect to these values are morally tolerable.

PART THREE: HOW SHOULD THE EXPANSION BE IMPLEMENTED?

There is no single, obvious moral consideration that can decisively determine, to the satisfaction of all, to whom incremental expansions of access to health insurance should be directed. Public policies necessarily entail a trade off of values, in which some interests and groups are relative winners and others relative losers. This trade off of values is engaged not only in the problem of to whom insurance should next be extended, but also the problem of through what mechanism. Moreover, mechanisms of incremental reform differ, not only in their moral implications for “who gets what” but also in the values they take to be most important and their underlying conceptions of what justice demands.

A moral analysis of mechanisms of incremental health care reform is complicated, however, by the interconnectedness of considerations of justice across different arenas of social policy. Of central importance is the fact that changes intended to reduce injustices in access to health insurance are also likely to have implications for considerations of justice in tax and employment policies. The massive tax subsidy for employment-based insurance which forms the bedrock of our current health insurance system has made access to health insurance a reality for the majority of Americans. At the same time, however, this tax subsidy is itself unjust in at least two important respects.

First, citizens who do not have access to insurance coverage through the workplace are comparatively disadvantaged because the fully tax deductible treatment of insurance premiums is available only to those fortunate enough to have employer-based coverage. While partial remedies of this injustice with respect to the self-employed are being implemented, many others either work for employers who offer no insurance benefits or lack the individual means to purchase private health insurance for themselves and their families. This disparity in insurance status is all the more striking from the perspective of distributive

justice because the government subsidy benefiting largely middle and upper class persons having employment-related insurance is an estimated 79 billion dollars of federal tax revenue annually, almost as much as the total annual expenditures for the Medicaid program.

Second, employees in the highest tax brackets and having the most generous insurance plans get the largest share of the tax subsidy, while the lowest paid workers enrolled in plans with the highest share of out-of-pocket costs receive the smallest public subsidy.

If, as some proponents of tax reform assert, the “principal cause of the gaps in coverage today is the inadequacy of the tax-favored employment-based insurance system” (Butler, this volume), then such proposals can be seen not only as a means to compensate for injustices in the current tax code but also as a means to reduce health care inequities by reducing the numbers of uninsured.¹

Other health policy analysts, however, rely on different assumptions and reach different conclusions about the requirements of justice. They argue that a more significant contributor to uninsurance is the lack of economic resources with which to purchase insurance. A third of those having incomes between 100% and 200% of poverty level are uninsured, and a majority of uninsured Americans are young, generally lower income adults and their families. Many of these still would not have adequate resources available for health insurance even if disparities in tax treatment are eliminated. Thus, an expansion of the tax subsidy in order to remedy the inequities in the current tax system may not appreciably reduce the injustice in access to health insurance. In addition, expanding the deductibility of health insurance premiums will not address the second source of inequity proponents of fundamental tax reform identify: the new deductions, like the existing ones, will yield the greatest benefit for the higher income earners who pay taxes in higher marginal brackets.

Although there may be powerful reasons of fairness for eliminating patently inequitable tax treatment for insurance between those with employer-based insurance and the self-employed who are forced to secure their own insurance in the private market, there may be competing considerations of justice which argue for dedicating any additional public resources to more efficient means of expanding the ranks of the insured. Thus, tax reform may eliminate an obvious unfairness in the tax treatment of health insurance but not do as much to improve access as alternative incremental insurance reforms. Similarly, incremental reforms that build on the existing employer-based system may have to accept the perpetuation of certain inequities in the tax code in order to preserve the foundation that provides a relatively secure base for insuring the majority of Americans.

¹ Some commentators like Butler now favor going beyond equalizing tax treatment to offering additional subsidies to low income citizens in order to enable the effective purchase of health insurance.

The choice between more fundamental tax-based reform and various incremental reforms of the insurance market thus presents rival interpretations of which type of unfairness represents the greater injustice. Despite the starkness of these choices, however, alternative reform proposals rooted in these rival interpretations still share some common assumptions. Although proposed mechanisms for extending access to insurance or enlarging the insurance options available to those priced (or otherwise left) out of the insurance market differ significantly, most suppose that implementation of their proposals will not fundamentally alter the pluralistic system of health care financing in the United States. Implementation will leave in place a combination of public and private effort. Some division of responsibility between employers, individuals, and government within a system of many sources of payment and means-tested approaches to subsidization is widely accepted as the near-term aim of future reform. As obvious as this common assumption may seem, it is nonetheless an important point. Whether for strategic or ideological reasons, most proposals currently focus on the value of getting more people access to insurance. Few proposals focus on integrating all health care finance options into a uniformly accountable system, such that all citizens enjoy an equal entitlement to some comparable level of health care access.

Proposals that rely on the expansion of Medicaid coverage or some outgrowth of Medicaid, however, reflect a greater commitment to bringing at least more low income citizens into a common, government-regulated system of insurance, although they fall far short of a wholesale move toward a single payer or universal coverage plan such as Canada's. To the extent that more persons are brought within one or more existing structures for meeting health care costs, there is a gradual movement toward standardization and a consequent pressure operating toward greater equality in the level of health care services more Americans receive, as well as a decrease in the number of uninsured.

Moreover, endorsement of incremental reforms of the current pluralist system of health care financing may mask some other important underlying value differences. In some cases perhaps, the endorsement of incremental reform may reflect a deeply held judgment about the value of a system in which the appropriate role of the public programs should be that of health care or insurance coverage provider of last resort. The preference for incremental reform, especially if the mechanisms for expansion rely primarily on the market, may reveal a distrust of or distaste for government as inefficient, unfair, or otherwise an inappropriate vehicle for meeting the health care needs of the public. For others, acceptance of the need for incremental reform may be merely a recognition of the wisdom of Voltaire's famous dictum cautioning against allowing one's vision of the best to become the enemy of one's efforts to achieve the good.

Another source of disagreement in underlying value commitments lies in the difference in importance various proposals place on the relative value of preserving a system of insurance in which risks of ill health and its associated financial burdens are shared more broadly, rather than borne largely by individuals making their own market decisions about the appropriateness of trade-offs. Those who stress primarily the importance of incremental expansion of the pool of insureds would seem to view health insurance itself as a good that should be available to more persons, perhaps on the assumption that insurance rather than greater ability to dedicate discretionary resources to meeting health care needs serves

important individual and social ends. Insurance as the primary vehicle for meeting health care needs provides a kind of safety net for individuals and their dependents and offers more persons the security of having access to health care that does not depend on the good luck and prudent judgment of individuals.

By contrast, proponents of eliminating the disparate tax treatment of insurance options available to all segments of society make either no or far more modest assumptions about the independent value of insurance as a mechanism for meeting health care needs. In its strongest form, the implication of treating individual medical savings accounts and actual unreimbursed medical expenditures as equivalent in tax consequences reflects a stronger preference for individuals to make provisions for their own health needs according to their own assessment of how much, if any, insurance to purchase. Thus, some tax reform proposals appear to take the opportunity for individuals to decide how best to meet their health care financing needs as morally more important than expanding the guarantee of insurance per se. Although proponents of the tax-based approach believe that the primary cause of gaps in insurance is the current tax structure, their position is indifferent to the ultimate choices of consumers, even a rejection altogether of traditional forms of shared risk through the purchase of insurance. Indeed, proponents of tax reform envision a variety of potential new financing mechanisms, including pooled purchasing of insurance through affinity groups such as unions and churches. The underlying assumption is that the ultimate source of insurance purchasing decisions ought to lie with individual choice. Such decisions include the choice of whether to purchase only catastrophic insurance or some more comprehensive benefits package, and perhaps (on some proposals), whether to purchase insurance at all, since the option would now be available to receive comparable favorable tax treatment for individual medical savings accounts or even actual medical expenditures not reimbursed by insurance.

A further consequence of giving individual choice great weight in the design of an insurance reform package is that the cumulative consequence of more individually chosen insurance decisions is likely to be an increase in the variation between the levels of care citizens receive. The potential for greater inequality among the levels of benefits available, with its attendant individual and social costs, must be weighed carefully against what many see as a morally worthy aim of freeing individuals from limitations of choice they now face in selecting insurance plans they cannot feasibly hold accountable through market exit.

Those who place greater weight on the importance of expanding the pool of insureds than expanding the scope of individual choice also worry more about adverse consequences of an individual's decision to underinsure. The underlying assumption often is that there is great value, both for the individual who may need expensive medical care and the community as a whole, in everyone having the security of health insurance and not having to make painful trade-offs between health care and other goods at times of crisis or the unexpected onset of ill health. The value to the individual is the hedge against uncertainty provided by the prior decision to become insured against catastrophic loss. The value to the community is that a fully (or near-fully) insured population will not result in "free riders" or persons who shift to others the often substantial costs of their choices either not to insure or to underinsure. Those who fail to provide adequately for themselves and their dependents

through insurance, or are unable to provide sufficient resources to meet the costs of current illness, may later seek services that ordinarily compassionate persons and institutions are hard-pressed to deny. The degree of variation in coverage permitted by the tax reform plans may increase opportunities for free riders and the resulting pattern of often hidden cost-shifting that occurs when institutions and individual providers struggle to meet the needs of all patients regardless of their ability to pay or level of insurance.

In short, some tax based proposals rely heavily on the values of individual choice and responsibility as a concomitant to their desire to eliminate tax based priorities benefiting primarily those insured by their employers. By contrast, those whose primary aim is the expansion of insurance see independent value in preserving the insurance mechanism itself as a way of providing greater security to individuals and avoiding the predictable and socially adverse effects of individual decisions.

Tax reform proposals also differ from other proposals in the extent to which they can be characterized as incremental reform approaches. While tax reform proposals are “incrementalist” in the sense that they too build on the existing pluralist financing, they have, as previously noted, the potential for more fundamental change of the current system, especially the extent to which employment-based insurance may no longer retain its position as the bedrock of the system. Other, perhaps less fundamental, proposals leave the employer-based system largely intact, but they too differ from one another in their overall implications. As the papers prepared for this project amply demonstrate, there are numerous complex interactions among the components of a pluralistic health care financing system. Any government intervention must be sensitive to the range of changes in market incentives that may exacerbate old inequities or contribute to new ones.

One of the best examples of the moral dimensions of problems arising from the interaction of public policy mechanisms operating in a mixed system of public and private components is the “crowd out” phenomenon. Assume that a decision has been made to target children as the top priority for expansion of health coverage. It is in the interest of efficiency to construct policies that minimize crowd out, such that limited dollars are spent only on expanding coverage to children who are currently uninsured. Children who are already covered through their parents work-based insurance should then be excluded. Although such a provision would minimize crowd out, it also would introduce a potentially profound injustice.

Consider two single mothers, both with ten year old twins and both with incomes 180% over the poverty line. Mother A maintains public washrooms in a bus station, a job she took solely because it provides health benefits for her children. Mother B works part-time for an office temporary agency, a job that offers no benefits but a pleasant work environment. Under the new program, Mother B’s children now would be eligible for subsidies or tax benefits, while Mother A’s children would not. Depending on the specific “anti-crowd out” provisions, Mother A’s children may not be eligible for the new program until they have been “uninsured” for some specified period of time, constraining Mother A to stay locked in her job or risk a period in which her children have no insurance. Worse yet, depending on the provisions of the new program, Mother B may receive more assistance than

Mother A towards the costs of their children's health insurance. For example, Mother A's employer may contribute only 50% of the cost of the children's coverage, while the new program may provide Mother B with the equivalent of an 80% benefit (Primus; Blumberg; and Merlis and Curtis, this volume).

In this case, the public policy pits considerations of justice in the distribution of public assistance and tax relief with considerations of justice in access to health insurance. Should the new program provide insurance assistance to all children whose family income is below a specified level, or only to those children in the defined income bracket who are currently uninsured? A decision to allow concerns about fairness in federal assistance to override efficiency-based concerns about crowd out may result ultimately in a smaller net decrease in the numbers of children who are uninsured and thus in a health care policy that is in some respects less just. This trade off may be more acceptable if the new program is designed with sensitivity to other moral concerns that are also relevant to the design of just health care policies. For example, if the children who remain uninsured are from higher income families, where it is more likely that needed medical care can be paid for out of pocket, and if children with diagnosed chronic illnesses, regardless of family income, also are included in the new program, the trade off between justice in federal assistance and justice in health care becomes less stark.

Consider also proposals to expand access to uninsured older Americans by permitting individuals in their early 60's to "buy-in" to Medicare. These proposals raise a related crowd out problem, with slightly different moral implications (Loprest and Moon, this volume). On the one hand, these proposals may be viewed as a compassionate response to older Americans with chronic illnesses or major disabilities who, because of concern that they will not be able to obtain private health insurance before they are eligible for Medicare, remain employed past the point that it is in the interests of their health to do so. On the other hand, these proposals can be expected to increase the numbers of people who retire or otherwise leave the employment-based insurance market to programs that are more directly federally subsidized. As a consequence, if resources are limited, the extent to which federal programs can be extended to other populations who currently have no or little access to the employment-based system may be constrained. If, however, the Medicare expansion program is restricted to only those near-elderly who have been unemployed for a specified period of time, the program will not resolve the moral problems raised by "job-lock" of the near-elderly who are ill. By contrast, to the extent that the program attracts those among the near-elderly who are healthy and employed, as well as those who are unemployed or have chronic illness, the more morally problematic the program becomes.

Similar moral tensions are raised by proposals to assist the self-employed with the costs of health insurance through tax reforms. These proposals definitely create crowd out; most self-employed individuals are already insured and so the lost federal revenue will not result in significant decreases in the rolls of the uninsured (Glied). If those "lost revenues" were targeted towards populations other than the self-employed, there would undoubtedly be a greater impact on the insurance problem. At the same time, however, the proposals address a recognized unfairness in the financing of health insurance and in the tax code generally which systematically disadvantages the self employed.

CONCLUSION

Our analysis of the ethics of incremental health care reform leads us to the following conclusions. First, unless those of us who currently benefit from public policies that subsidize the costs of our health insurance are willing to forego these benefits, we are obligated as a matter of basic fairness to extend similar benefits to the currently uninsured. There is simply no acceptable moral justification for the current state of affairs, in which most Americans receive assistance from the federal government with the costs of their health insurance but some do not.

Second, any public policy intended to remedy the basic unfairness of the current system must ensure that all citizens receive equal treatment with respect to access to health insurance as a consequence. Mere extension of existing federal tax policies to include the currently uninsured is not enough. Proposals for tax relief (credits and refunds) that still leave the uninsured with insufficient resources to purchase adequate levels of health insurance may remove the appearance of unfairness from current policy but they still leave unaddressed fundamental concerns about unequal treatment by the government in enabling financial access to health insurance. Such proposals wrap public policy in the language of justice only to mock its meaning.

Third, it is extremely difficult to determine to whom among the uninsured coverage should first be extended. The arguments favoring different criteria for priority-setting within the uninsured reviewed in Part Two are all compelling and demand satisfaction. This is because, as a moral matter, the only truly satisfying outcome is a public policy that ensures all Americans access to an adequate level of health insurance. Currently, however, an incremental approach to the expansion of coverage remains the most viable political strategy. Insofar as choices must be made, no single metric of justice will resolve the question. We believe that the case for expansion of coverage to the most vulnerable members of society is the most morally compelling, although the specific rationale for different groups among the vulnerable differs. The claim of children for societal assistance in securing important goods is generally greater than that of adults in view of the dependency and vulnerability of childhood. Similarly, the claim of those doubly disadvantaged by chronic illness and insufficient financial resources is strengthened by the fact that their special vulnerability is in large part a result of a societal institutional arrangement that makes poor health a limiting factor on the ability to obtain adequate health insurance and inadequacy of insurance coverage a substantial contributor to further financial disadvantage.

Fourth, the question of whether current inequities in federal policy should be addressed “in kind” or “in cash” turn heavily on arguments about the social utility of insurance and the importance of personal choice, as well as on considerations of justice. Those who favor addressing the problem of the uninsured by expansions of Medicare or Medicaid programs, or by policies that condition tax benefits on proof of insurance coverage, place a high value on the social utility of health insurance. By contrast, those who, for example, favor eliminating disparate tax treatment of insurance options through such vehicles as tax refunds and individual medical savings account take the opportunity for

individuals to decide how best to meet their health care financing needs as more morally important than social benefits of universal insurance coverage, per se.

Recent and ongoing changes in the organization and financing of health care have been dramatic and yet there has been little progress in eliminating the profound inequities that continue to plague the American system. In such a regrettable context, even incremental reform is welcome, as is any opportunity to highlight the ethical implications of the policy choices before us.

REFERENCES

- Ayanian, J. Z., B.A. Kohler, T. Abe, and A.M. Epstein. 1993. "The Relationship between Health Insurance Coverage and Clinical Outcomes among Women with Breast Cancer," *New England Journal of Medicine* 329 (5):326-31.
- Chollet, Deborah and Adele Kirk, *Understanding Individual Health Insurance Markets* (Henry J. Kaiser Family Foundation, March, 1998).
- GAO. 1998. "Health Insurance Standards: Implementing New Law Creates Challenges for Consumers, Insurers, and State and Federal Regulators," GAO/HEHS-98-67.
- Hilzenrath, David S. "Big HMO Rate Rise to Hit Older Americans," *Washington Post*, October 23, 1998, A1, A4
- Kilborn, Peter T. "The Uninsured Find Fewer Doctors in the House," *The New York Times*, August 30, 1998, p.14.
- Miller, W. *Egalitarianism and Self-Respect*. PhD Dissertation, Georgetown University.
- Nickel, James "Charity, Family Aid, and Welfare Rights," in *Poverty, Justice, and the Law*, Ed. George Lucas (Lanham, MD: University Press of America, 1986), 71-77.
- O'Neil, Onora, "Justice, Gender, and International Boundaries," in *Quality of Life*, Eds., Martha Nussbaum and Amartya Sen (Oxford: Clarendon Press, 1993), pp. 303-323.
- President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Securing Access to Health Care* (Washington, D.C.: Government Printing Office, 1983).
- United States Department of Health and Human Services, *Health, United States, 1998*, (DHHS Publication Number (PHS) 98-1232, Hyattsville, MD, 1998).
- Washington Post, 7/3/98, A21, reference to Elaine Ryan, American Public Welfare Association.



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