

# Reflections



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## ACCESS TO HEALTH CARE COVERAGE IN THE UNITED STATES: RATIONING PEOPLE RATHER THAN SERVICES

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### ABSTRACT

Access to health care coverage in the United States is far from equitable and raises many ethical questions related to fairness. Access refers to the ease in which an individual in need of medical services is able to obtain them. Under the framework of bioethics, issues surrounding access to health care coverage fall primarily under the principle of justice as it pertains to fairness, entitlement to and equitable distribution of resources (Trotochaud, 2006). Within the U.S. health care system, access to health insurance is the most critical factor for determining one's access to health care services.

### KEYWORDS

Oregon Health Plan, Prioritized List, Affordable Care Act, Medicaid, Medicare, Oregon Health Authority

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## Introduction: Defining Access to Health Care

Currently in the U.S., access to health care coverage and insurance is unequal and plagued by ethical issues regarding an individual's ability to obtain appropriate access to health care services. This unequitable and often unethical discrepancy in access is primarily due to a lack of a universal medical insurance. Many of those disenfranchised from medical coverage are adults who due to gender, state of residency, immigration, or employment status are not able to obtain coverage and thus cannot take advantage of preventive and primary care services resulting in costly and often life-threatening conditions. In fact, mortality rates exponentially increase in the uninsured, outlining the critical importance of redistribution of valuable health care resources. These issues are further compounded by an increasingly aging population and thus augmenting the pressure to address societal inequalities and create fairness within the healthcare landscape. As a society, difficult questions have been skirted regarding the increasing scarcity of health care resources. An individualistic mentality coupled with self-interest for re-election in politicians have limited dialogue about the difficult task of setting limits to medical services.

Nonetheless and importantly, the State of Oregon has pioneered a solution to address these systemic problems, the Oregon Health Plan. Establishing this health plan was not without difficulties and required an iterative approach in which stakeholders discussed reasonable allocation of health resources while addressing their goal to increase health care coverage. The state of Oregon has managed to create a transparent process in which patient access to healthcare and provider needs are balanced and aimed at providing access which is financed for the poor. Health plan administrators are then tasked with meeting the Prioritized List guidelines set forth by the state within the framework of accountability for reasonableness. All of this is with the overarching goal of revamping our current healthcare system landscape and shifting the paradigm from rationing based on people's ability to pay for health care services and instead start

focusing on a practical method for rationing services as called for by the theory of justice.

## Background: Health Care Coverage Disparity in the United States

Unlike most other industrialized countries, the United States does not have universal health care coverage. As a result, almost forty-four million Americans lacked health insurance coverage during 2002 (Trotochaud, 2006). Though there have been significant declines in the number of uninsured since 2002, mostly due to passage of the Affordable Care Act, presently millions remain without affordable coverage. Among the majority of the remaining uninsured are poor adults in states that either chose to not expand Medicaid or undocumented immigrants who do not qualify for Medicaid or Marketplace coverage. In addition to both poverty and citizenship status, there are numerous other factors that negatively impact an individual's ability to access health care coverage such as race, age, gender, education and employment status.

Despite the fact that uninsured individuals have some ability to obtain health care services, the reality is that these individuals are much more likely to lack a primary source of health care, to forego needed care, to take advantage of fewer preventative services, and to receive less treatment for chronic illnesses (Trotochaud, 2006). Delays in obtaining necessary treatments are serious, expensive and can have potentially fatal consequences. For example, data shows that the risk of death for uninsured women diagnosed with breast cancer is 30% to 50% greater than women with breast cancer who have insurance coverage. Even more alarming is a report which found a 25% increase in deaths for uninsured adults in comparison to insured adults (Trotochaud, 2006). These findings outline the critical importance to intervene for the millions of uninsured Americans who cannot receive even the most basic health services (Shaia, 1993).

This gross level of disparity in the current U.S. health care system poses a major problem

surrounding the distribution of valuable albeit finite health care resources. This creates a system in which *people's* access to services are rationed rather than the *services* themselves, thereby creating an implicit form of rationing which primarily excludes the poor and other disadvantaged individuals without insurance (Shaia, 1993). Access to health care services is therefore determined by one's ability to pay and inability to do so results in a cruel form of rationing caused not so much by government policy but rather a weak health care system infrastructure (Shaia, 1993).

### Discussion: The Principles of Justice and Health Care Coverage in Oregon

The principles of justice within a society require that the health care needs of its people under reasonable resource constraints are met (Daniels & Sabin, 2002). Since society is unable to meet the demand for all medical needs, let alone medical preferences, it must then collectively be determined which needs should be given priority and when resources would be better allocated elsewhere (Daniels & Sabin, 2002). Presently pressure is mounting to address these issues of fairness within the current health care landscape. Health care costs are rising rapidly due to new medical technologies and advancements; this is compounded by an increasingly aging population with high expectations of obtaining the best care available. Ultimately, society faces the challenge of balancing health care services against other important social goods (Daniels & Sabin, 2002).

Despite these mounting pressures, ironically American society remains largely unaware of the reality of health care resource limitations and has difficulty drawing the connection between rising costs and increasing scarcity issues. Moreover, for decades insured Americans have enjoyed free flowing medical benefits without the need to ever focus on costs or worry about constraints. Due to a predominantly individualistic culture and lack of public acknowledgement or debate, our society has been shielded from facing the difficult task of setting limits on medical services. However, this is necessary for expanding health care coverage to

those who lack proper access to basic services while ensuring fairness. U.S. political leaders have intentionally shied away from openly addressing these issues of scarcity and the need for fair management of health care services to avoid being held in a negative light and upsetting the public.

An important exception to this has been the state of Oregon who attempted to address rising health care costs and limited access to care for the impoverished uninsured through its progressive development of the Oregon Health Plan. Over the course of a few decades, numerous stakeholders have come together to establish reasonable priorities to create a basic Medicaid health care package. It has been an intensive, iterative activity centered on establishing a fair and reasonable rationing process to extend coverage to more uninsured individuals. The topic initially sparked public outcry and a heated debate ensued regarding what reasonable rationing in real-life practice should entail. Stakeholders included health care providers, consumers, commissioners, businesses, insurers, and lawmakers (Oregon Health Plan, 2006).

The State of Oregon has managed to achieve a transparent public process that ensures decisions are made in the best interest of patients and taxpayers while considering input from providers and members of the public (Oregon Health Authority, 2016). The level of transparent decision making marked Oregon's experiment as a radical transformation and this approach to reasonable rationing is still reflected today in what is known as the Prioritized List. The workgroup that led to the creation of the list were guided by principles centered upon the justice theory with the following beliefs 1) access to a basic level of care must be universal; 2) society is responsible for financing care for poor people; and 3) a "basic" level of care must be defined through a public process (Hotze, 2011). The list serves as a guide for Medicaid health plans, including my employer, a non-profit health plan organization. Specifically, the list serves as a guide to assist health plans in determining which health care services should be covered and which should be excluded.

## Analysis: The Accountability for Reasonableness Framework

From a meso-level, my organization upholds and adheres to these rules set forth at the macro level by state lawmakers and the general public. In turn, coverage of procedures is transparent and clearly communicated to the providers serving our members, to the members themselves, and to the general public. The rationing process involved in creating the Prioritized List has been attempted under the ethical framework of accountability for reasonableness and aims to address the four conditions outlined by bioethicists Jim Sabin and Norman Daniels (2002). These conditions include: publicity, relevance, revision & appeals, and enforcement. According to Daniels & Sabin (2002), these are some of the core conditions necessary for facilitating a fair procedure for setting limits to health care. The health plan that I work for aims to achieve reasonable rationing and fairness by addressing these four key conditions.

The first condition, publicity, pertains to transparent decision-making regarding limits to care and publicizing these rationales to our stakeholders. As mentioned previously, the organization's decisions are guided by state policies founded on evidence-based practice and public input. From an insurer's perspective, these Medicaid coverage determinations are straightforward and as a result not questioned. In addition, if a service is denied, we explicitly cite the reason(s) to ensure the member understands the rationale for denying the service. Nevertheless, it is still unclear to what extent clinicians within our provider networks engage in honest conversations at the individual level with members to clearly explain why they cannot receive a service, particularly if it is considered excluded.

The second condition, relevance, outlines the need to provide a reasonable explanation of how the organization seeks to provide "value for money" in meeting the various needs of its population under reasonable resource constraints. This includes a rationale that appeals to evidence, reasons and principles accepted by those who are inclined to find mutually justifiable terms of cooperation

(Daniels & Sabin, 2002). As outlined above, the Prioritized List was developed by a state commission that prioritized health care spending based on evidence-based practice and comparative effectiveness reports, all of which are available to the general public and open for comment during the rulemaking process. Based on this information, my organization readily supports and adheres to these guidelines & policies through its administration of Medicaid health care benefits, and can reference the Oregon Health Authority's website for additional clarification in more complex cases.

The third condition, revision and appeals, is addressed by the organization through its formal appeals and grievances process. This process is comprised of clear guidelines outlined by the State which are obeyed to assure fair and timely follow-up. The appeals and grievances process creates a channel in which the member can challenge the organization's decision and voice their concerns. In addition, the health plan also has a chance to justify its decision and/or reconsider its original determination.

The last condition, regulation, is repeatedly interwoven throughout the discussion and analysis of the organization's application of the other three conditions. As a health plan, the rationing process and determination of coverage is heavily regulated at a state level and also at a federal level by the Centers for Medicaid and Medicare Services. In addition, there are clearly defined rules that govern how the state and its' coordinated care organizations (CCOs) report out performance and demonstrate their ability to provide coordinated health care services efficiently, effectively and economically. The scenario outlined above is unique in the sense that most health plans do not operate within the framework of accountability for reasonableness, but rather within a market accountability context instead.

Market accountability is concerned with publishing performance and operation data to purchasers and health plan enrollees as a means of choosing between plans, clinicians, and treatments. However, this framework does not offer assurance that these

plans constitute a fair and reasonable array of choices (Daniels & Sabin, 2002). Instead, market accountability leaves it up to the consumer to make inferences about the health care choices available and regarding the commitments the health plan has toward achieving responsible and reasonable care. In comparison, accountability for reasonableness focuses on health plans publicizing reasons and rationales behind important limit-setting decisions. It also guarantees there is a mechanism in place for revisiting these decisions when a problematic context presents itself, as well as an appropriate channel for revising and improving these decisions as we continue learning from experience (Daniels & Sabin, 2002).

### Conclusion: Moving toward Reasonable Rationing of Finite Health Care Resources

Despite the progress made by the Oregon Health Plan, it is imperative that more health plans, both non-profit and for-profit, begin shifting toward the accountability for reasonableness framework to begin the difficult process of addressing issues of fairness, entitlement to and equitable distribution of our limited health care resources. More importantly, this process must be collaborative and include a wide variety of decision-makers and stakeholders across the macro, meso and micro levels of society. Raising social awareness around the unjust distribution of resources and the lack of access to basic health care services by many impoverished and disadvantaged individuals is a critical first step. Actively engaging the public in a limit-setting process characterized by transparency and accountability is necessary for achieving a system that is fair, justifiable and reasonable. Moreover, conformance to the four conditions outlined by bioethicists Jim Sabin and Norman Daniels (2002) will establish and reinforce best practices suitable for a variety of public and private institutions.

The U.S. health care system must shift the paradigm away from rationing people based on their ability to pay for health care services and start focusing on a practical method for rationing services as called for by the theory of justice. As pressure continues mounting in the current landscape, it is no longer

feasible to shield Americans from the problems of scarcity and the need for priority setting, nor is it acceptable to continue letting their assumptions go unchallenged that only poor individuals or publicly funded health plans require rationing of care and reasonable limits.

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