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# Ethical Challenges in the Era Of Health Care Reform

In truth, the United States is at the beginning of a long overdue and a much needed health care reform. We have seen the dismal statistics about our high cost health care system and some of the less than stellar outcomes (e.g., infant mortality) (Callahan, 2011; World Health Organization [WHO], 2011)). The purpose of this article is not to complain about the current health care system, but instead to focus on existing reform efforts — The Patient Protection and the Affordable Care Act (ACA), the ethical justifications for its creation, and ethical challenges it brings.

## Key Features of the Law

ACA offers new ways for consumers and providers to hold insurance companies accountable. The most important parts of the law are features described in the following discussion. Because of space limitation, I will highlight some elements of the law that are enacted through 2014 and clearly impact nursing. These selected features include insurance choices, insurance costs, rights and protection, and people age 65 and older.

### Insurance Choices

The intention of the law is to expand health care coverage to most U.S. citizens and permanent residents by requiring most people to have or purchase health insurance (HealthCare.gov, 2012a). Citizens will have a choice of private insurance, employer-paid insurance, Medicaid, Medicare, or state-based insurance exchanges.

*Affordable Insurance Exchanges*. Individuals and small businesses can purchase coverage through these exchanges, with premium and cost-sharing credits available to individuals and families with income between 133%-400% of the federal poverty guideline (in 2011, the poverty guideline was $18,530 for a family of three) (Werhane & Tieman, 2011).

Businesses with 50 or more employees need to make coverage available, and businesses with less than 25 employees will qualify for tax credits to offset their cost (Kaiser Family Foundation, 2011).

*Consumer Operated and Oriented Plan (CO-OP)*. The ACA produces a new kind of non-profit health insurer, called a Consumer Operated and Oriented Plan (CO-OP). CO-OPs are meant to offer consumer-friendly, affordable health insurance options to individuals and small businesses. By January 1, 2014, individuals will be able to buy a CO-OP health plan through the Affordable Insurance Exchanges.

*Pre-existing condition insurance plan*. All covered benefits are available to individuals, even to treat a pre-existing condition. This program offers temporary protection for people with pre-existing conditions until 2014, when insurance companies can no longer deny individuals coverage based on their health status.

*Young adult coverage*. Individuals can add or keep their children on their health insurance policy until they reach age 26. The law makes it easier and more affordable for young adults to get health insurance coverage.

### Insurance Costs

ACA holds insurance companies accountable. It also helps individuals keep their costs down.

*Value for individual's premium dollar.* ACA requires insurers selling policies to individuals or small groups to spend at least 80% of premiums on direct medical care and efforts to improve the quality of care. Unfortunately, this does not apply to self-insured plans.

*Lifetime and annual limits*. ACA restricts and phases out the annual dollar limits a health plan can place on most of its benefits. Furthermore, ACA eliminates these limits completely in 2014.

*Rate review.* Insurance companies must now justify proposed rate increases for health insurance. Insurance companies cannot raise rates by 10% or more without first explaining the reasons to the state or federal rate review program.

### Rights and Protections

The ACA puts consumers in charge of their health care, not insurance companies. The following rights and consumer protections are available.

*Preventive care.* Individuals may not have to pay a copayment, co-insurance, or deductible to receive recommended preventive health services, such as screenings (e.g., mammograms and colonoscopies), vaccinations (e.g. measles, polio, or meningitis), and counseling (e.g., smoking cessation, weight loss, healthy eating).

*Doctor choice and ER access*. Individuals can choose any available participating primary care provider and they can access out-of-network emergency rooms without prior approval. ACA prohibits health plans from requiring a referral from a primary care provider before women can seek coverage for obstetrical or gynecological (OB-GYN) care.

*People 65 and older.* ACA offers eligible elders a range of preventive services with no cost-sharing. ACA also provides discounts on drugs when older adults are in the coverage gap known as the "donut hole."

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**TABLE 1.**
**Views of Liberal Egalitarians vs. Libertarians and Free-Market Advocates**

| Liberal Egalitarians | Libertarians and Free-Market Advocates |
|---|---|
| Health care is a fundamental good and access to this good allows us to become full members of society. | Role of government is confined to protecting the freedom of all persons to choose their own goals and means to pursue them. |
| This right to health care must be exercised by removing all barriers to access. | People have a right to non-interference. |
| Justice, equality, and community are values. | Freedom and personal responsibility are values. |
| Health care is a right. | Health care is a commodity. |
| Single-payer system is the solution. | Decentralized market mechanisms with personal payment are the solution. |

*Preventive services*. The list is significant and begins with an annual wellness visit. Other important preventive services include bone mass measurement; cervical cancer screening, including Pap smear tests and pelvic exams; colorectal, prostate, and diabetes screening; influenza, pneumonia, and hepatitis B immunizations; and many other services.

There are other services and features in the ACA that could be discussed, but we will now move to discuss the ethical justifications for the ACA. The controversy it has created in the eyes of individuals with a free-market or libertarian view will be compared to those with a liberal-egalitarian outlook.

## Ethical Justifications for the ACA

Since 1986, the Emergency Treatment and Labor Act has prohibited hospitals from refusing acute care to any individual who could not afford to pay (CMS.gov, 2012). "Consequently, $100 billion of care annually is 'cost-shifted' onto patients who can pay, almost all whom are insured. This shift raises the average annual health insurance premium roughly $1,000 for every insured family" (Crowley, 2009, p. 10). This lack of distributive justice for the insured is one reason why insurance is being mandated in ACA. It is equally unfair to mandate that all citizens have insurance if insurance is not affordable, as this could cause significant harm to individuals and families already struggling financially. Therefore, the ethical principles of beneficence and nonmaleficence are supported by the features of Affordable Insurance Exchanges and the development of Consumer Operated and Oriented Plans.

Ethical reasoning for health care reform has relied primarily on distributive justice as justification for change, specifically due to lack of access to care for the underinsured and uninsured (Lachman, 2009). According to the U.S. Census Bureau, 46.3 million people in the United States were uninsured in 2008 (ProCon.org, 2012). The United States is the only developed nation in the world that does not guarantee health coverage.

Table 1 offers a comparison of views of persons who support distributive justice, see health care as a right, and therefore want a single-payer system with those individuals who want to continue the free-market system. "To single-payer advocates, the primary goal of health policy is ensuring that everyone can obtain some minimal level of health care" (Sade, 2007, p. 1429). Making access to health care widely available permits individuals to be fully functioning members of society and the moral community (a group of people drawn together by a common interest in living according to a particular moral philosophy).

On the other hand, Americans who are libertarians and free-market advocates mostly look beyond the natural (genetic) and social (upbringing) lottery that places some at a disadvantage and instead look to the individual's free will and personal responsibility for actions (Callahan, 2011; Pariser, 2012; Trotter, 2011). They believe health care is one of the many options from which to choose to improve their lot in life. Their belief in personal responsibility can make them unsympathetic to people with unhealthy lifestyles for whom they would ultimately have to spend their insurance dollars. They also resent having to fund treatments they personally would not choose (e.g., transplants, mechanical ventilation for person in persistent vegetative state). Though many wealthy individuals support health care reform out of benevolence, they do fear the loss of freedom which is central to their value system.

However, two additional factors drive change for health care reform — significant cost and quality problems. In 2007, health care expenditures totaled $2.2 trillion, 16.2% of the U.S. economy. Health care employs more than 14 million people and is the largest industry in the United States. Of the 193 WHO member states, the United States is ranked first in per capita health care expenditures ($6,719) (ProCon.org, 2012). The present health care system is not giving the utility for the dollars spent. This cost problem is a reason that ACA has a focus on physicians counseling individuals on end-of-life options.

> It found that about 30 percent of Medicare dollars are spent during the last year of life, and half of that is spent during the last 60 days. In 2009 dollars, Dr. Gordon calculated, that amounts to $70 billion a year, much of it spent on futile care that prolongs suffering (Brody, 2009, para 20).

Unfortunately, politics initially got in the way in 2009 with the "death panel" jargon and this counseling was dropped from ACA; however, this end-of-life options counseling was incorporated into 2011 Medicare reimbursement for health care providers (HealthCare.gov, 2012b).

WHO (2011) statistics also indicate the money spent is not putting us at the top of the list in quality outcomes. The infant mortality rate for the United States in 2009 was seven deaths per 1,000 live births, ranking the United States 43rd among WHO nations. Rates for Sweden, Spain, Italy, Germany, France, Czech Republic, Slovenia, and Iceland are all half of the United States rate. Quality is a focus of ACA in the preventive realm and with quality measurement. Two essential principles of the ACA are that:

1. Provider reimbursement for health services is based, in part, on the relative quality and patient experience of the care provided.
2. Information about that comparative quality and patient experience will be publicly accessible.

Quality and patient satisfaction will be rewarded by data from hospital comparison required by the Hospital Consumer Assessment of Healthcare Providers and Systems for Medicare patients. "The implications of Value-Based Purchasing (VBP) regulations for hospitals are clear — FY2013 implementation at 1% of base DRG payments, rising to 2% by FY2017" (Acton, 2012, para 2). Hospitals will have to earn it back by achieving and maintaining high quality and positive patient experiences. This consequential focus in the patient care experience supports the autonomous choice of the patient for hospitals and physicians.

## Ethical Challenges of ACA

### Legal Challenge

Before discussing three key ethical challenges health care providers will face, the legal challenge before the Supreme Court needs to be addressed. This challenge determined if the ACA requirement to purchase health insurance violates Article 1, Section 8, Clause 3 of the U.S. Constitution:

> Congress shall have the Power To lay and collect Taxes, Duties, Imposts, and Excises, to pay the Debts and provide for the common Defence and the general Welfare of the United States; but all Duties, Imposts and Excises shall be uniform throughout the United States… (Werhane & Tieman, 2011, p. 83)

The argument against this mandate is that the government has never required people to buy any good or service as a condition of lawful residence in the United States. However, every working person is required to pay into Social Security and Medicare. The counter argument is that these are government-mandated and government-run programs. This argument ultimately could support a Supreme Court decision of only a government-run single-payer system, an action libertarians and free-market advocates oppose. Second, there are requirements for car insurance for drivers, and flood insurance for persons who live within authorized distance from a possible flood plain. Because *all* people will need health care at some point in their lives, the argument could be made that insurance should be a requirement so as not to burden the moral community with the costs of those who do pay for insurance (Hamel & Nairn, 2011).

On June 28, 2012, the U.S. Supreme Court endorsed most of the Patient Protection and Affordable Care Act, including the contentious individual mandate that requires most Americans to obtain health insurance. In a 5-4 decision, the court said the federal government has the power to fine Americans who do not acquire insurance because it is considered a tax (Jaslow, 2012).

### Electronic Medical Records

The requirement for electronic records could generate a significant ethical challenge for privacy and confidentiality. Unfortunately, the $20 billion for health information technology from the American Recovery and Reinvestment Act (ARRA) did little to change the current HIPPA privacy paradigm (Crowley, 2009). Furthermore, it is likely patients will carry their personal health records in their own electronic devices or retrieve them through the Internet. A transformation in rural health care is likely through telehealth and telehomecare. These innovations will bring expertise to patients to facilitate the best choice in their treatment decisions. The challenge will be to assure informed consent and confidentiality in this expanded digital age.

### Chronic Disease Management

Individuals with chronic illness benefit significantly from palliative care services, not just at end-of-life care but throughout the disease progression. The ACA focus on chronic disease management is best exemplified by this phrase: "An integrated care approach to managing illness which includes screenings, check-ups, monitoring and coordinating treatment, and patient education" (HealthCare.gov, 2012b, para 1). Feministic ethics, with its focus on managing the particulars of any person's situation, celebrates this personalized service to individuals who must manage illnesses often for many years. In her book, *Caring: A Feminine Approach to Ethics and Moral Education,* Nell Noddings (2003) argued that a morality based on rules is inadequate. She contended this approach loses the richness of the moral dilemmas people face, and only situational and contextual knowledge of the individual can help resolve the moral quandaries of life.

### Shaping Health Care Policy

According to the *Code of Ethics for Nurses*, provision 9 (American Nurses Association [ANA], 2001), nurses have an obligation to "work individually as citizens or collectively through political action to bring about social change" (p. 25). This responsibility to shape social (health care) policy calls for nurses to voice concerns about the meaning of the rejection of the individual mandate for society. The libertarians and free-market advocates

> …reinforce a caricature of American individualism and weaken a sense of responsibility for oneself and fellow citizens…It neglects one side of the equation, forgetting that we are not only individuals with the freedom to choose, but also members of society called to uphold a common good. (Hamel & Nairn, 2011, p. 94)

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Therefore, nurses and nursing associations have the ethical challenge to stand firm for patients and ensure the long-term sustainability of our health care system. Nurses need to advocate for the people without a voice — those discriminated against because of health status and lack of insurance.

## Conclusion

ACA has provided a forum for debate about not only health care insurance, mechanisms to maintain financial stability of its systems, and strategies to ensure access to millions of people, but also has contributed to defining American society's values. It is easy to argue against the individual mandate impingement on choice and freedom. However, other provisions provide children, adults, and elders with coverage and services that will help keep them healthy and support them in their management of chronic diseases, while quelling the fear of bankruptcy.

The Supreme Court will decide the legal matters in ACA, but it will not resolve the ethical matters. Can Americans continue to allow the self-protective practices of insurance companies in excluding high-risk individuals (e.g., pre-existing conditions, lifetime caps on benefits)? The principle of autonomy was never meant to abandon the moral relationships that continue to be necessary for the human good. "The nurse respects the worth, dignity and rights of all human beings irrespective of the nature of the health problem" (ANA, 2001, p. 7). MSN

**REFERENCES**

Acton, A. (2012). *The hidden risk (or reward) of HCAHPS.* Retrieved from http://blog.healthstream.com/blog/bid/103384/The-Hidden-Risk-or-Reward-of-HCAHPS

American Nurses Association (ANA). (2001). *Code of ethics for nurses with interpretative statements*. Silver Spring, MD: Author.

Brody, J.E. (2009). *End-of-life issues need to be addressed.* Retrieved from http://www.nytimes.com/2009/08/18/health/18brod.html

Callahan, D. (2011). Health care reform: Can a communitarian perspective be salvaged? *Theoretical Medicine and Bioethics, 32*(5), 351-362.

CMS.gov. (2012). *Emergency Medical Treatment & Labor Act (EMTALA).* Retrieved from http://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA/index.html?redirect=/EMTALA/

Crowley, M. (2009). *Connecting American values with health care reform*. Garrison, NY: The Hastings Center.

Hamel, R., & Nairn, T. (2011*). The individual mandate: A rancorous moral matter. Health Progress, 92(4*), 88-95.

HealthCare.gov. (2012a). *Affordable Care Act.* Retrieved from http://www.healthcare.gov/law/full/

HealthCare.gov. (2012b). *Chronic disease management.* Retrieved from http://www.healthcare.gov/glossary/c/chronic.html

Jaslow, R. (2012). *Medical groups laud Supreme Court's decision on Affordable Care Act.* Retrieved from http://www.cbsnews.com/8301-504763_162-57462837-10391704/medical-groups-laud-supreme-courts-decision-on-affordable-care-act/

Kaiser Family Foundation. (2011). *Summary of new health reform law.* Retrieved from www.kff.org/healthreform/8061.cfm

Lachman, V.D. (2009). *Ethical challenges in healthcare: Developing your moral compass*. New York, NY: Springer.

Noddings, N. (2003). *Caring: A feminine approach to ethics and moral education*. Berkeley, CA: University of California Press.

Pariser, D.M. (2012). Ethical considerations in health care reform: Pros and cons of the affordable care act. *Clinics in Dermatology, 30*(2), 151-155.

ProCon.org. (2012). *Right to healthcare: Did you know?* Retrieved from http://healthcare.procon.org/

Sade, R.M. (2007). Ethical foundations of health care system reform. *Annuals of Thoracic Surgery, 84*(5), 1429-1431.

Trotter, G. (2011). The moral basis for healthcare reform in the United States. *Cambridge Quarterly of Healthcare Ethics, 20*(1), 102-107.

Werhane, P., & Tieman, J. (2011). Clearing the brush: Myths surround the Affordable Care Act. *Health Progress, 92*(4), 82-84, 86-87.

World Health Organization (WHO). (2011). *World health statistics 2011*. Retrieved from http://www.who.int/whosis/indicators/WHS2011_IndicatorCompendium_20110530.pdf