

A Note on the Oregon Health Authority's Recent Ban on Elective Surgery for Smokers with Medicaid Insurance

DONNA K. HAMMAKER, JD, MGA,¹ THOMAS M. KNADIG, EDD, MDIV, MA,² AND BLAKE J. TOBIAS, JR.³

hammaker@nih-cml.com,¹ thomas.knadig@uphs.upenn.edu,² bt695292@sju.edu,³

¹ National Institute on Health Care Management & the Law, Philadelphia, Pennsylvania, U.S.A.

² University of Pennsylvania Health Care System, Philadelphia, Pennsylvania, U.S.A.

³ Saint Joseph's University, Philadelphia, Pennsylvania, U.S.A.

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I. INTRODUCTION¹

Most debates about Medicaid avoid identifying practical and accurate mechanisms designed to encourage appropriate delivery and use of health care. It is an instance of a mindset looking at Medicaid without necessarily seeing the complete reality of what must be looked at. Half of the health status of the Medicaid-insured or what makes the insured healthy or unhealthy is determined by their lifestyles.² Thus, it is commendable that the Oregon Health Authority (OHA) is taking an aggressive look at preventable health conditions, the onset of which can often be avoided by living a healthy lifestyle.

Each year, more than 40 percent of premature deaths in the United States result from unhealthy behaviors.³ Tobacco smoking is one of the unhealthy behaviors directly related to numerous illnesses and diseases generally preventable or that may be delayed from occurring or decreased in severity by not smoking. Accordingly, OHA's Medicaid policy change that targets how to reduce occurrences of smoking-related diseases as well as the number of smokers is laudable. Two foci of the OHA Medicaid reform are addressed in this commentary. First, is getting the Medicaid-insured involved in their own health care so that their smoking-related diseases and illnesses can be delayed or prevented altogether. Second, is restricting the Medicaid-insured who choose to smoke from access to elective surgery. This commentary focuses on the latter issue while paying attention to the former.

In exploring the ethical justification for the elective surgery ban, two existing justifications exist. One justification is a consequentialist argument that the elective surgery ban may deter people from smoking. The other justification is that the elective surgery ban seeks punitive justice for engaging in the habit of smoking.

Last, we postulate that the elective surgery ban is justified as an effort to protect and maintain the common good. In this instance, the common good is defined as the responsible use of Oregon's tax revenues. A full exploration of the common good is not made in this commentary because our intent is to bring attention to the issue of how the Oregon Medicaid reform can continue its restructuring

¹ This commentary was adapted from two textbooks: Hammaker, Donna K., and Thomas M. Knadig, 2018. *Health Care Management and the Law*. 2nd ed. Burlington, MA: Jones & Bartlett Learning; _____. *Health Care Ethics and the Law*. 2017. Burlington, MA: Jones & Bartlett Learning.

² See Mantel, 2017; Solar and Irwin. 2010.

³ Center for Disease Control and Prevention, 2014; See also Rhodes, 2015.

*Address correspondence to: Donna K. Hammaker, JD, MGA, The National Institute on Health Care Management & the Law, Philadelphia, PA 19103, U.S.A. E-mail: hammaker@nih-cml.com.

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efforts. We encourage the community of JHEA scholars to address the apparent conflict between the common good and the legitimate medical needs of the Medicaid-insured who choose to smoke.

II. THE MEDICAID FUNDING CRISIS AND TWO FOCI OF OHA'S MEDICAID POLICY CHANGE

According to OHA, Oregon provides Medicaid insurance to approximately 1 million of its residents.⁴ The need to trim Oregon's Medicaid spending is undisputed. However, out of the billions of dollars that OHA spends annually on Medicaid insurance, less than 4 percent is devoted to improving lifestyles.⁵ Also, while 80 percent of OHA's Medicaid costs are devoted to medical treatments,⁶ medical treatments affect only 10 percent of the Medicaid insureds' health status.⁷ Thus, the issue is whether OHA spending should be directed to health status issues.

One focus of OHA's Medicaid reform is on developing an initiative to aid the Medicaid-insured to obtain healthier lifestyles or at least avoid unhealthy lifestyles. Tobacco smoking results in increased Medicaid costs, yet preventive care has not been widely implemented. One reason for this is that the institutionalized models of the health care industry are far more focused on treating symptoms than preventing diseases from ever occurring. By asking the following questions—"Which diseases and chronic health conditions are preventable?" "When are they preventable?" "Is it possible for Medicaid to be restructured to provide a financial incentive for the Medicaid-insured to adopt healthy lifestyles?"—OHA could shift its focus from treating preventable diseases to tailoring preventive interventions to develop healthy lifestyles. This new approach to health care is called "prospective medicine." By using predictive analytics to identify Medicaid-insured smokers who are at great risk of developing preventable diseases, preventive interventions can occur. It is expected that the Medicaid of the future will have a great emphasis on prospective medicine. Like other states, Oregon is moving in the direction whereby prospective medicine takes the lead in implementing its Medicaid policies.

The other focus of OHA's Medicaid reform is determining who can access the health care delivery system in Oregon. OHA has taken a proactive step by placing a ban on elective surgery for Medicaid-insured smokers if they refuse to stop smoking by taking advantage of smoking cessation programs. However, decisions to restrict access to the health care delivery system are different from helping the Medicaid-insured to modify their unhealthy behaviors. The former requires a stronger ethical justification than the latter.

It is undisputed that OHA incurs great Medicaid costs by insuring smokers with unhealthy lifestyles. If OHA does not ban elective surgery for Medicaid-insured smokers the additional costs of treatment are passed onto and shared with the public, most of whom are nonsmokers. OHA's elective surgery ban is a "lifestyle discrimination policy" whose philosophical and ethical justifications stem from the deterrence theory of consequentialism. The policy discriminates against smokers in the sense that it deters the Medicaid-insured from adopting unhealthy behaviors and in turn provides Medicaid-insured smokers with incentives to develop healthy behaviors. Numerous research studies quote smokers testifying that they would have healthier lifestyles without incentives to not smoke tobacco. Evidence is beginning to emerge that incentivizing better lifestyle choices might be effective.

However, this consequentialist approach that employs deterrence as the primary reason for the elective surgery ban is not ethically sufficient. The ban in and of itself must hold its own ethical justification. Accordingly, we attempt a deontological and communitarian philosophical exploration within the context of distributive justice and fairness.

III. OHA'S WAR ON TOBACCO SMOKING

In 1964, the federal government first released a report stating that smoking tobacco is a health hazard and a primary contributor to lung disease, facts known at least as far back as the 1800s.⁸ Since then, substantial research has established that smoking dramatically

⁴ Crawford et al., 2015.

⁵ Oregon Health Authority, 2014.

⁶ Wheaton et al., 2018.

⁷ Crawford et al, 2015.

⁸ Maxeiner, 2013.

increases the risk of death from a plethora of diseases and chronic health conditions; smoking is the leading risk-factor for disability.⁹ However, despite widespread awareness and acceptance of the risks of smoking, 1 in 6 Americans still smokes tobacco.¹⁰

In 2017, OHA declared war on smoking behaviors for one simple reason: smoking-related health care costs are one avoidable, major drain on Medicaid. OHA spends over \$8.4 billion on Medicaid with approximately \$1.7 to \$6.7 billion for smoking-related diseases and chronic health conditions.¹¹ In addition to this direct cost, smokers take longer to recover from common illnesses.¹² Many of the health care costs attributable to smokers, including increased Medicaid costs, are ultimately shared by the nonsmoking taxpayers in Oregon.

The OHA's \$1.7 to \$6.7 Billion Annual Medicaid Cost Burden¹

- ✓ Health insurers pay as much as 40 percent more in health care costs than that paid for nonsmokers
- ✓ Adverse health effects from smoking count for nearly 90 percent of the lung cancers, coronary heart disease, and chronic obstructive lung disease
- ✓ Smokers cost an extra \$100,000 to \$5 million in health care costs over a lifetime

Accordingly, the OHA has opted to pass on costs attributable to smoking-related illness to those Medicaid-insured who smoke. This option results in the elective surgery ban for Medicaid-insured smokers. This approach of passing on Medicaid costs to smokers with preventable smoking-related health conditions is to pursue fairness in distribution. The amounts saved from banning elective surgery are intended to, and by all accounts do, offset at least some of the costs inherent in providing Medicaid insurance to smokers. In this way, the increased health care costs are borne by those who create the risk as opposed to those who do not pose the same economic risk.

To achieve this economic justice and fairness through access restrictions presupposes that Medicaid-insured smokers are morally responsible for the health care expenses they incur; their act of smoking is a rational, voluntary choice. The issue of whether to start smoking or to continue smoking is a voluntary or involuntary rational choice is controversial for smoking is an addiction. This topic was philosophically explored in the research article by Marvin Lee and Peter Grossnickle published in the foregoing issue of the *Journal of Healthcare Ethics & Administration*.¹³ Thus, we will not engage in this discussion. But we point out that the ethical justification for the access restrictions is a form of punitive justice. In other words, Medicaid-insured smokers are punished for what they have done and for what they choose to do. In the following section, we seek a positive, communal justification for the same act.

IV. DISTRIBUTIVE FAIRNESS: A DEONTOLOGICAL CONSIDERATION

Given that health care resources are finite, the prevailing view is that Medicaid policies that cover smokers at the expense of non-smokers is not fair. Focusing on the ban on elective surgery for smokers, the point is not merely to spend less or save more tax dollars to maintain the Medicaid system. If this were the case, OHA would have to allow those with serious illness not to access health care while letting relatively healthy smokers unrestricted access to care. OHA could save money by preferring insureds whose care is less costly. Cost savings alone is not the sole purpose of OHA's ban on elective surgery. What is at stake is distributive justice, that is, fairness in distribution.

However, what is fairness? Fairness is an elusive concept. Throughout the history of Western tradition, different philosophers and theologians have proposed diverse meanings of fairness. So far, we have talked about two versions of distributive justice or fairness in this commentary. Justifying the ban on elective surgeries in terms of its intended consequence, which is deterrence, is one way of achieving fairness from a consequentialist perspective. On the other hand, understanding the ban on elective surgery to seek punitive justice is a deontological consideration yet without reference to the common good or to positive social responsibility. Thus, we are proposing a deontological ethical justification with a communalist implication.

⁹ World Health Organization, 2017.

¹⁰ Wheaton et al., 2018.

¹¹ Satomi et al., 2018.

¹² Federal Trade Commission, 2016.

¹³ Lee and Grossnickle, 2017.

Within the Medicaid spending paradigm, while smoking tobacco is one of the causes for the Medicaid funding crisis, not every Medicaid-insured smoker is chronically ill or has a costly chronic health condition. Thus, imposing the ban on elective surgeries on relatively healthy smokers might appear unfair. Medicaid is just one of the social health care programs in the United States that is intended to treat the most vulnerable populations of our society. Medicaid is a common good which requires active communal effort to protect and maintain its sustainability. Accordingly, it is possible to consider the ban on elective surgery as a call for the unified will of Oregon taxpayers to protect the common good. As a result, the ban on elective surgeries is a justified deontological measure to actively pursue the common good.

Ethical justifications must ultimately address the intentions or will of the Medicaid-insured smoker. Thus, smokers who lack the will to pursue the common good may be punished or left out according to this view of distributive fairness. It can be argued that this view justifies the ban on elective surgeries as a discriminatory punishment for smokers because they are the group unwilling to pursue the common good. This makes this view conceptually the same as the punitive justice model. One may also argue that this view ultimately promotes the idea that Medicaid-insured smokers should have limited access to Medicaid insurance because of their deliberate non-cooperative desires to contribute to the common good as exhibited by their smoking habits. The core issue here is how to define Oregon's "collective will to pursue the common good." It is Oregon's collective will that is at issue here, not individual wills in relation to their daily habits and activities. Thus, the collective will should be defined at a societal or policy level. OHA's ban on elective surgery for Medicaid-insured smokers is a policy-level expression that reflects the collective will of Oregon taxpayers. In ending, we state that the purpose of this commentary is not to construct a full-blown deontological theory but to alert the JHEA community of scholarship to the issues inherent in society's ability to continue funding Medicaid with ethical access policies when there is a finite level of public resources.

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