

Meanwhile, the major provisions of the ACA represent a tremendous step toward interstate equity. The ACA establishes a national eligibility standard for Medicaid and a single, national formula for tax credits that subsidize the purchase of health insurance by middle-income families that cannot obtain affordable coverage through an employer. The quite narrow variation in state approaches to defining EHBs that is likely to result from the secretary's decision represents a modest potential source of inequity relative to the overall direction of the law.

The secretary's decision is consistent with the overall federalist structure of the ACA and the U.S. health care system as a whole. Under the ACA, states are responsible for establishing health

insurance exchanges, retain primary responsibility for regulating private health insurance, and continue to have a great deal of discretion in the design and administration of the Medicaid program.

Uniform national standards are fair — and are always appealing to people who believe that the chosen standards will conform to their values and preferences. But in this environment of uncertainty, with sizable preexisting local variability in insurance markets and substantial disagreement surrounding the fundamental value of sharing risk, embracing federalism in defining the EHBs is not just good politics — it is good policy.

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## Fair Enough? Inviting Inequities in State Health Benefits

Jennifer Prah Ruger, Ph.D.

The Obama administration scored a political point in December with its bulletin on essential health benefits, appeasing critics of the Affordable Care Act (ACA) by giving states the right to determine what those benefits should be.<sup>1</sup> The proposal is politically savvy. But is it fair?

The ACA stipulation that certain essential health benefits must be offered by health plans participating in the new state insurance exchanges is a huge step toward a more fair and equitable health care system. The 30 million uninsured Americans who have had limited or no access to care will be guaranteed at least some health care; for some, this could mean seeing a doctor for the first time in years.

Now, the policy outlined by the secretary of health and human services (HHS) gives states considerable flexibility in selecting benchmark plans to which all other health plans in that state must be "substantially equal." Health plans will be allowed to change the makeup of specific benefits and set their own quantitative limits. So, for example, the number of psychologist visits permitted to a patient with depression or the number of hospital days provided after surgery can vary according to state. Some states may be more generous than others, and where one lives will be a key determinant of the benefits one receives. Moreover, the Department of Health and Human Services is "considering

whether to allow substitution across the benefit categories," which would mean that some "important services or benefits in particular categories" could be eliminated altogether. Thus, there will be no uniform standard for the quantity or quality of health care that must be provided.

But what if this policy means shoddy health care for some patients and top-of-the-line health care for others — a two-tiered system? And what if variations in quality lead to disability, dysfunction, complications, or premature death? Quite different outcomes can be achieved in a person with full access to high-quality health care and one who lacks such access, even if the two have the same health condition. Hyper-

tension, for instance, affects almost 20% of the U.S. population, yet millions of Americans have undiagnosed hypertension, and only 58% of patients receive appropriate treatment.<sup>2</sup> And research shows that less than 3% of postmenopausal women with distal radial fractures received bone-density testing, and less than 25% received osteoporosis treatment within 6 months after their fracture occurred.<sup>3</sup> Such gaps in care increase the risk of poor health outcomes.

Moreover, a state-by-state approach carries potential for discrimination against patients with rare, severe, or costly health conditions. Refsum's disease, for instance, which is caused by a lack of the enzyme that breaks down phytanic acid, leads to skin disorders, loss of the sense of smell, night blindness, deafness, and heartbeat abnormalities that may result in sudden death. Neurologic, ophthalmologic, dermatologic, and generalist care are necessary for its diagnosis and evaluation. Treatment involves lifetime adherence to a strict special diet and close monitoring by clinicians; plasmapheresis and cochlear implants may be needed. Functioning and even survival could be compromised by a lack of access to high-quality care. Yet patients' ability to obtain such care when they need it will probably vary according to state. Currently, a Medicaid patient in Mississippi, for example, is permitted only 12 physician visits per year, whereas a Medicaid patient in New York has "beneficiary-specific utilization thresholds" that are based on age, sex, clinical diagnosis, prescription drugs, and procedures.<sup>4</sup> Although a uniform national benefits package might also omit rare or costly health

conditions, it would at least avoid the troubling arbitrariness of state-based variation in coverage. And if it proved wanting, correcting one national package to ensure comprehensive coverage of high-quality services would be more efficient than attempting to revise dozens of different state plans.

I believe that the HHS proposal reflects an inadequate view of equality. A better approach would be to establish uniform standards so that all Americans would have access to the same high-quality goods and services.<sup>5</sup> Such a policy could mean the difference between life and death, and it has been well tested and long debated. Indeed, this solution is grounded in the Aristotelian principles of vertical and horizontal equity. Vertical equity calls for different quantities and intensities of goods and services for persons with different needs. For example, patients with conjunctivitis and those with glaucoma need different treatments to restore normal ocular function. Horizontal equity demands that persons with the same needs receive the same treatment. Providing such persons disparate care — as might well happen under the flexible system established by HHS — represents horizontal inequity.

Those who object to the uniform-standards solution will counter that it idealistically and naively seeks, as measures of fairness, the same health outcomes and the same amounts of care for everyone. In fact, however, it is based on the principle of proportionality — the notion that similar cases should be treated similarly and different cases differently, in proportion to their differences. Medical cases in which the health needs are the

same are deemed alike; those in which the health needs are different are considered unlike. Such a solution would also require that health care be provided in keeping with medical necessity and medical appropriateness and that patients and their doctors — not state insurance exchanges, state governments, or private health plans — be the ones to make such assessments, within the scope of national standards.

Persons with the same health condition may require different amounts of care because of differences in severity or in their ability to improve their health with the available resources. Two patients may both have diverticular disease, for example, but one may simply have diverticulosis, which may be treatable with a dietary change or mild pain medication, while the other has diverticulitis, which might require surgery and colon resection. The principle of equal access I propose would call for differential provision of health care resources to achieve the same desired outcome for both patients — giving each what he or she needs to reach a medically determined level of functional health.

There is no perfect health care system. But setting a goal of equal access to high-quality, evidence-based care would be a step in the right direction. Unceasing effort to standardize comprehensive health coverage and reach a gold standard of care is essential to attaining this goal.

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## BECOMING A PHYSICIAN

# What Life Is Like

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The summer before I began medical school, the handyman working in our kitchen told me exactly how many more refrigerators he needed to repair in order to afford his coronary-artery bypass surgery. My excitement about having achieved a lifelong dream was suddenly displaced by doubt. What if the healing touch of my prospective colleagues remained out of this man's reach? As if in search of an answer, I've spent the past 5 years playing different characters in this uniquely American health care tragedy.

Most medical schools seek to augment anatomy with humanity through a concurrent curriculum. At the University of Miami, this includes a lecture from university president Donna Shalala, a former U.S. secretary of health and human services.

During her visit to our class in 2007, recounting a conversation she had with a young worker at a nail salon about employer-sponsored health insurance, Ms. Shalala encouraged us to ask people what their lives are like. The notion was as innovative as it was simple. It was exactly what I had done in the kitchen with the handyman a few months earlier. And it was my first inkling that caring for patients should begin with caring about them.

Through the Mitchell Wolfson Sr. Department of Community

Service, University of Miami Miller School of Medicine students have the opportunity to gain early clinical experience, with faculty supervision, at our student-run health fairs and clinics that reach into some of the most underserved communities in the country. We colloquially refer to this exercise as "seeing patients." In reality, our fund of knowledge as first-year medical students limits us to asking people what their lives are like.

In the conversations we had, it became clear that some of our patients were eligible for but not enrolled in federal and state health insurance programs. So we added a station at each health fair to supplement access to us with access to the system. After the mother of our first enrollee in the State Children's Health Insurance Program let her gratitude shine through her tears, asking people what their lives are like became a habit for me. It has been so ever since.

Sometimes I have encountered polite but palpable resistance. Often people's immediate reaction went unspoken: *What could you, an upper-middle-class white kid, possibly know about my life?* Though I'll never know for sure, that sentiment probably often manifested as casual agreement with requests that I later learned were preposterous.

How can you eat more fruits

and vegetables if your neighborhood doesn't have a grocery store? How can you take your medicine every day if getting it requires 2 hours of public transportation each way to drop off the prescription and then an encore to pick it up the next day? With unemployment above 13% in the construction industry,<sup>1</sup> what is the difference between a sick day and a resignation letter? *What could I possibly know?*

The conversations proceeded in fits and starts because of my "unconscious incompetence." I could readily recite the 11 criteria for identifying lupus. I didn't know that once it prevails over the kidneys, Medicare pays for the necessary dialysis. I could effortlessly name the complications of a myocardial infarction and the medicines necessary to prevent another. I didn't know that versions of most of those drugs are available at Walmart for \$4 per month.<sup>2</sup> And I could easily remember that a glycated hemoglobin level greater than 10 is an indication for insulin therapy. I didn't know that homeless patients with diabetes usually don't receive insulin because they don't have refrigerators. I had answers for my patients — but no solutions.

Suddenly, each exam room became my kitchen. The handyman was never there, but his story always was. Though I tried to adopt