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Gloria Jean Ate Catfood Tonight: Justice and the Social Compact for Health Care in America

*Lawrence Singer**

Gloria Jean ate catfood tonight. It's not that Gloria Jean planned on eating catfood. She did not wake up intending to do so. Nor had she thought about it . . . much. She didn't particularly like the taste. Nor did she relish the idea of eating it again. For no matter what she did to catfood—how she prepared it (with what minimal ingredients she had)—there was little she could do to disguise the taste of what it really was.

Gloria Jean lived alone now, so there was no one with which she could enjoy her repast. Conversely, there was no one to witness her shame. She felt dirty, a failure, and disgusted with herself for sinking so low as to eat what she ate.

She had always been a proud woman, attractive in her day, and hard working. The mother of three children, she had been a good provider, as she had to be after her husband died twenty years ago, at the age of thirty-four, leaving her with three girls. She quit college—had to—and took the first job offered, as a cleaning lady on the night shift. The hours were long, and juggling day care was hard. But she enjoyed the physical labor of the work, the satisfaction of a job well done. It was meant to be only for a short time, but the days turned to weeks, to months, to years. She bought her own house and saved a little. Life was good.

Life was good that is, until she was injured in an auto accident. It had not been her fault, but the other driver lacked insurance and Gloria Jean's insurance was poor. She struggled with the pain, and her boss noticed her slowdown and dismissed her. Twenty years at an end.

The bills mounted and she worked through her savings. Eventually she found less physically demanding work—for a lot less money. She lost the house and had to move to a more affordable apartment with no

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air conditioning and transient heat.

The pain continued and a visit to the emergency room one intolerable night revealed other problems, including diabetes and elevated blood pressure. Medications were crucial for Gloria Jean to have the same quality of life—to have life at all—yet they were expensive. Oh, so expensive. So tonight, like last night, Gloria Jean ate catfood for dinner. And tonight, Gloria Jean saved just enough money to buy her pills for one more week.¹

This is our health-care system in America. A system where the social contract, premised upon the quid pro quo of hard work and support for democracy, is broken. More than forty-three million people lack insurance.² For them there are few health care options. “Dermabrasion,” “Botox,” and “therapeutic massage” are not in their vocabulary. This was not how it was meant to be. This cannot be justice in America.

I. THE INSURANCE ACCESS CONNECTION

While other industrial nations have publicly committed to finance or provide health care to all their citizens, the United States stands alone among industrial nations in premising the vast bulk of health care delivery on a privately funded insurance system.³ Many nations, including South Africa, Hungary, and Italy, constitutionally guarantee access to health care services.⁴ Still others, such as Canada, while not enshrining the right to health care in their constitution, have adopted a system of universal access.⁵ Even nations significantly less developed

1. This story is fictitious to illustrate the painful trade-offs that individuals lacking health insurance or financial resources to pay for medical care must make every day. For a compilation of real stories reflecting these choices, see KAISER COMMISSION ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., IN THEIR WORDS: THE UNINSURED TALK ABOUT LIVING WITHOUT HEALTH INSURANCE, available at <http://www.kff.org/uninsured/2207-index.cfm> (last visited Feb. 9, 2005).

2. See Mark Taylor, *Hospitals Play Hardball*, MODERN HEALTHCARE, May 26, 2003, at 4 (describing the trend of hospitals threatening cutbacks in service to cover the cost of uncompensated care).

3. See Jason Saunders, *International Health Care: Will the United States Ever Adopt Health Care For All?—A Comparison Between Proposed United States Approaches To Health Care and The Single-Source Financing Systems of Denmark and The Netherlands*, 18 SUFFOLK TRANSNAT'L L. REV. 711, 711–12 (1995) (describing the United States as one of the only industrialized nations that does not guarantee health care as a fundamental right).

4. Amanda Littell, *Can a Constitutional Right to Health Guarantee Universal Health Care Coverage or Improved Health Outcomes?: A Survey of Selected States*, 35 CONN. L. REV. 289, 299–310 (2002).

5. *Id.* at 304

than the United States—Poland, for example—have committed to health care for all.⁶

In the United States only certain segments of the population—seniors (ages sixty-five and older), indigent children and certain poor adults, certain categories of the disabled, and chronically ill—are guaranteed insurance, either through the Medicare or Medicaid programs or other state insurance plans. Problematically, the government programs that do exist, particularly Medicaid and the State Child Health Insurance Program (the two programs primarily directed toward providing insurance coverage for the poor), are experiencing financial difficulties, resulting in significant cutbacks in persons eligible for these programs.⁷ Also, these programs generally reimburse health-care providers at or below their cost of care, typically after lengthy delays in payment. Accordingly, hospitals, physicians, and other caregivers have little incentive to locate in areas where there are large populations of poor. Institutions with significant Medicaid patient populations almost always are financially challenged, encountering great difficulty in maintaining an appropriate level of quality and access to essential services.⁸

In short, a health-care system often touted as the best in the world, a system justifiably praised for its path-breaking technological and pharmacological discoveries, is hinged upon a precarious fulcrum: these wonders are only available to those with access to “good” (*i.e.*, high paying) health insurance coverage. To not have insurance is to effectively be denied access to routine medical services, and often to encounter severe difficulties in accessing urgent and, sometimes, emergent care.

II. THE UNINSURED

Over forty-three million Americans under age sixty-five lacked health insurance in 2002, an increase of almost two-and-a-half million people over the previous year and the largest annual increase in more than a decade.⁹ During the course of any one year, millions more may lack coverage for a short period of time. While the majority of

6. *Id.* at 303–04

7. See Sarah Lueck, *States' Spending on Medicaid Slows*, WALL ST. J., Sept. 23, 2003, at A2 (detailing decline in states' spending on Medicaid).

8. See Taylor, *supra* note 2, at 4 (detailing hospital negotiations with government entities for increased reimbursement).

9. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., *THE UNINSURED: A PRIMER—KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE* (Dec. 2003), available at <http://www.kff.org/uninsured/4085.cfm> [hereinafter *THE UNINSURED: A PRIMER*].

Americans obtain health insurance through their employers as a benefit, employment is not a guarantee of coverage.¹⁰ Many small employers are unable to afford coverage for their employees or choose not to offer a plan. There is no federal or state law requiring them to do so. Further, even when coverage is offered, employees may not participate because benefits are limited or costs (to the employee) are so high. This is evident by the fact that only nineteen percent of the uninsured are from families having no individual in the workforce.¹¹

Lack of insurance goes well beyond that population euphemistically referred to as the “poor.” With recent double-digit increases in health insurance premiums, access to health care has become a middle class issue.¹² Bankruptcy is openly discussed as an option for companies to rid themselves of retirees’ accrued health benefits.¹³ In other instances, employers are moving to defined-contribution plans, whereby employees are provided with a fixed dollar amount from their employer and encouraged to seek coverage satisfying their needs. Many times, savings in health care coverage are the first budget item that employers target to ratchet down costs, often making health insurance unaffordable for low- and moderate-wage workers. Political pressure is increasing, as groups like the American Association of Retired Persons (“AARP”) and others have moved to secure expanded benefits for seniors.¹⁴

It is important to note that while income is *the* primary determinant of insurance status, race and ethnicity play a troubling role as well. Hispanics are more than three times as likely as non-Hispanic Caucasians to lack insurance.¹⁵ African-Americans ages sixty-five and older are twice as likely as whites of the same age to report that they decided not to fill a prescription because they couldn’t afford it.¹⁶

10. *Id.* at 5.

11. *Id.* at 8.

12. John F. Cogan et al., *Healthy, Wealthy, and Wise*, WALL ST. J., May 4, 2004, at A20; Robert Guy Matthews, *A Retired Steelworker Struggles With a Health-Insurance Crisis*, WALL ST. J., May 12, 2003, at A1.

13. See Lee Hawkins Jr., *GM’s Liabilities For Retiree Health Top \$60 Billion*, WALL ST. J., March 11, 2004, at A3 (showing burden placed on companies to fund healthcare benefits).

14. See American Association of Retired Persons, *Health Insurance and Medicare*, available at <http://www.aarp.org/healthcoverage> (detailing AARP’s plan for securing expanded benefits for seniors). Despite this pressure, it is unlikely that Congress will enact significant reforms in the near future because of the massive, and still growing, budget deficit.

15. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., *LACK OF COVERAGE: A LONG-TERM PROBLEM FOR MOST UNINSURED* (Jan. 2004), available at <http://www.kff.org/uninsured/loader.cfm?url=/commonspot/security/getfile.cfm&PageID=30779>.

16. Marie C. Reed et al., *Unequal Access: African American Medicare Beneficiaries and the Prescription Drug Gap* (July, 2003), available at <http://www.hschange.com/CONTENT/586>.

Studies continue to document that racial minorities receive less aggressive, and often lower quality, medical care than their white counterparts.¹⁷ Thus, by continuing to sit idle while these inequities accrue, we are enabling a health-care system that passes critical judgments on services premised upon income and skin color.

III. THE COSTS OF THE UNINSURED

Perversely, it is doubtful that the choice we have made—to allow a large uninsured population with limited access to health care services—is actually an economically efficient choice. The costs incurred to service this population are enormous. A recent report by the Kaiser Family Foundation found that providing care to the uninsured cost \$125 billion in 2004.¹⁸ These monies are amassed by providers who treat uncompensated care as a cost of business, increasing their charges to paying patients and insurers in order to have the funding necessary to cover “charity care.”

The lack of insurance most directly affects access to routine, health-promoting care—prenatal care, well-baby checkups, routine physicals and monitoring, treatment for debilitating but not life-threatening conditions and pharmaceuticals—which often involve relatively minimal expenses but save significant expenses from being incurred later when a medical condition is exacerbated due to lack of attention.¹⁹ Further, because primary care is often foreclosed, individuals may lack contact with a primary-care physician, ultimately seeking care at the hospital emergency department for non-emergent conditions. Of course, the emergency department is the most expensive locus for routine care to be sought, driving medical costs ever higher.

Beyond the financial costs, strong evidence indicates that a lack of insurance has a significant, deleterious effect on health. A study by the Institute of Medicine found that as much as \$130 billion in lost economic value to the nation can be attributed to poorer health of the

17. See *Health Centers Help Narrow Racial Health Disparities, Study Says*, BNA'S HEALTH CARE DAILY REPORT, Sept. 29, 2003 (reporting medical treatment disparities based upon racial characteristics in the United States); Sidney D. Watson, *Race, Ethnicity and Quality of Care: Inequalities and Incentives*, 27 AM. J.L. & MED. 203 (2001) (asserting that caregivers provide different care to minorities because of bias, prejudice, class, and money).

18. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., *THE COST OF CARE FOR THE UNINSURED: WHAT DO WE SPEND, WHO PAYS, AND WHAT WOULD FULL COVERAGE ADD TO MEDICAL SPENDING?* (MAY 10, 2004), available at <http://www.kff.org/uninsured/7084.cfm>.

19. See Vanessa Fuhrmans, *Higher Co-Pays May Take Toll on Health*, WALL ST. J., May 19, 2004, at D1 (detailing the potential for increased long-term health care costs due to an increase in out-of-pocket costs of preventative medication).

uninsured.²⁰

The moral costs related to denial of health services also deserve recognition. Society is no doubt degraded by operating a have/have not health-care system, condemning individuals to a permanent underclass because they lack the resources to access necessary health-care services.

The failure to provide for a universal health insurance system also forces individuals to make employment choices based upon insurance offerings, stifling creativity and career options as workers choose not to seek opportunities where access to health insurance may be limited.²¹ These choices, or lack of choices, further inflate society's costs associated with lack of access.

IV. PUBLIC AND PRIVATE RESPONSES

The government developed several programs to provide insurance coverage for discrete populations, principally seniors and children. Furthermore, federal and state governments reacted to the problem of the uninsured by imposing certain mandatory service requirements upon hospitals. Institutions and individual health care professionals may also provide free or reduced-cost care as part of their institutional mission or as an outgrowth of their individual sense of professionalism. It is important to briefly review these options, to gauge their effectiveness and their shortcomings.

A. Programmatic Responses

1. Medicare

In a speech at the commencement ceremony for the University of Michigan on May 22, 1964, President Lyndon B. Johnson called on the nation to strive for a "Great Society": "The Great Society rests on abundance and liberty for all. It demands an end to poverty and racial injustice . . . [b]ut that is just the beginning."²² One important response

20. INST. OF MED. OF THE NAT'L ACADS., HIDDEN COSTS, VALUE LOST: UNINSURANCE IN AMERICA (JUNE 17, 2003), available at <http://www.iom.edu/report.asp?id=12313>.

21. Indeed, the availability of affordable health insurance has become one of, if not the most, dominant goal of union bargaining campaigns. See, e.g., Julie Appleby, *Health Insurance Costs Fire Up Unions*, USA TODAY, Jan. 9, 2003, available at http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?cmd=Retrieve&db=PubMed&dopt=Abstract&list_uids=10964640 (reporting the increasing importance of health care costs to union negotiations with employers). The link between health insurance and health has been made repeatedly. See, e.g., *id.* (documenting the strong link between insurance and the early diagnosis of cancer).

22. President Lyndon B. Johnson, *The Great Society*, Commencement Address at University of Michigan (May 22, 1964), available at http://www.nps.gov/malu/documents/johnson_great_society.htm.

to President Johnson's call was the creation of the Medicare program.

The purpose of the Medicare program is to provide health insurance to the nation's seniors, as well as certain disabled individuals. It provides coverage without regard to income or medical history.²³ Most individuals sixty-five and over are automatically entitled to Medicare Part A, which primarily covers hospital stays and related services. Part B, the supplementary Medical Insurance Program, is voluntary, but covers ninety-five percent of all Part A beneficiaries.²⁴ Part B coverage extends to physician care and outpatient services, among other things. Part A is financed by a payroll tax paid by both employers and employees.²⁵ Both beneficiary premiums and general revenues finance Part B.²⁶ Premiums cover approximately twenty-five percent of Part B spending.²⁷

The Medicare program also includes the Medicare+Choice program, a managed-care option involving contracts with Medicare to provide both Part A and B services to enrolled beneficiaries.²⁸ In addition, a new Medicare Part D was added in December 2003, extending coverage to prescription drugs.²⁹ Financial support for Medicare Part D flows from a mixture of federal funds and beneficiary premiums.

The Medicare program has accomplished its goal of assuring health care for the nation's seniors. It enjoys strong public support, both by recipients and health-care providers. It remains to be seen, however, whether such support will continue.³⁰ Significantly, the program pre-Part D implementation was under severe financial stress. The 2004 Medicare Trustee's Annual Report indicates that in 2004 the Medicare Part A trust fund, which is used to pay claims, will start paying out more than it is taking in and will be bankrupt in 2019.³¹ The 2003

23. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., *MEDICARE AT A GLANCE, FACT SHEET 1-2*, available at <http://www.kff.org/medicare/1066-06-index.cfm> (Apr. 2003).

24. *Id.*

25. *Id.*

26. *Id.*

27. *Id.*

28. *Id.*

29. Social Security Act, 42 U.S.C. § 1395w-101 (Supp. 2004).

30. Specific aspects of the program are under challenge. It is questionable whether the new pharmaceutical benefit ultimately proves helpful, or even remains, as numerous concerns surrounding its cost and value have arisen. See, e.g., Editorial, *The High Price of Drugs*, CHI. TRIB., May 2, 2004, at C10 (discussing potential drug price increases in response to the new Medicare drug benefit).

31. John D. McKinnon, *Medicare's Health to Fail Rapidly*, WALL ST. J., March 24, 2004, at A2.

Report projected financial failure in 2026, likely indicating an even more precarious standing than even just this one-year period would predict.³²

There is no doubt that Medicare will be overhauled in hopes of bringing some semblance of financial stability.³³ Commonly presented proposals such as reducing benefit options, outsourcing program operations, increasing the age of eligibility from sixty-five to sixty-seven or higher, and other steps are all but certain to harm access to service and swell the ranks of the uninsured as individuals wait even longer to gain access to this essential government program.

2. Medicaid

Medicaid, also created as part of the Great Society program, was enacted in 1965 as companion legislation to the Medicare program.³⁴ Established as Title XIX of the Social Security Act, its primary purpose is to extend medical assistance to children, persons with disabilities and those who qualify due to financial need.³⁵ Medicaid is larger than any single private health insurer, covering twelve percent of the non-elderly population; over one-half of Medicaid beneficiaries are children.³⁶ Medicaid also assists low-income Medicare beneficiaries by paying Medicare premiums and the costs of services not covered by Medicare.³⁷

Medicaid is structured as a joint federal-state program. The federal government provides matching funds—payments to states for a share of the costs they incur for services provided to Medicaid beneficiaries—and sets broad guidelines for eligibility and scope of coverage. In turn, the states administer the programs and make specific decisions about eligibility and benefits. States also have the option to seek a waiver from the federal guidelines in order to expand their programs' eligibility

32. *Id.*

33. *See generally*, David A. Hyman, *Medicare Meets Mephistopheles*, 60 WASH. & LEE L. REV. 1165 (2003) (critiquing the Medicare program for its inability to provide cost efficient care to beneficiaries).

34. Cindy Mann et al., *The Evolution of Public Health Coverage for Children*, 13 FUTURE OF CHILD. J. 1, 1 (Spring 2003), at http://www.futureofchildren.org/information2827/information_show.htm?doc_id=175199.

35. The Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (1965). Interestingly, a major component of Medicaid is funding skilled nursing care for the indigent elderly and those who have made themselves indigent through “asset spend down.”

36. THE UNINSURED: A PRIMER, *supra* note 9. *See supra* note 9 and accompanying text (reporting facts and statistics concerning the United States population without health insurance coverage).

37. *Id.*

or benefits, or to provide services in an innovative manner (such as through managed-care plans). Many states have chosen to do so.³⁸ The federal government currently pays about fifty-seven percent of Medicaid program costs.³⁹

Federal law requires states to provide Medicaid assistance to children under age nineteen who come from families with incomes less than the poverty level.⁴⁰ The income threshold is higher—133% of the poverty level—for children under age six and for pregnant women.⁴¹ For various reasons, such as immigration status and wherewithal to navigate a bureaucratic system, many individuals who qualify for program enrollment have failed to do so, leaving about a quarter of poor children uninsured.⁴²

Parents of dependent children qualify for Medicaid, though income eligibility levels are set so much lower than eligibility standards for children that forty percent of indigent adults under age sixty-five fail to qualify for assistance.⁴³ In July 2002, only eighteen states provided eligibility for parents at the federal poverty level; thirteen states declare that parents at fifty percent of the poverty level are “over income” for Medicaid purposes.⁴⁴

Medicaid’s promise of assuring widespread access for the poor is a largely unfulfilled promise. Most states have significantly limited eligibility, as Medicaid enrollment has been decoupled from welfare assistance. States have also reduced optional coverage, significantly ratcheting back the number of individuals eligible for Medicaid benefits.⁴⁵

38. See, e.g., Kentucky, available at <http://www.cms.hhs.gov/medicaid/waivers/KYwaiver.asp?state=KY> (allowing a private non-profit entity to manage the Kentucky Medicare delivery system and providing non-emergency medical transportation); Tennessee, available at <http://www.cms.hhs.gov/medicaid/waivers/Tnwaiver.asp?state=TN>, <http://www.state.tn.us/tenn-care/> (covering uninsured without access to group health insurance up to two hundred percent of the federal poverty level).

39. Mann, *supra* note 34, at 3.

40. THE UNINSURED: A PRIMER, *supra* note 9.

41. *Id.*

42. *Id.* Illegal aliens are not eligible for Medicaid coverage, disenfranchising millions of people residing in the United States. Unfortunately, denying them coverage does not make the cost of their care go away.

43. *Id.*

44. Cindy Mann et al., *The Evolution of Public Health Coverage for Children*, 13 FUTURE OF CHILD. J. 1, 1 (Spring 2003), at http://www.futureofchildren.org/information2827/information_show.htm?doc_id=175199.

45. In June 2003, the Wall Street Journal reported that this “optional” coverage has been extended to fifteen million persons. At the time of the article, twelve states had targeted cuts of almost 500,000 beneficiaries. Sarah Lueck, *Facing a Crunch, States Drop Thousands from*

Medicaid reimbursements for services are exceptionally poor, often covering less than one-half of service costs, and then only after significant delays in payment. Institutions and medical practitioners have little incentive—short of a desire to foster the public good—to service this population. Even with these good intentions, the inability to generate an acceptable return from services rendered jeopardizes the ability of these health-care providers to continue in operation. In essence, then, Medicaid perpetuates the fiction of providing widespread access to care for the indigent, when in fact the real reach of the program is greatly circumscribed.

3. State Child Health Insurance Program

To address the problem of the growing number of uninsured children, Congress enacted the State Child Health Insurance Program (SCHIP) in the Balanced Budget Act of 1997.⁴⁶ SCHIP was established as a complement to Medicaid by covering low-income children (below two hundred percent of the federal poverty level) not otherwise eligible for Medicaid assistance.⁴⁷

SCHIP is funded through a federal matching block grant program designed to allocate \$40 billion over a ten-year period. As a block grant, the program gives states more flexibility than Medicaid to experiment with a variety of approaches to expanding coverage for low-income, uninsured children.⁴⁸ States have three options in designing their SCHIP program.⁴⁹ First, states can simply expand eligibility for health coverage under an existing Medicaid plan.⁵⁰ Medical services covered under this Medicaid expansion essentially mirror those services provided by the state.⁵¹ Under a second approach, states can create a wholly new, separate child health program.⁵² Lastly, states have the option of combining these two approaches.⁵³

SCHIP has been a successful program. By June 2003, thirty-nine

Medicaid Rolls, WALL ST. J., June 26, 2003, at A1.

46. 42 U.S.C. § 1397 *et seq.* (2000).

47. THE UNINSURED: A PRIMER, *supra* note 9.

48. Eugene Lewit et al., *Health Insurance for Children: Analysis and Recommendations*, 13 FUTURE OF CHILD. J. 1 (Spring 2003), at http://www.futureofchildren.org/information2826/information_show.htm?doc_id=161393.

49. CENTER FOR MEDICARE AND MEDICAID SERVICES, WELCOME TO THE STATE CHILDREN'S HEALTH INSURANCE PROGRAM, at <http://www.cms.hhs.gov/schip/about-SCHIP.asp> (last visited Jan. 5, 2005).

50. *Id.*

51. *Id.*

52. *Id.*

53. *Id.*

million children were enrolled in SCHIP programs nationwide.⁵⁴ Because the SCHIP enrollment process requires children to be vetted first for Medicaid eligibility, SCHIP's impact has actually been much broader than its enrollment numbers indicate. The Centers for Disease Control and Prevention estimate that between 1997 and 2002 SCHIP and Medicaid's enrollment together accounted for a one-third reduction in uninsured children in the United States.⁵⁵ Still, a March 2003 report estimated that 6.8 million children have failed to enroll in SCHIP, likely due to parental malaise or fear of government or bureaucratic hurdles.⁵⁶

Like any public program geared toward the needy, SCHIP faces severe financial strain. The matching block grant approach of the program leaves it vulnerable to the vagaries of state budgets, which must match the federal contribution for the federal grant to be awarded. Indeed, in November 2003, it was reported that six states—Alabama, Colorado, Florida, Maryland, Montana, and Utah—froze SCHIP enrollment.⁵⁷ When a freeze occurs, states deny access to insurance to children not previously enrolled in the SCHIP program.⁵⁸

SCHIP calls for a ten-year federal commitment, but the program has only received a five-year funding allotment. This lack of funding seriously undermines the program's goal of enhancing access to services.

Beyond service failures due to a lack of financial resources, there also remain significant gaps in coverage provided to certain children based on their legal-or illegal-alien status. Undocumented children are barred from enrolling in Medicaid.⁵⁹ Even children legally residing in the United States face barriers, such as a federal law imposing a five-year wait for Medicaid and SCHIP eligibility for all children entering the country after August 1996.⁶⁰

Finally, of course, the SCHIP program, like Medicaid is a "negative payor" of services; in other words, service reimbursement is often below the cost of rendering the service. Accordingly, few institutions and providers are inclined to focus significant resources on this population. Again, what we see upon examination of the SCHIP

54. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., *OUT IN THE COLD: ENROLLMENT FREEZES IN SIX STATES* (Dec. 2003), available at <http://www.kff.org/medicaid/4159.cfm>.

55. *Id.*

56. *Id.*

57. *Id.* at 2.

58. *Id.*

59. Mann, *supra* note 34, at 5.

60. *Id.*

program are serious weaknesses in the safety net designed to serve some of society's most vulnerable members.

B. Regulatory Responses

1. Emergency Medical Treatment and Active Labor Act

Faced with horror stories of hospitals refusing care to patients presenting to the emergency department but unable to pay, Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA) in 1986.⁶¹ The statute requires that any patient who comes to a hospital emergency department requesting examination or treatment for a medical condition must be provided with a medical screening examination to determine if she is suffering from an emergency medical condition.⁶² If she is, then the hospital is obligated to either provide treatment until she is stable or to transfer her, pursuant to statutory and regulatory directives, to another hospital.⁶³ If the patient does not have an emergency medical condition, the statute imposes no further obligation on the hospital, although state law—statutory or common—may impose such obligations.

EMTALA has been effective in assuring that hospital emergency departments ("E.D.") are open to all, regardless of ability to pay. Nevertheless, violations have occurred, and questions surrounding the strength of enforcement have been raised.⁶⁴ The law, in fact, has been the subject of significant litigation as the exact contours of its reach are tested and refined.⁶⁵

Unfortunately, full compliance with the law leaves significant gaps in health care access. The law only reaches emergency care. Any care requested that is deemed not to be emergent by the emergency room physician need not be rendered. These patients may be readily discharged from the E.D. having received little or no treatment. The law is also restricted to hospitals, the most expensive locus of care.

61. Emergency Medical Treatment and Active Labor Act, Pub. L. No. 99-272, 100 Stat. 164 (codified as amended at 42 U.S.C. § 1395dd (2000 & West Supp. 2004)).

62. Social Security Act, 42 U.S.C. § 1395dd(a) (2000 & West Supp. 2004).

63. 42 U.S.C. § 1395dd(b)(1) (2000 & West Supp. 2004).

64. Press Release, Public Citizen, Hospitals in Nearly Every State Violate Federal Patient Dumping Law, Study Shows (July 12, 2001), available at <http://www.citizen.org/pressroom/release.cfm?ID=170>.

65. See, e.g., *Roberts v. Galen of Va., Inc.*, 525 U.S. 249 (1999) (holding no showing of improper motive necessary to establish hospital's violation of EMTALA when hospital refused to stabilize patient with emergency condition); Wendy W. Bera, *Preventing "Patient-Dumping": The Supreme Court Turns Away the Sixth Circuit's Interpretation of EMTALA*, 36 HOUS. L. REV. 615 (1999) (discussing effect of Supreme Court declining to apply improper motive test).

Arguably, EMTALA incentivizes individuals to seek care at the E.D., because they know they will be seen, even though a less-intensive setting may be more appropriate.

The law also fails to address payment issues, so that while indigent patients will be seen and perhaps treated, they will incur charges that they have no hope of paying. Charge and collection practices affecting so-called “charity-care” patients have been a point of significant contention and controversy.⁶⁶

Finally, the most significant downfall of the law is that it is essentially an unfunded mandate, requiring hospitals to act but not necessarily compensating them to do so, unless the patient has insurance. As such, it indirectly imposes costs on all of us, at a time when resources might be better deployed toward developing a comprehensive system of care.

2. Federal and State Charity-Care Requirements

Many health care institutions, particularly hospitals and skilled nursing facilities, enjoy tax-exempt status. As such, they are exempt from paying federal income taxes⁶⁷ and state and local income, sales and property taxes.⁶⁸ In essence, this freedom from taxation generates an enormous public subsidy to these institutions, typically justified by the good works these organizations conduct.⁶⁹

66. See METRO. CHI. HEALTHCARE COUNCIL, REPORT OF THE TASK FORCE ON CHARITY CARE AND COLLECTION PRACTICES FOR THE UNINSURED OF THE ILLINOIS HOSPITAL ASSOCIATION AND THE METROPOLITAN CHICAGO HEALTHCARE COUNCIL (2003), available at <http://www.ihatoday.org/public/charitycare.pdf> (recommending steps Illinois Hospitals might take to respond to concerns of over-billing the poor and using aggressive collection practices). The controversy surrounds three fundamental issues: (1) must tax-exempt hospitals provide some level of charity (free) care in order to maintain their tax-exempt status; (2) differential pricing policies that result in uninsured persons being charged higher prices for their hospital care than patients with an insurance company that has bargained for the price of care on their behalf; and (3) collection practices that some consumer advocates have claimed to be overly aggressive. All of these issues are raised in the class-action litigation recently filed against many of the nation’s health-care systems by a consortium of law firms led by Richard Scruggs, a class-action attorney who earned notoriety in his massive litigation efforts against the tobacco companies. For a summary of the hospital class action litigation, including documents related to the suits, see www.nfplitigation.com.

67. Federal tax exemption is achieved through compliance with Internal Revenue Code Section 501(a) and its related provisions. Income generated from sources not linked to a “charitable” purpose will be subject to tax, however.

68. Each state has its own particular test for determining worthiness of exemption from state and local taxation. See, e.g., *Utah County v. Intermountain Health Care, Inc.*, 709 P.2d, 265 (Utah 1985) (holding hospital property not eligible for charitable exemption unless gift to community by non-reciprocal provision of services or through alleviation of a government burden).

69. Another public subsidy provided to hospitals and skilled nursing facilities that chose to

Federal tax-exemption principles—and assuredly state law as well—require that exempt organizations both make their facilities available to those unable to pay and actually provide some modicum of free (“charity”) care. Tax-exemption is therefore an important underpinning of providing the uninsured access to health care services. A recent Internal Revenue Service (“IRS”) Field Service Advisory clarified the role that charity care plays in the IRS’s determination of exempt status.⁷⁰ The Advisory—essentially advice from the IRS’s Chief Legal Counsel—instructs that institutional policies to provide charity care are not enough to satisfy IRS requirements, and that only a demonstration that such policies actually result in the delivery of “significant health care services to the indigent” will suffice.⁷¹ The Advisory goes on to propose fourteen questions, which should be examined to determine the institution’s commitment to charity care.⁷²

State tax-exemption laws also generally require a commitment to serving the indigent and uninsured. Some states have taken these general principles further, enacting legislation demanding specific levels of charity care. Texas’s charity-care law, for example, stipulates that each not-for-profit hospital is required to provide a certain amount of free health care to people who have no health insurance or who cannot afford to pay for hospital care.⁷³ Patient eligibility criteria are set by the hospital and are based on a patient’s ability to pay.⁷⁴ In exchange, Texas not-for-profit hospitals are exempt from state taxes.⁷⁵

In yet another illustration of state charity-care mandates, Ohio is in the process of enacting a charity-care law. Ohio House Bill No. 248 stipulates “each non-for-profit hospital shall provide charity care during each calendar year in an amount equal to at least four percent of the hospital’s total gross receipts for compensated care for the preceding

avail themselves of it is direct grants through the “Hill-Burton” program. Hospital Survey and Construction Act, Pub. L. No. 79-725, 79 Cong. Ch. 958, Aug. 13, 1946, 60 Stat. 1040. Institutions benefiting from Hill-Burton funding must, in some instances, provide a certain level of uncompensated services in perpetuity. See HEALTH RESOURCES AND SERVICES ADMINISTRATION, THE HILL-BURTON FREE CARE PROGRAM, at <http://www.hrsa.gov/osp/dfcr/about/aboutdiv.htm> (last visited Jan. 5, 2005) (mandating that facilities assisted under Title XVI must provide uncompensated services in perpetuity); see also Sara Rosenbaum, *Finding a Way Through the Hospital Door: The Role of EMTALA in Public Health Emergencies*, 31 J.L. MED. & ETHICS 590, 591 (2003) (reviewing Hill-Burton as a foundation for the modern charity-care system of healthcare).

70. Field Service Advisory: Section 501, Internal Revenue Service (Mar. 9, 2001).

71. *Id.*

72. *Id.*

73. TEX. HEALTH & SAFETY CODE ANN. § 311.045 (2000).

74. *Id.*

75. *Id.*

calendar year.”⁷⁶ The amount that Ohio’s Medicaid program would pay for the charity care if it were provided to a Medicaid recipient is used to determine the value of the charity care rendered.⁷⁷

The charity-care commitment mandated by tax-exemption, while helpful to aiding access to services, suffers from several shortcomings. First, except for the relatively few states that have moved to quantify the charity-care commitment, the commitment itself remains largely undefined. As such, few institutions are likely to be found wanting strictly for failure to fulfill this mandate.

More significantly, enforcement of the charity-care mandate is spotty, with little federal oversight and only occasional (although lately more active) state review.⁷⁸ Additionally, there is no private right of enforcement, so only the federal or state government may pursue an action against violators. Finally, as the numbers of uninsured have grown, and private and governmental insurance programs have slashed reimbursement, decreasing institutional funding is available for charity care, causing institutions to aggressively parcel out charity to only the most desperately needy.⁷⁹

C. Private Responses

No review of access would be complete without mentioning the strong institutional and individual commitment that many organizations and professionals have to providing free or reduced-cost services. Such charitable giving funds a significant portion of access costs. No other industry in the country is called upon to literally give away its services on such a massive scale. It is a true testament to health-care providers that a charitable mission is so deeply imbued within that system.

At the same time, reimbursement cuts and significantly expanding costs are challenging providers’ abilities to maintain their charitable commitments. We simply cannot impose ever greater un-reimbursed costs on our care providers and expect quality and accessibility of services to not be impacted.

76. H.B. 248, § 1, 125th Gen. Assem., Reg. Session (Ohio 2003–04) (to be enacted at § 3727.30 of the Ohio Revised Code), available at http://www.legislature.state.oh.us/bills.cfm?ID=125_HB_248.

77. *Id.*

78. There has been increasing attention paid to this issue as a result of several articles in the national press. See, e.g., Lucette Lagnado, *Hospital Found ‘Not Charitable’ Loses Its Status as Tax Exempt*, WALL ST. J., Feb. 19, 2004, at B1 (describing how a hospital loses its tax status).

79. See, e.g., *Lo v. Provena Covenant Med. Ctr.*, 796 N.E.2d 607 (Ill. App. Ct. 2003) (holding a suspension of physician privileges for reducing quality of care to be a valid executive action). See also METRO. CHI. HEALTHCARE COUNCIL, *supra* note 66, at 1 (responding to criticisms of discriminatory pricing of health care services in Illinois).

V. HEALTH CARE AND THE SOCIAL COMPACT

As we look at the totality of programs, laws, and social underpinnings girding access to health care, we see a system (and I hesitate to use that term) littered with inadequacy. Several fundamental truths behind health-care access become evident:

1. The insurance-access link is irrefutable. To not have “adequate” insurance, which extends coverage to routine (primary) care, prescription drugs, inpatient and outpatient care, mental health services, and skilled nursing care, is the functional equivalent of not having access to these services. Forty-three million Americans and growing lack such access. The harm to these individuals lacking coverage is enormous. The cost to society, through lost productivity and costs shifted onto the “system” to fund the insured is equally so.

2. Insurance programs geared toward the poor (Medicaid and SCHIP) are wholly inadequate. There are significant holes in their coverage, they are severely under-funded, they distort behavior, and they enjoy little political support. And these problems are getting worse, not better. In the fiscal year 2001, approximately 2,000 families in Texas opted to relinquish custody of their children so that these young people, by becoming wards of the state, would qualify for needed mental health services.⁸⁰ A 1999 study conducted by the National Alliance for the Mentally Ill found that twenty percent of families with children having severe emotional problems relinquish custody to the state in order to access services.⁸¹ A December 2003 report estimated that in 2003 between 1.2 million and 1.6 million persons would be cut from state Medicaid and SCHIP programs, as states move to cut health-care expenditures in the face of significant budget deficits.⁸² Almost one-half of those cut are children.⁸³ These are real people, with real needs, living meaningful lives. This simply cannot be the type of society we are trying to build.

3. Medicare, which enjoys widespread support, is in serious trouble. The financial costs of running the program, in an era of rapid and

80. MENTAL HEALTH ASS'N OF TEX., RELINQUISHMENT OF CUSTODY, *available at* <http://www.mhatexas.org/RelinquishmentofCustody>.

81. DARCY E. GRUTTADORO, NAT'L ALLIANCE FOR THE MENTALLY ILL, THE TRAGEDY OF CUSTODY RELINQUISHMENT, *at* <http://www.nami.org/youth/custody.html> (last visited Jan. 4, 2005).

82. LEIGHTON KU & SASHI NIMALENDRAN, CENTER ON BUDGET AND POLICY PRIORITIES, LOSING OUT: STATES ARE CUTTING 1.2 TO 1.6 MILLION LOW-INCOME PEOPLE FROM MEDICAID, SCHIP AND OTHER STATE HEALTH INSURANCE PROGRAMS (Dec. 22, 2003), *available at* <http://www.cbpp.org/12-22-03health.htm>.

83. *Id.*

expensive advances in medical technology, make the program unsustainable in its current form. Attempts to rein in costs are all but certain to diminish the widespread access to services that is a hallmark of the program. Regulatory responses to the access crisis—EMTALA, charity-care laws, and their ilk—provide no direct financial support for delivery of care, and therefore are weak efforts to buck up a wholly inadequate access assurance mechanism.

4. Tinkering with the current hodgepodge of systems (with tax credits, employer incentives, and the like), or even adding more programs, simply will not fundamentally change the access equation. So long as we have a system of haves and have-nots—“good” access for those fortunate enough to have “good” insurance, a secondary system for those with poor coverage, and no system for the rest—we will never assure that all individuals have access to quality health care.

5. The health insurance-employment link must be severed. We must find other ways to encourage people to work, if this is indeed the policy rationale behind coupling employment and insurance, than making something as essential as health care available only to the employed and the “worthy” poor.

We must, therefore, take a stand that all individuals, apart from their employment status, are entitled to adequate health care. We must stand for the fundamental dignity of each person, regardless of race, ethnicity, and socioeconomic status, to have access to one of the basics of life. We must make the choice to no longer live in a society which turns its back on its poor (and increasingly its middle class) and accepts the premise that more than forty million Americans do not count, and that if we ignore them, they and their problems and the cost to society of addressing those problems, will somehow go away.

Of course there is no easy answer. The number of individuals in need of medical care and unable to appropriately access it is daunting, the dollar amounts needed to address the problem overwhelming. But we should agree that to not begin addressing the health-care access issue is simply no longer an option. Our health-care system is in crisis. Real people will be hurt, and die, and cost us more money because they failed to seek timely and likely less expensive medical care. Real institutions will close and real doctors will leave the profession, harming health care access for us all. Gloria Jean ate catfood for dinner. SHE ATE CATFOOD FOR DINNER. America must be better than this.

