2006

The Fundamental Law That Shapes the United States Health Care System: Is Universal Health Care Realistic within the Established Paradigm?

William P. Gunnar

Loyola University Chicago, School of Law

Follow this and additional works at: http://lawecommons.luc.edu/annals

Part of the Health Law and Policy Commons

Recommended Citation


Available at: http://lawecommons.luc.edu/annals/vol15/iss1/7

This Article is brought to you for free and open access by LAW eCommons. It has been accepted for inclusion in Annals of Health Law by an authorized administrator of LAW eCommons. For more information, please contact law-library@luc.edu.
The Fundamental Law That Shapes the United States Health Care System: Is Universal Health Care Realistic Within the Established Paradigm?

William P. Gunnar, M.D.*

"The law, in its majestic equality, forbids the rich as well as the poor to sleep under bridges, to beg in the streets, and to steal bread," Anatole France, Le Lys Rouge, ch. VII (1894).1

I. INTRODUCTION

Between 1993 and 2002, I was a partner and physician employee for a private practice group operating in the Chicagoland area. My medical staff privileges at a number of inner city and suburban hospitals required that I provide emergency services regardless of a patient's ability to reimburse me for those services. My privileges were also contingent upon a guarantee that I accept Medicaid reimbursement schedules for patients with Medicaid coverage. Further, due to the nature of my hospital-based surgical practice, I accepted referrals of all patients on a non-emergency basis regardless of their ability to pay. The moral and ethical philosophy of the private practice group that billed and collected for my services was to provide medical care to all patients that required our services.

The patient population to whom my partners and I provided health care services resulted in a substantial rate of non-reimbursement. Approximately 10% of the patients receiving health care services were self-pay, which usually resulted in no pay. The business manager of our office would negotiate Medicare reimbursement rates with many of these patients and place them on a monthly payment plan. A few patients faithfully mailed twenty to thirty dollars per month for years until their obligation was met. The vast majority of self-pay patients were never heard from again and after six months of unreturned calls and unanswered requests by mail,

* 4th year law student, Loyola University of Chicago School of Law, Part-Time Evening Division, and Associate Professor of Surgery, Loyola University Stritch School of Medicine.

1. Lewis v. Thompson, 252 F.3d 567, 588, n.32 (2d Cir. 2001).
the patient's outstanding responsibility was written off as non-compensated care. In addition, turning these patients over to a collection agency rarely returned a payment.

Medicaid covered twenty-five percent of the patients receiving medical services from our medical practice. Medicaid reimbursement for medical services, as determined by the federal government and the state of Illinois, approximated one-third of Medicare reimbursement rates. Despite the fact that our business office would bill electronically within days of providing medical service, we did not receive payment from the Illinois Department of Public Aid for months.

For every one hundred patients that our private practice group serviced, we collected approximately fifty Medicare reimbursements, fifteen reimbursements from employee-based health plans (typically Medicare rates plus 10-20%), twenty reimbursements from Medicaid, and no reimbursement from ten self-pay patients. As Medicare reimbursements for physicians declined in the 1990s and overhead costs of doing business (including medical malpractice insurance premiums, staff salaries and benefits, and supplies and equipment) continued to rise, it became increasingly more difficult to provide services to self-pay and Medicaid patients from a financial perspective. Sometime in 2001, I began to ask myself two questions: First, "should I refuse to provide health care services to a patient that I know will not be able to pay me?" And second, "who works for free without volunteering?"

My experience providing health care services in the Chicago "free market" has proven to me that the uninsured person seeking health care in the United States is not denied physical access to health care. For example, any person can walk into a hospital or physician's office and request health care services, regardless of whether that person has health insurance. However, the uninsured patient faces two barriers when accessing the health care system.

First, a health care provider may refuse health care services to any person requesting preventive or non-emergency care who fails to provide proof of guaranteed payment. In such situations, any moral or ethical considerations for the person denied care because of their inability to pay are moot, considering the free market of health care in the United States.

Second, the uninsured patient, often with limited access to resources, will avoid seeking non-emergency and preventive care due to the cost and the penalties associated with non-payment. Any person accessing the health care system without proof of insurance coverage has the option of

guaranteeing full payment or negotiating a discounted rate and delayed payment schedule. In this respect, a contractual agreement to receive health care services is quite similar to, for instance, purchasing a car. Under the terms of the contract, failure to reimburse the physician or facility for services rendered will result in billing requests and demands for payment with the possibility of collection and legal action in the event of non-payment.

From the perspective of the physician, providing health care services to the uninsured person has an economic impact on both the physician's practice and personal income. Rendering free care is essentially a tax imposed on that practice and income with virtually no form of relief or consideration. Historically, physicians could offset charitable care from collections received for health care services provided to patients with Medicare or traditional employee-based health insurance coverage. But the health care system has changed over the past decade, resulting in decreased physician reimbursement rates from Medicare, Medicaid, and employee-based health plans. In addition to decreased reimbursement rates, physicians are also facing increased physician practice overhead expenses, particularly in relation to professional liability insurance rates. Thus, providing health care services to an uninsured patient now has a substantially greater economic impact on the physician provider than it did a decade ago.

Second, the physician practice incurs costs associated with the billing and collection of payment from the uninsured patient. In the case of nonpayment, the repeated phone calls, mailing of statements, and requests for reimbursement take up a substantial amount of time and energy of the office staff. In the event of a delayed payment schedule, the office staff monitors the payment plan and allows the patient's billing file to remain open for months or even years. Further, sending the patient's unpaid bills to collection requires a second contractual arrangement with a collection agency that guarantees a fifty percent return to the collection agency for any payment recovered.

Third, in some cases, the physician health care provider is often pressured to provide services to the uninsured or public aid patient. For example, I was obligated to provide the following services for rates lower than those paid by Medicare: 1) emergency care to an uninsured patient presenting to a hospital emergency department; 2) all health care services provided to a Medicaid patient under an agreement with the hospital to "opt-in" to a federal reimbursement program for Medicare and Medicaid; and 3) all health care services provided to an uninsured patient who was...

3. Id. at 467-76.
admitted to the hospital in need of care, where any refusal to provide services would violate the reasonable standard of care as well as the hospital bylaws.

Fourth, the uninsured patient presenting to the hospital often suffers from advanced disease as well as significant co-morbid conditions. In my experience, patients with advanced disease typically require prolonged hospitalization, greater time and effort from their treating physicians, as well as substantial use of resources. Such services provided to the uninsured patient detract from those physician activities directed at enhancing the overall practice income through the care and treatment of patients from whom one expects acceptable reimbursement.

This commentary will provide an overview of the laws that impact the delivery of health care services provided to individuals without health insurance coverage. It will also provide an understanding of the legal foundation upon which the U.S. health care system rests and the forces that are resistant to change within that system. Universal health care, or the provision of health care services to all persons, is a laudable goal but unobtainable within the current paradigm. Part II provides a brief overview of the uninsured population and the impact that a lack of health care insurance coverage has on that population. Part III outlines the constitutional importance and judicial interpretation of those statutes that impact an individual’s right to health care services. Part IV examines the legislative intent behind federal statutes that either qualify or deny an individual the right to receive federal and/or state health care funding. Part V explores the social contract that continues between the uninsured patient and the health care provider as well as outlines any incentives that exist for the health care provider in delivering charitable health care. Finally, Part VI summarizes the constitutional and legislative forces that are resistant to changing the U.S. health care system and ultimately concludes that universal health care in this country can never be fully achieved.

II. A BRIEF OVERVIEW OF THE UNINSURED PERSON AND THE EFFECT THAT A LACK OF HEALTH CARE COVERAGE HAS ON OVERALL HEALTH

Current estimates of the number of U.S. citizens that lack health insurance have increased to forty-five million, nine million of whom are children.4 The uninsured represent 18% of the nonelderly population5 and

the percentage of uninsured adults varies by state, ranging from a low of 7.8% in Minnesota to 31.2% in Texas, with almost one-half of the uninsured residing in only five states. In addition, the vast majority of uninsured working adults are black and Hispanic; only 11% are white.

In addition to uninsured citizens, thirty-three million non-citizen immigrants currently reside in the United States, about nine million of whom are here illegally and are presumed to be uninsured. The number of illegal immigrants is expected to increase by 500,000 per year, with approximately one-half arriving from Mexico.

The lack of health care insurance coverage establishes considerable barriers to health care. Persons without health insurance are more likely to postpone seeking health care and avoid filling prescriptions because of the cost, have problems paying their medical bills, and nearly a quarter of them will be contacted by a collection agency. Additionally, in 2003 approximately one-third of all uninsured persons who needed health care did not receive it. Persons that delay or fail to receive timely health care are more likely to develop serious illness, become hospitalized for conditions that could have been avoided, and ultimately die. A report by the Institute of Medicine estimated that at least 18,000 U.S. citizens die prematurely each year due to a lack of health care coverage.

---

5. KAISER REPORT, supra note 4.
6. Id. (noting that almost half of the uninsured population lives in California, Texas, New York, Florida, and Illinois).
8. JOHNSON REPORT, supra note 4
9. Seam Park, Substantial Barriers in Illegal Immigrant Access to Publicly-Funded Health Care: Reasons and Recommendations for Change, 18 GEO. IMMIGR. L.J. 567, 568 (2004) (noting that illegal immigrants are often prohibited from receiving public health insurance and are unable to obtain medical insurance through their places of employment because they often are employed in low-wage, low benefit jobs in the agricultural and service sectors); see also Julie F. Costich, Legislating a Public Health Nightmare: The Anti-Immigrant Provisions of the “Contract with America” Congress, 90 KY. L.J. 1043, 1057 (2002) (explaining that immigrants are more likely than citizens to be uninsured).
10. Park, supra note 9, at 568.
12. See KAISER REPORT, supra note 4; see also JOHNSON REPORT, supra note 4.
13. See KAISER REPORT, supra note 4.
14. Id.
15. Id.
16. Id.
III. The United States Constitution and Judicial Interpretation Offer No Positive Right to Health Care

A. The United States Constitution does not recognize a right to health care.

Although the Declaration of Independence proclaimed that all persons have the "unalienable" rights of life, liberty, and the pursuit of happiness, it did not guarantee these rights. In its original form, the U.S. Constitution was a framework of government and not a charter of fundamental rights. The few individual rights outlined in the original document consisted of the right to a jury trial, the writ of habeas corpus, protection for contracts, and protection against ex post facto laws. The Constitution did not explicitly guarantee or promote an individual's right to health care.

During the 1700s, state constitutions guaranteed individual rights for the most part. Large towns throughout the states provided health care for the indigent and "the protection of health and the provision of care were assumed to be responsibilities of local and provincial governments." In return for the individual's obedience, the state had the authority and duty to protect the public's health through a "social contract." Over time, however, capitalism and the free-market economy overwhelmed the social contract and health care was no longer considered a fundamental obligation of state government.

In 1791, the Bill of Rights established the first ten amendments to the U.S. Constitution. The primary concerns of the Bill of Rights were civil and political rights, rather than social and economic ones. The constitutional guarantees against federal governmental oppression towards state actions were the primary insurers of fundamental rights. Following the Civil War, the adoption of the Thirteenth, Fourteenth, and Fifteenth Amendments, known as the Reconstruction Amendments, brought federal

18. Id.
19. Id.
21. Id. at 718; see also Davis, supra note 17, at 958.
23. Id.
24. Id. at 719-20.
25 Davis, supra note 17, at 958-59.
26. Id. at 959.
protections against slavery and ensured fundamental rights for all citizens.\textsuperscript{27} The effect of the Reconstruction Amendments was to give the federal government the power to supersede state authority when state governments acted independently and in violation of individual fundamental rights.\textsuperscript{28} From this time forward, fundamental rights of U.S. citizens could be legislated by the authority of Congress.\textsuperscript{29}

In the past fifty years, multiple attempts have been unsuccessfully made to federally mandate universal health care for all U.S. citizens.\textsuperscript{30} The last attempt occurred in the 1990s, when the Clinton administration proposed universal health care legislation to Congress, which was unable to secure enough support.\textsuperscript{31} Previously, Presidents Roosevelt, Truman, Nixon, and Carter all tried to implement health care reform, but failed due to the strength of countervailing special interests.\textsuperscript{32} Thus, the United States remains one of the only industrialized nations, and the sole remaining Western democracy, to allow a large "percentage of its population to go entirely without health insurance coverage."\textsuperscript{33} Central to this consistent position of the U.S. government is the failure of the U.S. Constitution to recognize an explicit right to health care.\textsuperscript{34}

\textsuperscript{27} Id. at 960.
\textsuperscript{28} Id.
\textsuperscript{29} Id. at 960-61.
\textsuperscript{30} See generally E. Richard Brown, Keynote Address: Allocation of Health Resources in the Clinton Administration, 16 WHITTIER L. REV. 3, 5-8 (1995) (discussing differences between the Clinton Plan, the Chafee Bill, and the Cooper Bill).
\textsuperscript{31} Rory Weiner, Universal Health Insurance under State Equal Protection Law, 23 W. NEW ENG. L. REV. 327, 327 (2002) (stating that some observers believed the health care system would reform itself through free-market competition, particularly among insurance companies and health plans); see also Saunders, supra note 20, at 712 (noting that President Clinton offered a health care reform proposal to Congress which attempted to introduce health care as a fundamental right offered by market-driven insurance pools and controlled by a federal agency).
\textsuperscript{32} Saunders, supra note 20, at 791 & n.46.
\textsuperscript{33} James B. Roche, Health Care in America: Why We Need Universal Health Care and Why We Need It Now, 13 ST. THOMAS L. REV. 1013, 1013 (2001). The author further notes that the United States is the only industrialized democracy not to have ratified the International Covenant on Economic, Social and Cultural Rights, which provides that health care is a fundamental right. Id. at 1015.
\textsuperscript{34} Anita Pereira, Live and Let Live: Healthcare is a Fundamental Human Right, 3 CONN. PUB. INT. L.J. 481, 490 (2004); see also Saunders, supra note 20, at 721-22 (stating that "The United States recognizes The Charter of the Organization of American States and the American Convention on Human Rights, but is not a member of the American Declaration of Rights and Duties of Man, a positive rights law which recognizes health care as a right.").
B. The United States Supreme Court does not interpret the Constitution to offer a positive right to health care under the Due Process Clause of the Fourteenth Amendment.

Until the twentieth century, the U.S. Supreme Court interpreted the Bill of Rights to enumerate a list of fundamental rights. In 1905, the theory of substantive due process emerged from the Court’s decision in *Lochner v. New York*, which provided for a contemporaneous interpretation of the Constitution and ultimately led to the expansive list of “fundamental rights protected by natural law and social compact in addition to those rights listed in the Bill of Rights.” In 1965, the Court further expanded the interpretation of the Bill of Rights to guarantee fundamental rights from governmental intrusion.

In 1973, the Court articulated for the first time that the judicial test for a fundamental right was “whether there is a right... explicitly or implicitly guaranteed by the Constitution.” The text of the Constitution identified the explicit rights. A standard for determining implicit rights guaranteed by the Constitution has never been articulated by the Court. When the Court determines that the Constitution implicitly guarantees a fundamental right, it does so by grounding the right in the “liberty” protected by the Due Process Clause of the Fourteenth Amendment. For example, the Court has held that the Constitution implicitly defines a right to privacy that encompasses the right to have an abortion, use contraception, marry, procreate, have family relationships, control the education of one’s

35. Davis, supra note 17, at 959.
37. Davis, supra note 17, at 962 (citing Calder v. Bull, 3 U.S. 386, 388 (1798)).
39. San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 33 (1973); see also Harris v. McRae, 448 U.S. 297, 312 (1980) (noting that if a law impinges upon a fundamental right explicitly or implicitly secured by the Constitution, the law is presumably unconstitutional).
41. Id. at 261 & n.83.
42. Id. at 262; see also Harris, 448 U.S. at 312 & n.18.
children, and maintain bodily integrity. Under fundamental rights analysis, a litigant challenging a governmental action has the burden of proving that the challenged action infringes upon a fundamental right. Where the Constitution does not explicitly define an asserted right, the Court has the freedom to carve out new fundamental rights.

When the Court determines that an implicit fundamental right exists, the governmental action will only be upheld if the government can show that the action promotes a compelling state interest. Furthermore, the Court has held that under a strict scrutiny analysis, the litigant challenging a governmental action must prove that the governmental action places an undue burden on the exercise of the individual's fundamental right. Under the heightened scrutiny analysis, the Court will find the challenged governmental action unconstitutional only if the individual's rights have been unduly burdened by the government action.

When the Court determines that a fundamental right does not exist or the governmental action does not unduly burden an existing fundamental right, the Court will evaluate the governmental action using the rational basis test. For a governmental action to be constitutional under this standard, the action must merely bear a rational relationship to a legitimate state interest. Under the lesser "mere rationality" standard, the Court has held that welfare benefits, housing, federal employment, a funded education, and pregnancy-related medical care, including medically necessary abortions, are not fundamental rights.

50. Davis, supra note 17, at 967.
51. Id.
52. Id.
54. Jeffrey, supra note 40, at 247.
55. Id. at 248.
56. Id. at 247; see also San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 40 (1973).
60. Rodriguez, 411 U.S. at 37.
63. Jeffrey, supra note 40, at 262.
The Due Process Clause of the Fourteenth Amendment affords protection against unwarranted government interference with freedom of choice in the context of certain personal decisions, but "does not confer an entitlement to such funds as may be necessary to realize all the advantages of that freedom." The financial condition of the individual is not created by the government and cannot be considered an obstacle in the path of freedom of choice. "Whether freedom of choice that is constitutionally protected warrants federal subsidization is a question for Congress to answer, not a matter of constitutional entitlement." Thus, the Court has determined that under due process, the Constitution imposes no obligation on the States to pay any medical expenses, let alone the costs associated with the health care of the indigent.

C. The United States Supreme Court does not extend the Equal Protection Clause of the Fifth and Fourteenth Amendments to recognize a suspect class based upon wealth.

Government actions that do not impinge on a right or liberty protected by the Constitution will be presumed valid in the absence of a statutory classification that is suspect. The Court has held that the constitutional guarantee of equal protection is not a source of substantive rights or liberties, but rather a "right to be free from invidious discrimination in statutory classifications and other governmental activity." When a government action classifies on the basis of a suspect classification, the Court will strictly scrutinize the action. In this manner, the Court has applied strict scrutiny analysis to the classifications of race, ethnicity, national origin, and, when made by a state, legal alienage. However,

64. Harris, 448 U.S. at 317-18.
65. Id. at 316.
66. Id. at 318.
67. Maher v. Roe, 432 U.S. 464, 469 (1977); see also Youngberg v. Romeo, 457 U.S. 307, 317 (1982) (supporting idea that "a State is under no constitutional duty to provide substantive services for those within its borders.").
68. See Maher, 432 U.S. at 478; see also Jeffrey, supra note 40, at 248.
69. Harris, 448 U.S. at 322.
70. Jeffrey, supra note 40, at 249.
71. Id. at 248 (noting that to satisfy a strict scrutiny analysis, the government action must further a compelling state interest that cannot be achieved by less intrusive means).
73. See, e.g., Bakke, 438 U.S. at 290-91.
since the Constitution grants the federal government the power to regulate naturalization and immigration in Article I § 8 of the Constitution, the Supreme Court has held that alienage classifications by the federal government merit only deferential scrutiny. In addition, it should be noted that alienage is a suspect classification for legal aliens, but not for illegal aliens. An intermediate level of scrutiny will be applied to the quasi-suspect classifications of gender and legitimacy.

The Court has never held that financial need alone identifies a suspect class for purposes of equal protection analysis, although it has acknowledged that every denial of federal or state funding to an indigent creates a wealth classification. The Court stated that "the Constitution does not provide judicial remedies for every social and economic ill." On the other hand, the Court's failure to acknowledge a right to federal and state funding does not mean it is unsympathetic to the plight of the indigent. A governmental statute may be challenged successfully on equal protection grounds with proof of purposeful discrimination. In such a case, one must show that the state legislature "selected or reaffirmed a particular course of action at least in part because of its adverse effects upon an identifiable group." Although "laws and regulations allocating welfare funds involve "the most basic economic needs of impoverished human beings," such classification systems may survive equal protection challenges if a reasonable basis for the classification is shown.

75. Jeffrey, supra note 40, at 249 n.48; see also, e.g., Bernal v. Fainter, 467 U.S. 216, 219 (1984) (stating, "a state law that discriminates on the basis of alienage can be sustained only if it can withstand strict judicial scrutiny."); but see, e.g., Cabell v. Chavez-Salido, 454 U.S. 432, 438-39 (1982) (noting the public function exception to the general rule that alienage classifications merit strict scrutiny).
78. Jeffrey, supra note 40, at 247
81. Maher v. Roe, 432 U.S. 464, 471 n.6 (1977) (noting that "[i]n cases such as Griffin v. Ill., 351 U.S. 12 (1956), and Douglas v. Cal., 372 U.S. 353 (1963), the Court held that the Equal Protection Clause requires States that allow appellate review of criminal convictions to provide indigent defendants with trial transcripts and appellate counsel. These cases are grounded in the criminal justice system, a governmental monopoly in which participation is compelled... Subsequent decisions by the Court have made it clear that the principles underlying Griffin and Douglas do not extend to legislative classifications generally.").
83. See id.
85. See Maher, 432 U.S. at 479 (quoting Dandridge v. Williams, 397 U.S. 471, 485
The Court’s analysis of state or federal legislation related to health care funding is indistinguishable under the Fifth and Fourteenth Amendments. The Court has repeatedly held that “poverty, standing alone, is not a suspect classification.” Congress and state governments may designate classes of individuals to whom health care funding will be available, once qualified, as long as governmental action is rationally related to a legitimate governmental purpose.

D. The United States Supreme Court holds that prisoners must receive health care under the Cruel and Unusual Punishment Clause of the Eighth Amendment.

The Cruel and Unusual Punishment Clause of the Eighth Amendment proscribes tortures and other “methods of punishment” and thereby dictates “broad and idealistic concepts of dignity, civilized standards, humanity, and decency” to the prisoner population. The treatment a prisoner receives in prison and the conditions under which he is confined are subject to scrutiny under the Eighth Amendment. The Court has held that punishments that do not comport with the evolving standards of decency as set by society are repugnant to the Eighth Amendment. In addition, punishments that “involve the unnecessary and wanton infliction of pain” also violate the Eighth Amendment. The standard of decency imposes a duty on prison authorities to provide prison inmates with adequate food, clothing, shelter, and medical care, as well as to take reasonable measures to guarantee prisoners safety.

The government is obligated to provide medical care to incarcerated persons because they rely on prison authorities to meet their medical needs. Denial of medical care under such conditions can result in pain
and suffering. More serious conditions may produce torturous circumstances and even death. Thus, the Court has concluded that the deliberate indifference of serious medical conditions of prisoners constitutes unnecessary and wanton infliction of pain under the Eighth Amendment.

"Deliberate indifference" may manifest itself in a prison physician's response to a prisoner's medical needs or as a result of a prison official intentionally denying or delaying access to medical treatment. An Eighth Amendment violation based on a prison official's deliberate indifference requires the inmate to prove something more than mere negligence, but less than an act or omission that occurred for the very purpose of causing harm or with knowledge that harm would result.

The deliberate indifference standard not only requires more than the prison official's mere knowledge of an excessive risk to inmate health or safety for liability, but the prison inmate must also prove disregard for an excessive risk to inmate health or safety. The Court's analysis mandates a subjective inquiry into the prison official's state of mind or consciousness, which requires evidence of knowledge and disregard by that particular prison official, not just a reasonable person.

Therefore, a prison inmate's guaranteed medical treatment under the Eighth Amendment must be sufficient to prevent unnecessary and wanton infliction of pain. However, reasonable efforts by prison officials are sufficient to avoid liability under the Cruel and Unusual Punishment Clause of the Eighth Amendment. Contrary to an interpretation that the Eighth Amendment provides a fundamental right to health care, health care in this context is neither adequate nor sufficient to meet basic and appropriate standards of medical care.

law and requires the governmental entity responsible for supplying the prisoner with health care to pay all relevant costs).
97. *Id*.
98. *Id* at 104.
100. *Farmer*, 511 U.S. at 835; *Estelle* v. *Gamble*, 429 U.S. 97, 105-06 (1976) (noting that since Eighth Amendment liability does not extend to unforeseeable accidents or inadvertent failures to provide medical care, prison officials are not required to provide medical care after failed executions by electrocution but instead may proceed immediately to the second attempt).
102. *Id* at 838 (applying the subjective component of the Eighth Amendment as set forth in *Wilson* v. *Seiter*, 501 U.S. 294, 298 (1991)).
103. *Id* at 842-43 n.8.
104. *Id* at 844 (citation *Bell* v. *Wolfish*, 441 U.S. 520, 547-48 (1979)).
E. The United States Supreme Court extends liberty interests via the Due Process Clause to persons with compromised freedoms.

An Eighth Amendment claim of deliberate indifference to a prisoner's serious medical needs requires a formal adjudication of guilt that is in accord with procedural due process of law. Persons who are awaiting trial or sentencing and require medical care while under government custody are not protected under this right. Rather, the Court has held that the proper constitutional provision guaranteeing medical care to the injured detainee is the Due Process Clause of the Fourteenth Amendment.

In this context, a person injured in the course of apprehension and custody by the police has a due process right to appropriate and necessary medical treatment. Although the Court has not defined the parameters of this right, the Court has clarified that the individual's due process rights are at least as great as the Eighth Amendment protections available to convicted prisoners.

Similarly, the Court has held that the liberty interests of a mental health patient involuntarily institutionalized include a clear Fourteenth Amendment right to "adequate food, shelter, clothing, and medical care." The Appellate Courts have extended such a liberty interest to any special relationship imposing a duty on a state or municipality "to provide care and treatment for persons in its custody in situations less extreme than permanent incarceration or institutionalization." A special relationship exists when the state exercises sufficient control to significantly limit a person's freedom to obtain adequate medical care.

Therefore, a person with a medical condition will at least be constitutionally guaranteed minimally adequate medical care if incarcerated, institutionalized, or otherwise placed under government control that significantly compromises that person's freedom of access the

107. Id. at 244.
108. Id. at 245.
109. Id. at 244 (citing Bell v. Wolfish, 441 U.S. 520, 535 (1979)).
111. Wideman v. Shallowford Cmty. Hosp., 826 F.2d 1030, 1034 (11th Cir. 1987); see also, e.g., Taylor v. Ledbetter, 818 F.2d 791, 797 (11th Cir. 1987), cert. denied, 489 U.S. 1065 (1989) (holding that when children are involuntarily placed in foster care, the state may be liable for injuries the child suffers as a result of the foster care); Maddox v. City of L.A., 792 F.2d 1408, 1415 (9th Cir. 1986) (noting that medical care must be secured for persons injured while in police custody); Hamm v. DeKalb County, 774 F.2d 1567, 1573 (11th Cir. 1985), cert. denied 475 U.S. 1096 (1986) (finding that due process requires states to provide pretrial detainees with at least minimally adequate levels of food, space, and medical care).
112. Wideman, 826 F.2d at 1036.
Is Universal Health Care Realistic?

health care system. Health care in this context reflects Eighth Amendment standards, which are neither adequate nor sufficient to meet basic and appropriate standards of medical care and which are contrary to an interpretation that the Due Process Clause provides a fundamental right to health care.114

IV. CONGRESS PROVIDES FEDERAL FUNDING FOR BASIC HEALTH CARE TO ELIGIBLE PERSONS, EXPLICITLY DENIES FEDERAL FUNDS TO UNQUALIFIED ALIENS, AND UNDER CERTAIN CIRCUMSTANCES GUARANTEES ACCESS TO HEALTH CARE TO ALL PERSONS

A. Medicaid provides federal funding for basic health care to eligible persons.

Title XIX of the Social Security Act, commonly known as Medicaid, was enacted in 1965 as companion legislation to the Medicare program.115 This need-based program provides low-income individuals116 broad coverage for medical expenses including prescription drugs, dental and eye care, and long-term custodial care in a nursing home or by home care attendants.117

Under Medicaid provisions, the federal government and the states share the cost of providing specified benefits to certain federally specified categories of needy individuals.118 Although a state is not required to participate in Medicaid, its plan must comply with federal statutes and regulations that state chooses to do so.119 Compliance requires the state to designate a Medicaid agency to administer the plan120 and submit a “plan for Medical assistance” to the Department of Health and Human Services (HHS).121

Upon approval from HHS, the state establishes eligibility standards, sets

113. Id. at 1035.
114. Pereira, supra note 34, at 490-92.
118. Diane Rowland, Medicaid: Issues and Challenges for Health Coverage of the Low-Income Population, 7 J. Health Care L. & Pol’y 106, 110 (2004); see also Singer, supra note 115, at 621 (observing that the federal government currently pays approximately fifty-seven percent of Medicaid program costs).
119. Lewis v. Thompson, 252 F.3d 567, 569 (2d Cir. 2001); see Weiner, supra note 31, at 351.
121. 42 U.S.C. § 1396a(b) (2003).
the rate of payment for services, and administers the Medicaid plan.\textsuperscript{122} The federal government then partially reimburses the state for expenditures in subsidizing medical services provided.\textsuperscript{123}

At a minimum, the federal government requires that the participating state provide Medicaid coverage to persons determined to be “mandatory categorically needy,” a group which includes those already receiving some other need-based government benefit, most commonly Aid to Families with Dependent Children (AFDC).\textsuperscript{124} Mandatory Medicaid benefits must cover basic physician, laboratory, and hospital services.\textsuperscript{125}

The state may elect to expand the scope of persons eligible for Medicaid coverage in two ways.\textsuperscript{126} First, the group of persons eligible to receive Medicaid can be expanded to include the “optional categorically needy.”\textsuperscript{127} Individuals in this group are either uniquely vulnerable or in need of medical supervision, including the elderly, the blind, and the disabled.\textsuperscript{128} This group of individuals may also meet the “income and resource requirements” for other forms of governmental aid, such as AFDC, even though they do not receive such assistance.\textsuperscript{129} Secondly, a state may extend Medicaid coverage to the “optional medically needy,” persons with higher income and resources but who otherwise qualify as “optional categorically needy.”\textsuperscript{129} The optional Medicaid benefits that these individuals receive include prescription drug coverage and community-based long term care.\textsuperscript{131}

Medicaid programs provide funding for health services to over fifty million individuals in the United States and represent the nation’s largest health care program.\textsuperscript{132} Individual state costs associated with running a Medicaid program and the actual reimbursement rates for the health care services covered by Medicaid impact the availability of these services.\textsuperscript{133} In 2002, optional state programs generated 65% of Medicaid spending and

\begin{footnotes}
\item[123.] \textit{Lewis}, 252 F.3d at 569-70.
\item[125.] Rowland, \textit{supra} note 118, at 110.
\item[126.] 42 U.S.C. §§ 1396a(a)(10)(A)(ii)(I)-(VIII) (2003); \textit{see Lewis}, 252 F.3d at 570.
\item[127.] \textit{Id.}
\item[128.] \textit{Id.}
\item[129.] \textit{Id.}
\item[130.] 42 U.S.C. § 1396a(a)(10)(C) (2003); \textit{see Lewis v. Thompson}, 252 F.3d 567, 570 n.4 (2d Cir. 2001) (stating that one group of individuals classified as “optional categorically needy” are individuals under the age of twenty-one, known as “Ribicoff children,” named after Senator Abraham Ribicoff, who helped to assure their inclusion in Medicaid coverage).
\item[131.] Rowland, \textit{supra} note 118, at 110.
\item[132.] \textit{Id.} at 106, 109-11.
\item[133.] Singer, \textit{supra} note 115, at 621-22.
\end{footnotes}
83% of the optional spending went to the elderly and disabled populations, the bulk of which was used for long-term care and prescription drug coverage.\(^{134}\) Overall, children and their parents represent three-quarters of all beneficiaries and 30% of all spending, while the elderly and disabled account for a quarter of beneficiaries and 70% of spending.\(^{135}\) State budgetary constraints dictate the availability of health services coverage and the number of persons eligible for optional programs.\(^{136}\) As the demands on Medicaid spending increase, states are forced to restrict Medicaid expenditures, either by decreasing reimbursement to health care providers for health care services rendered or by rationing optional benefits.\(^{137}\)

In addition, health care providers, particularly physicians, have little motivation to care for the Medicaid population because reimbursement rates for services provided are exceptionally low.\(^{138}\) Because it reimburses providers at rates oftentimes below the cost of providing service, Medicaid is thus considered a negative payor.\(^{139}\) Furthermore, reimbursement to the health care provider for Medicaid services rendered is often delayed.\(^{140}\) The result is that Medicaid beneficiaries do not receive the same level of health care services enjoyed by Medicare beneficiaries or those with an employer-based health plan.

### B. Congress extends funding for health care services to children.

Medicaid has been amended multiple times in the past forty years to extend coverage to children beyond the standards applicable to adults.\(^{141}\) Those categories of health care services considered optional for adults are mandatory for qualified persons under the age of twenty-one.\(^{142}\) Furthermore, Medicaid specifically mandates coverage of all services listed in special educational and early intervention plans developed for children.

---

134. Rowland, supra note 118, at 115.
135. Id.
136. Id. at 116-17.
137. See id.; see also Singer, supra note 115, at 621.
138. Singer, supra note 115, at 622.
139. Id. at 623.
140. Id.
142. Rosenbaum, supra note 141, at 11 (noting that except for a small number of medically needy children who "spend down" to eligibility by incurring high health care costs, all Medicaid enrolled children under the age of twenty-one are entitled to Early and Periodic Screening Diagnostic and Treatment services, which consists of all immunizations recommended by the Advisory Committee on Immunization Practices and all medically necessary diagnoses and treatments determined as necessary to treat or "ameliorate" a child's physical and mental health condition).
with disabilities under the Individuals with Disabilities Education Act. 143 In this regard, Congress intended Medicaid to ensure qualified children access to a comprehensive health care system.144

In 1997, Congress further extended federal coverage of health care services for children that were not otherwise eligible for Medicaid assistance by enacting the State Child Health Insurance Program (SCHIP) as a part of the Balanced Budget Act. 145 SCHIP is a federal matching block grant that emphasizes the importance of federally-subsidized health care for uninsured children without access to Medicaid. 146 Under SCHIP, the state may augment Medicaid by expanding the scope of children's health care coverage, operate SCHIP as a separate program and extend coverage to uninsured children with income above mandatory Medicaid eligibility levels, or choose a hybrid of the two options.147

Despite the umbrella of health care coverage afforded by SCHIP, persons in the United States under the age of twenty-one are not guaranteed health care. 148 First, many eligible children are never enrolled in SCHIP. 149 Second, individuals may not qualify for SCHIP because of certain citizenship eligibility criteria, including five-year waiting periods for legal alien residents.150 Furthermore, SCHIP reimbursement schedules pay health care providers at "below cost," 151 effectively limiting access to those health care providers that have agreed to participate in Medicare and Medicaid programs.

C. Congress denies federal funding for health care services rendered to "unqualified" aliens.

On August 22, 1996, President Clinton signed into law the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA), also known as the Welfare Reform Act, which created a comprehensive scheme for determining an alien's eligibility for federal, state and local benefits and

144. Id.
145. 42 U.S.C § 1397 (2000); Singer, supra note 115, at 622.
146. Rosenbaum, supra note 141, at 16-17; Singer, supra note 115, at 622 (noting that SCHIP allocated $40 billion over a ten year period); Dubay et al., supra note 7, at 23 (stating that all but 16% of low-income uninsured children are now eligible for coverage under either Medicaid or SCHIP).
147. Rosenbaum, supra note 141, at 17.
148. Singer, supra note 115, at 623-24; Dubay et al., supra note 7, at 27 (noting that despite the level of federal and state funding, 23% of all uninsured children and 16% of low-income uninsured children remain ineligible for one of these programs).
150. Id.
151. Id.
services.\textsuperscript{152} The legislative intent behind PRWORA is explicit, as policy considerations require that "the availability of public benefits not constitute an incentive for immigration to the United States."\textsuperscript{153}

PRWORA categorizes aliens as being "qualified" or "not qualified" and then, based on the categorization, specifies the public benefits available to those aliens.\textsuperscript{154} Congress defines "qualified alien" as an alien who, at the time he applies for, receives, or attempts to receive a federal public benefit, is either: (1) an alien who is lawfully admitted for permanent residence; (2) an alien who is granted asylum; (3) a refugee; (4) an alien who is paroled into the United States; (5) an alien whose deportation is being withheld; (6) an alien who is granted conditional entry; or (7) an alien who is a Cuban and Haitian entrant.\textsuperscript{155}

In enacting PRWORA, Congress made a clear statement that the immigration policy of the United States denies public benefits to all but a narrowly defined class of immigrants.\textsuperscript{156} Furthermore, Congress intended to deny health, welfare and postsecondary education benefits on the federal, state, and local levels to aliens who are "not qualified."\textsuperscript{157} PRWORA provides an exception where all persons, regardless of immigrant status, may receive federal Medicaid assistance for emergency medical conditions, immunizations, and testing and treatment of symptoms of communicable diseases.\textsuperscript{158}

Yet, Medicaid benefits are available to certain non-citizens. Specifically, an alien is entitled to Medicaid benefits for health care if he or she fulfills the criteria established by the state\textsuperscript{159} and if the alien is "qualified" under the provisions of PRWORA.\textsuperscript{160} States that desire to extend Medicaid coverage to individuals otherwise "not qualified" may do so at the state's expense.\textsuperscript{161} To do so, PRWORA requires the state to enact legislation after August 22, 1996, that affirmatively provides state and local benefits to illegal immigrants considered "not qualified."\textsuperscript{162} Even though state statutes

\textsuperscript{155} 8 U.S.C. § 1641(b) (2000).
\textsuperscript{157} 8 U.S.C. §§ 1611(c)(1)(B), 1621(b) (2000).
\textsuperscript{158} 8 U.S.C. § 1621(b)(1), (3) (2000).
\textsuperscript{160} 8 U.S.C. § 1641(b) (2000).
\textsuperscript{162} 8 U.S.C. § 1621(d) (2000).
enacting health care programs jointly funded by the federal government may extend to otherwise “not qualified” aliens, their constitutionality is analyzed under a rational basis standard because the state has an interest in both complying with national immigration policy and allocating scarce public resources.163

Alternatively, PRWORA allows the state authority to limit the eligibility of “qualified” aliens for state public benefits.164 In practice, however, the constitutionality of state legislation limiting health care benefits to individuals “qualified” under the federal scheme will be evaluated under strict scrutiny and the Equal Protection Clause of the Fourteenth Amendment.165 Furthermore, PRWORA may preempt state statutes that restrict alien eligibility for public benefits when the application of the state statute impacts immigration.166

Many illegal immigrants are concerned that federal authorities will discover their immigration status if they receive federal, state or local subsidies.167 State legislation may not preempt access to information possessed by the Department of Homeland Security’s Bureau of Citizenship and Immigration Service168 regarding the immigration status of an alien in the United States, whether lawful or unlawful.169 PRWORA requires that the United States Attorney General establish procedures by which a state or local government can verify immigration status at the time an alien applies for a federal, state, or local health care benefits.170

Thus, the impact of PRWORA on aliens “not qualified” for federal benefits is considerable, as it limits benefits for health care to emergency medical conditions, immunizations, and treatment for communicable diseases.171 Any state may elect to extend state and local benefits to this

166. See League of United Latin Am. Citizens v. Wilson, 997 F. Supp. 1244, 1253-55 (C.D. Cal. 1997) (noting that in De Canas v. Bica, 424 U.S. 351 (1976), the Court articulated a three part test to determine whether a state statute related to immigration is preempted by federal law and under that test, the Court determined that the state initiative denying illegal aliens access to benefits or public services was preempted by PRWORA).
167. Park, supra note 9, at 569-70.
171. Costich, supra note 9, at 1057 (noting that since immigrants are more likely than citizens to be uninsured, restrictions on eligibility for government-funded health care coverage impair access to health care for immigrants to a greater extent than to U.S.
population at the state’s sole expense; however, to date only three states have chosen to do so. Furthermore, PRWORA deters access to health care for illegal immigrants through provisions that potentially initiate deportation proceedings.

Alternatively, aliens are constitutionally protected against state statutes that on their face or as-applied limit health care benefits to aliens otherwise “qualified.” States that statutorily extend limitations or bar public health care either through Medicaid or another independent medical assistance program to otherwise “qualified” indigent aliens will trigger strict scrutiny analysis under the Equal Protection Clause of the Fourteenth Amendment, which will likely lead to a finding of unconstitutionality. In addition, state statutes that classify aliens by immigration status and then determine availability of health care benefits based upon that classification are preempted by PRWORA and thus unlawful.

D. Congress mandates all persons to receive health care services for an emergency medical condition.

In 1986, Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA), which ensures that all persons have equal access to emergency medical care, regardless of insurance coverage or the ability to pay for health care services. Prior to the enactment of EMTALA, neither state actions nor federal legislation successfully enforced an
affirmative duty of the health care provider to provide health care services
to all persons presenting to an emergency department.\textsuperscript{180} Under the
provisions of EMTALA, hospitals or physicians that fail to meet
appropriate standards for patient care are subject to substantial monetary
penalties assessed by the Office of the Inspector General, possible
termination of Medicare participation imposed by the Centers for Medicare
and Medicaid Services (CMS),\textsuperscript{181} and civil actions by injured plaintiffs or
hospitals claiming financial loss from an inappropriate transfer.\textsuperscript{182}

Specifically, EMTALA requires a hospital with an emergency
department to provide a medical screening examination to any requesting
individual whether or not that individual is eligible for federal health care
benefits.\textsuperscript{183} When the hospital determines the person in the emergency
department has an emergency medical condition, the hospital must either
stabilize the medical condition\textsuperscript{184} or transfer the person to another medical
facility.\textsuperscript{185} The Social Security Act defines an emergency medical condition
as a medical condition, including emergency labor and delivery,
manifesting itself by acute symptoms of sufficient severity, including
severe pain, such that the absence of immediate medical attention could
reasonably be expected to result in placing the patient's health in serious
jeopardy, serious impairment to bodily functions, or serious dysfunction of
any bodily organ or part.\textsuperscript{186}

The obligations of a hospital and physician faced with an individual
presenting herself to a qualified emergency department are satisfied under
EMTALA if: (1) the medical screening exam identifies an emergency
medical condition and the person is admitted to the hospital as an in-patient
for further treatment; (2) the medical screening examination fails to identify
an emergency medical condition; (3) the medical screening exam identifies

\textsuperscript{180} Act provided federal grants to states for the construction of hospitals and required those
hospitals to: (1) provide services to all persons residing in the area for as long as the entity
existed, known as the community service obligation; (2) maintain an emergency room and
provide emergency services to all persons without regard to an ability to pay; and (3)
participate in Medicare and Medicaid).

\textsuperscript{182} Brian Kamoie, \textit{EMTA: Dedicating an Emergency Department Near You}, 37 J.
HEALTH L. 41, 45 (2004); see Collins v. DePaul Hosp., 963 F.2d 303, 307 (10th Cir. 1992)
(noting that EMTALA is not a federal malpractice law because negligent care, if
evenhanded, is not considered to be a violation of EMTALA).

\textsuperscript{183} 42 U.S.C. § 1395dd(a) (2000).


an emergency medical condition that requires transfer to another facility; or (4) the person requests transfer to another facility. However, the EMTALA obligation remains with the transferring hospital until arrival at the receiving hospital. CMS has concluded that the conditions of participation under Medicare satisfy these EMTALA requirements for persons admitted to a hospital.

Thus, EMTALA represents an unfunded mandate for health care providers to provide limited health care services to every person that presents to an emergency room and requests treatment. Because uninsured persons and Medicaid enrollees receive little resistance to entry under EMTALA, they tend to seek health care services in the emergency department rather than from a physician’s office. In effect, the hospital emergency department has become the primary care treatment center or safety net provider for persons whose insurance status otherwise bars access to the free market health care system.

V. HEALTH CARE DELIVERY IN THE UNITED STATES HAS EVOLVED FROM A CHARITY-BASED SYSTEM TO A FREE MARKET SYSTEM WITH FEW TAX INCENTIVES

A. The United States health care system has traditionally provided services to all persons, despite an inability to pay.

Until the late 1800s, the poor and the sick were cared for in charitable hospitals. Hospital income was derived largely or entirely from voluntary charitable donations, not government subsidies, taxes, or patient fees. Generally, patients with sufficient means in need of medical treatment and their private physicians avoided care in any hospital because

---

188. Id.
189. Id. (noting that the governing body of a Medicare participating hospital must ensure its medical staff has written policies and procedures for appraising emergencies, initial treatment, and referral (when appropriate), including a discharge planning process that applies to all patients, reflected in a hospital-wide quality assurance program and medical staff bylaws).
190. Singer, supra note 115, at 625.
191. Lee, supra note 178, at 166.
192. See Bruce Siegal et al., Health Reform and the Safety Net: Big Opportunities; Major Risks, 32 J.L. MED. & ETHICS 426, 427 (2004) (noting that since the passage of EMTALA, hospital emergency departments have been transformed into safety net providers for uninsured persons).
194. Id.
hospitals had a dual role of caring for the medical problems as well as the social problems associated with indigence.  

By the 1920s, hospitals transformed from charitable institutions to free market medical treatment facilities primarily financed by payments from patients.  

Technical advancements in medical treatment, particularly in the fields of surgery and anesthesia, produced large increases in the cost of delivering health care, thus raising hospital budgets accordingly.  

The desire to maximize revenues forced hospitals to focus attention on attracting paying patients and the physicians that served them.  

Hospitals had “gone from treating the poor for the sake of charity to treating the rich for the sake of revenue,” while physicians, once prohibited from charging patients for care provided in hospitals, now routinely charged patients for hospital services.  

Once completed, this “revolution in health care” transformed a “healing profession” into an “enormous and complex industry, employing millions of people and accounting for a substantial proportion of our gross national product.”

Today, delivery of charitable health care services to the uninsured and indigent is provided by a “safety net” of health care providers.  

Broadly defined, the “safety net” includes community health centers, public health department clinics, rural health clinics, free clinics, individual physician practices that provide health care services to indigent and uninsured patients, and any for-profit or non-profit hospital with an emergency department as defined by EMTALA.  

Safety net providers are dependent upon government financing, typically a blend of Medicaid, federal and state grants, Disproportionate Share Hospital (DSH) funding, and local taxpayer support.

195. Id. at 270 n.7.  
196. Id. at 270.  
197. Id. at 270 n.9.  
198. Utah County, 709 P.2d at 270 n.9.  
199. Id. at 271.  
200. Id. at 272.  
201. Siegel, supra note 192, at 426.  
202. Id.  
203. Id. at 427 (stating that federal Medicaid DSH payments to hospitals in 2003 totaled approximately $8.6 billion and in 2004 federal grants to community health centers were over $1.62 billion); see also John D. Blum, Longevity and the Future Challenges of Health Policy: The Physical Extension of Life May Be the Single Greatest Accomplishment of the 20th Century, 11 EXPERIENCE 4, 8 (2001) (noting there is no unifying regulatory scheme in health care, but rather a bizarre quilt of federal and state initiatives, that along with the pressures of the market, work to deliver services and structure the composition and types of agents that provide health care).
B. Health care facilities can recoup losses from uncompensated care through non-profit status.

For over one hundred years, federal, state, and local governments have recognized the importance of awarding hospitals relief from corporate income and property tax in exchange for providing health care to the poor and indigent. The rationale is that the shift of the cost to provide free charity care offsets any loss to the government's revenue. Currently, the Internal Revenue Code (I.R.C.) § 501(a) provides that federal income tax exemption applies to "charitable" organizations described in I.R.C. § 501(c)(3). Charitable in this context "reflects the common law and the substantial value accorded to nonprofit care for the sick." The Internal Revenue Service (I.R.S.) in its 1969 Revenue Ruling 69-545 recognized the "promotion of health" as a charitable purpose when a "community benefit" standard is met. To date, the I.R.S. has not quantified the amount of charity care a hospital must provide to meet this standard.

A hospital's federal income tax exemption status under I.R.C. § 501(c)(3) does not automatically guarantee property tax exemptions under state and local laws. In addition, federal law does not require property tax exemption by state law in order to satisfy provisions of I.R.C. § 501(c)(3). However, most states look to the language of I.R.C. § 501(c)(3) when determining if any given hospital satisfies the charitable contribution required to receive property tax relief. The federal government's relaxed standards on the amount of charity care required by a

205. I.R.C. § 501(c)(3) (2000) (providing for the exemption from federal income tax of corporations organized and operated exclusively for religious, charitable, scientific, or educational purposes, provided no part of the organization's net earnings inures to the benefit of any private shareholder or individual).
208. Neville M. Bilimoria, Patients Challenge Nonprofit Hospital's Charitable-Care Practices, 93 Ill. B.J. 134, 135 (2005); see also Standards for Tax-Exemption, CCH Health Care Compliance Professional's Manual 20, 870 (2005) (requiring hospitals to operate in charitable manner and maintain relationships, practices, and agreements that do not result in private interests).
209. Bilimoria, supra note 208, at 136.
210. Id.
hospital to qualify for tax exemption impacts state and local governments through loss of property tax revenue. Estimates indicate that nonprofit hospitals in the United States currently receive exemptions of over four billion dollars for each federal, state, and local tax jurisdictions.

C. Federal and state governments provide incentives for physician volunteerism.

Reflective of a social contract, approximately two-thirds of all physicians provide charity care. Yet, federal, state and local governments do not consider physician health care providers for tax incentives similar to those afforded to hospital entities under nonprofit status when providing charity care. Only Virginia recognizes physician tax credits for the delivery of free health care services in a nonprofit health care facility, which are based on Medicaid reimbursement schedules and are not to exceed $125 per hour.

Since the 1960s, federal and state governments have enacted legislation to provide financial incentives and relief from medical malpractice liability for physicians who have volunteered their services in underserved areas or to designated charitable activities. Financial incentives took the form of increased reimbursement for practice in underserved areas, cancellation of loans to physicians that serve in those areas, loans and grants to establish and maintain clinics, subsidy of medical malpractice insurance, money given to rural hospitals and communities to attract and retain physicians, and state assistance for resident training in primary care fields.

In 1997, Congress passed the Volunteer Protection Act (VPA), which protects all volunteers working for nonprofit organizations or other government entities from liability for certain harms caused by their acts or omissions during the course of service. Under the VPA, physician

---

212. Burns, supra note 206, at 679.
217. Id. at 822-24.
immunity extends to acts of simple negligence and limits gross negligence to acts proven by clear and convincing evidence of willful and wanton conduct. Although the VPA preempts state law from offering fewer protections, the VPA allows states to enact legislation providing physicians with greater protections.

Thus, a physician doing business in the free market of health care receives no tax benefit or relief from medical malpractice liability when providing "routine" charitable care to the uninsured or Medicaid patient. On the contrary, the current general climate of low physician reimbursement rates, rising overhead costs, and rising malpractice premiums has fueled certain entrepreneurial activities on the part of physicians. Many primary care physicians have chosen to limit their practice to insured patients that pay an additional retainer fee for "concierge care," also known as "boutique medicine." Specialist physicians, particularly in the fields of cardiac care, neurosurgery, and orthopedics have financed specialty care hospitals. Such specialty care facilities have produced large financial returns for physician investors while selectively providing health care services to insured patients. Furthermore, specialty care hospitals lack an emergency department and are not required to provide treatment for emergency medical conditions under EMTALA.

VI. THE FOUNDATION OF THE UNITED STATES HEALTH CARE SYSTEM

Universal health care is best defined as equal access to equal quality health care services by all individuals. Arguably, every person with sufficient funds in the United States has an equal protection right of access to all health care services. Access to the health care system is directly dependent upon access to sufficient funds. The foundation of the U.S.
health care system as embodied by the U.S. Constitution, Supreme Court jurisprudence, state constitutions, and federal and state statutes will never support universal health care funding under such strict a definition for the following reasons:

1) The Constitution does not explicitly identify health care as a fundamental right. The impact of this omission is to subject all federal and state legislation to a mere rationality standard, thereby allowing denial of health care funding to classes of individuals based upon wealth and immigration status. Only an amendment to the Constitution or ratification of a binding international treaty would result in changing this position, and the likelihood of such an outcome is remote.226

2) For over two hundred years, the Supreme Court has consistently interpreted the Constitution and the Bill of Rights as not explicitly or impliedly providing an individual a fundamental right to health care. The Court can be expected in the future to remain unchanged in its position that social and economic rights are not fundamental.227

3) Congress has the prerogative of qualifying individuals for federal health care funding. Theoretically, federal funding for health care could be extended to all qualified persons as a single-payor system replacing Medicaid and traditional employer-based health insurance. “Socialization” of health care is widely criticized because it is inconsistent with the free market and freedom to contract ideology.228 Furthermore, government-run programs have the potential to increase cost, diminish options for access, and compromise quality of care.229 A federally-funded single-payor health care system would not provide funding to millions of

226. Davis, supra note 17, at 952 n.4 (indicating that Supreme Court Justice Ginsburg stated that any attempt to amend the Constitution to include fundamental rights such as housing, employment, and health care would create a “far more stunning” defeat than the Equal Rights Amendment for women, which failed in the 1980s).

227. Id. at 964.

228. Carolyn V. Juarez, Liberty, Justice, and Insurance for All: Re-Imaging the Employment-Based Health Insurance System, 37 U. Mich. J.L. Reform 881, 900 (2004); see also Dubay et al., supra note 7, at 8 (noting that the single-payor strategy would likely be a lengthy, uphill battle in the United States, as it has been defeated many times in the past and would certainly meet fierce resistance from a wide array of influential interest groups).

229. Juarez, supra note 228, at 900-01.
individuals currently "not qualified" based upon immigration status, under current federal immigration policy and PRWORA.

4) State governments could extend health care coverage to all persons within their borders, even illegal immigrants, by way of health care legislation or a state constitutional amendment that recognizes health care as a fundamental right.230 Such legislation would pass mere rationality analysis because the state has a legitimate goal of promoting the health and welfare of its citizens. Undoubtedly, however, resource allocation to social programs would certainly prohibit such action.231 Moreover, state-based universal coverage is inherently unfair because the burden of providing state health care funding is unequally dispersed amongst the states, placing the greatest impact on the taxpayers of the state with the greatest proportion of uninsured and Medicaid patients.

In lieu of universal health care, the uninsured and underinsured in this country currently rely on Congress to guarantee: (i) access to health care services for emergency medical care under EMTALA; (ii) tax incentives to non-profit hospitals for providing charitable care; (iii) financial incentives for physicians and protection from malpractice liability in the provision of health care services in underserved areas; and (iv) federal, state and local funding for safety net providers, including community health centers and public hospitals. These assurances represent the "social contract," the agreement that the government will provide certain benefits to its citizens in return for tax-based financing of these benefits.232

VII. CONCLUSION

Universal health care cannot be achieved in the United States due to the strength and complexity of the current health care system. The obstacles to change are substantial; health care is not a fundamental right by

---

230. Weiner, supra note 31, at 333-34 (2002) (reporting that six states — Alaska, Hawaii, Michigan, North Carolina, New York, and Wyoming — have constitutional provisions requiring the legislature to promote and protect the public health. None of these states have interpreted such provision to mean that the state must expand access to health care for the uninsured or underinsured).

231. Id. at 367 (noting that the state has primarily a financial interest in distributing health care resources unequally because its ability to help the uninsured is limited). See also Carol S. Weissert, Promise and Perils of State-Based Road to Universal Health Insurance in the U.S., 7 J. HEALTH CARE L. & POL’Y 42, 65-66 (2004) (stating that all fifty states and the District of Columbia have implemented Medicaid cost containment measures to account for budgetary difficulties).

constitutional language or judicial interpretation, Congress will not rescind immigration policy, and state fiscal budgets are insufficient to provide for distribution of limited state funds. But that is not to say that future legislation cannot have as its intent and effect greater access of the uninsured and Medicaid patient to preventive or non-emergency care.

Federal and state health care funding currently directed to persons that qualify under a need-based formula could be expanded to provide basic health care services to a greater portion of low-wage working persons and their immediate families. To do so would still leave millions of persons with unequal access to the health care system due to immigration status or resistance by health care providers in providing services at undesirable reimbursement rates. Future legislation must provide incentives for physicians in the free market to provide health care service in order to effectively break down the barriers to health care access faced by persons whose coverage reimburses service providers at rates lower than those scheduled by Medicare and those that do not have insurance at all.

Without appropriate incentives, physicians will continue to resist providing charitable care on a voluntary basis. Physician health care providers are the cornerstone of preventive and non-emergency health care. The physician has a choice whether or not to provide health care services to persons without insurance or Medicaid coverage. Although the U.S. health care system evolved from a charity-based system, the free market as it exists provides few substantial incentives for physicians to provide charity care.

From my perspective, physician health care services provided at reimbursement rates less than Medicare rates are considered a “negative payor” and thereby constitute charity care. In exchange for such charitable services, a physician could receive incentives similar to the tax considerations given to non-profit facilities that provide charity care to the uninsured patient or to Medicaid under I.R.C. § 501(c)(3). One method of doing so would require physicians providing such services to electronically bill the state Medicaid agency as per protocol. The “charitable portion” would then be calculated from a scheduled Medicare reimbursement rate less the actual payment received. The physician would then be allowed a federal tax incentive, either in the form of a credit or deduction, which could be applied against his/her personal federal income tax responsibility for that year in which the charitable care was provided. 233

Furthermore, protections provided to physicians under the VPA should be extended to all health care services for the Medicaid and uninsured

233. Physician tax incentives for charitable care and potential ideas for future legislation is the focus of a future article.
patient. Physicians should be protected from liability for certain harm caused by acts or omissions while providing "routine" charitable care. Such legislation would not only further encourage physicians to provide charity care on a routine basis, but also proffer relief from the rising overhead of medical malpractice premium rates by sharing liability with the federal government.

Universal health care for all persons may not be a fundamental right in the United States, but physical access to health care services is fundamental. Opportunity remains within the existing U.S. health care system to break down the economic barriers to health care services experienced by the uninsured and Medicaid populations.