

# Coverage and Care for the Medically Indigent: Public and Private Options

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## I. INTRODUCTION

As of March 1984, about 35 million people had no health insurance coverage, public or private, although some of them were only temporarily uncovered. Up to 40-odd million more, often called the "underinsured," had incomplete coverage.<sup>1</sup> These people, with little or no insurance, need periodic medical attention as much as or more than the well insured, but face far more trouble getting it.<sup>2</sup> Often, they have been forced to rely on the charity of providers, particularly hospitals.

From a hospital's viewpoint, the issue is how much "uncompensated care" to give. As every newspaper reader or "Sixty Minutes" viewer knows, hospitals in today's more competitive environment have more limited ability to care for the needy with public funds or from margins earned caring for the better-off.<sup>3</sup> From the patient's perspective, the problem is access to care. One hears of patients being shuttled from hospital to hospital in search of care, even when the need seems urgent,<sup>4</sup>

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<sup>1</sup>On the numbers of uninsured and underinsured, see *infra* text accompanying notes 11-29.

<sup>2</sup>See *infra* text accompanying notes 27-29.

<sup>3</sup>According to data from the American Hospital Association, for the year ending June 1986, hospitals' net patient margin was only 0.8%; total net margin (including non-patient revenues) was 5.4%, down from 2.0% and 6.3% the previous year. Hosp. Research & Educ. Trust, *Selected Hospital Performance Indicators: June 1985 & 1986*, ECON. TRENDS, Fall 1986, at 5.

<sup>4</sup>See, e.g., Cahan & Pave, *When the Patient Can't Pay the Medical Bill*, Bus. Wk., Feb. 18, 1985, at 59; Taylor, *Ailing, Uninsured and Turned Away*, Washington Post, June 30, 1985, at A1, col. 3.

and of hospitals "dumping" impecunious patients on the nearest public hospital legally obligated to take them.<sup>5</sup> The problems that poor patients have in receiving more routine care from physicians, hospital outpatient departments, or other providers are far less dramatic or well documented.

The intertwined problems of the uninsured population and of uncompensated care have grown rapidly in the recent past and are likely to continue to grow in the near future. Private insurance, public programs, and hospital margins are all in a "cutback" era, and unfortunately, the uninsured are on the cutting edge.<sup>6</sup>

Under our legal system, states and localities bear the ultimate responsibility for fashioning whatever responses are made. Indeed, the uninsured/uncompensated care problem was high on the agenda of most state legislatures during the 1986 sessions and will probably remain so for 1987.<sup>7</sup> Billions of dollars in new assistance seem needed. The current federal administration is unlikely to offer new assistance for these efforts.<sup>8</sup> Thus, it seems likely that the usual American genius for weaving together various strands of partial solutions through varied mechanisms will have to come into play. This Article suggests what such mechanisms may be.

## II. THE NATURE AND EXTENT OF PROBLEMS

### A. *The Medically Indigent and the Uninsured*

The problem of providing health care for those who cannot or do not provide for themselves can be seen from a number of perspectives. In fact, there is no consensus on what "the" problem is. Localities around the country differ tremendously in their populations' medical needs and in their patterns of medical financing and delivery, and there is probably even more diversity in practical and philosophical approaches to proposed solutions in each area. Some people are concerned only about providing emergency care for the very poor and uninsured; others worry that even many insured people are not well covered and hence cannot pay, in full, providers who treat them.

Nevertheless, it seems clear that insufficient financing adversely affects access to care and, thus, the health of the medically indigent. By

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<sup>5</sup>See, e.g., Schiff, Ansell, Schlosser, Idris, Morrison & Whitman, *Transfers to a Public Hospital*, 314 NEW ENG. J. MED. 552 (1986); Wrenn, *No Insurance, No Admission*, 312 NEW ENG. J. MED. 373 (1985); *The 'Dumping' Problem: No Insurance, No Admission* (letters) 312 NEW ENG. J. MED. 1522 (1985); Knox, *Some Local Hospitals 'Dump' The Uninsured*, Boston Globe, Feb. 6, 1984, at 31, col. 2.

<sup>6</sup>See *infra* text accompanying notes 46-64.

<sup>7</sup>See, e.g., INTERGOVERNMENTAL HEALTH POLICY PROJECT, GEORGE WASHINGTON UNIV., *MAJOR CHANGES IN STATE MEDICAID AND INDIGENT CARE PROGRAMS* (July 1986).

<sup>8</sup>See *infra* note 63.

“medically indigent,” this Article means the class of people who cannot afford necessary medical care from their own resources or from health insurance coverage, if any.<sup>9</sup> It should be noted that the Article follows general usage by recognizing that even middle class people can become “medically” indigent when their net medical bills, after insurance, are very high relative to their income and assets. Of course, the likelihood of medical indigency is far less for such people than it is for those who begin with low incomes and little or no insurance coverage.

### B. *The Uninsured: Number and Characteristics*

People without public or private health insurance are the core of the medical indigency problem.<sup>10</sup> People who have coverage, but coverage that does not fully protect against catastrophic losses—and hence against medical indigency—are a lesser problem.<sup>11</sup>

How many people are uninsured and face problems of medical access? Who are they and why do they lack resources? How much care do they get now? What is the extent of the financial shortfall? All of these pertinent questions can be answered only imperfectly from available evidence.

To understand who lacks coverage, one must appreciate how most

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<sup>9</sup>None of the three elements—necessary care, poverty, and lack of (adequate) insurance—readily allows of a clear-cut, operational definition. Opinions vary greatly on how much medical care is truly needed, on how poor one must be to be truly needy, and on what constitutes inadequacy in insurance. Moreover, deciding on medical indigency in advance of a known level of medical need (or spending) is even more difficult.

<sup>10</sup>“Insurance” as used here means any financing method available to a patient other than out-of-pocket payment or charity. Public coverage includes Medicare, Medicaid, and other medical assistance plans. Private coverage need not be “insurance” under the state insurance code. It may be conventional coverage from a commercial life and health insurance company, such as Prudential, or from a not-for-profit Blue Cross/Blue Shield plan; or it may be one of many alternative styles of coverage from a health maintenance organization (HMO), a preferred provider organization (PPO), or some other financing and delivery entity. Finally, it may resemble any of the above but be managed on a self-insured basis by an employment group that “insures” its own risk rather than placing it with a separate insurer.

<sup>11</sup>Such people generally have coverage for routine hospital stays and some physician and other services as well, but not for very large medical expenses. At some point, their uncovered bills become sizable compared with their income (especially if they cannot work), and they become medically indigent. The best estimate of the extent of such problems comes from 1977 national survey data indicating that 13% of the population under 65 was uninsured. Depending on the definitions applied, an additional 10 to 24% of the under-65 population is *underinsured*. The smaller figure consists of those who have at least a 5% expectation of out-of-pocket expenses exceeding 10% of annual family income; the larger figure includes all those whose insurance does not limit out-of-pocket hospital expenses. Farley, *Who Are the Underinsured?*, 63 MILBANK MEM. FUND Q. 476 (1985); see also M. SULVETTA & K. SWARTZ, *THE UNINSURED AND UNCOMPENSATED CARE* 3, 19 (1986) (Tables 1 and 4).

Americans are covered. After World War II, private health insurance grew by leaps and bounds. Provided largely as a fringe benefit of employment, private coverage was greatly encouraged by its exclusion from income taxation and its inclusion as a subject of collective bargaining.<sup>12</sup> In 1965, public coverage took a quantum leap with the congressional enactment of Medicare, largely for the aged, and Medicaid, for the "deserving" poor, as defined by participating states.<sup>13</sup> Coverage continued to expand through the 1970's, not only in terms of the number of people covered but also in the breadth and depth of the benefits provided;<sup>14</sup> as a result, the number of uninsured people declined.<sup>15</sup>

In contrast, the early 1980's saw a rise in the number of people without coverage,<sup>16</sup> for reasons considered below. As of early 1984, about 35 million people under age sixty-five, or about seventeen percent of them, reported that they lacked health coverage at the time surveyed. Most of them were probably uninsured for the full year, some for only part of the year.<sup>17</sup>

Table 1 shows the growth in the uninsured population between 1977 and 1984.

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<sup>12</sup>In 1945, only 32 million people were privately covered for hospital inpatient care; by 1965, 139 million were. HEALTH INS. ASS'N. OF AMERICA, SOURCE BOOK OF HEALTH INS. DATA, 1986 UPDATE, Table 1.1, at 3. The average marginal "tax subsidy" for U.S. workers has been estimated to exceed 35% of premiums, C. PHELPS, TAXING HEALTH INSURANCE: HOW MUCH IS ENOUGH? (The Rand Corporation, Report P-6915, 1983), or about 10% of total private health insurance spending, CONGRESSIONAL BUDGET OFFICE, CONTAINING MEDICAL CARE COSTS THROUGH MARKET FORCES (May 1982). See generally Pauly, *Taxation, Health Insurance and Market Failure*, 24 J. ECON. LIT. 629 (1986).

<sup>13</sup>Social Security Act, tit. XVIII & XIX, 42 U.S.C. §§ 1395, 1396 *et. seq.* (1982 & Supp. 1985).

<sup>14</sup>See HEALTH INS. ASS'N OF AMERICA, *supra* note 12.

<sup>15</sup>K. SWARTZ, WHO HAS BEEN WITHOUT HEALTH INSURANCE? CHANGES BETWEEN 1963 AND 1979 (Urban Institute, 1984).

<sup>16</sup>M. SULVETTA & K. SWARTZ, *supra* note 11, at 1, 3; see also HEALTH INS. ASS'N. OF AMERICA, *supra* note 12.

<sup>17</sup>M. SULVETTA & K. SWARTZ, *supra* note 11, at 3; see also K. SWARTZ, INTERPRETING THE ESTIMATES FROM FOUR NATIONAL SURVEYS OF THE NUMBER OF PEOPLE WITHOUT HEALTH INSURANCE: A PROJECT SUMMARY REPORT (Urban Institute, 1985). Surveys done in 1977 and 1980 compared those without coverage for the full year with those uncovered only part of the year. About three-quarters of those uninsured at a single point in time were uninsured all year; about 9% of 13%, for the 1977 survey. An additional 4% were uninsured part of the year. See M. SULVETTA & K. SWARTZ, *supra* note 11, at 3; Friedman, *Health Insurance and Cross-Subsidization*, HOSPITALS, Oct. 16, 1985, at 126. (interview with Jack Hadley and Katherine Swartz). Most estimates of the uninsured exclude people aged 65 and older because virtually all of them are now covered by Medicare, after the expansions of recent years to include federal workers and others.

TABLE 1  
INCREASES IN THE UNINSURED OVER TIME  
(SELECTED SURVEY ESTIMATES, UNDER AGE 65)

Year	Millions of Uninsured	Percentage of Population
1977	26.2	13.8%
1978	26.0	13.7
1980	28.6	14.6
1982	30.7	15.2
1983	32.7	16.1
1984	35.1	17.1

(adapted from M. SULVETTA & K. SWARTZ, *supra* note 11, Table 1).

Why have the numbers of uninsured people climbed? One reason is Medicaid cutbacks in eligibility, encouraged by recession-induced shortfalls in expected state revenues and required or encouraged by federal welfare and Medicaid changes in 1981.<sup>18</sup> Medicaid now covers only about forty percent of people below the poverty line.<sup>19</sup>

The recession of the early 1980's also put many people at least temporarily out of work and hence out of private health coverage as well.<sup>20</sup> Unemployment was especially high in heavy industry, hit by both recession and intensifying foreign competition. Jobs lost in this sector, traditionally the best insured area of the economy, often were not regained, and replacement jobs in service and other industries were far less likely to offer employer-paid health insurance.<sup>21</sup>

<sup>18</sup>See generally R. BOVBERG & J. HOLAHAN, *MEDICAID IN THE REAGAN ERA: FEDERAL POLICY AND STATE CHOICES* (1982); J. HOLAHAN & J. COHEN, *MEDICAID: THE TRADE-OFF BETWEEN COST CONTAINMENT AND ACCESS TO CARE* (1986). Medicare eligibility cutbacks, in contrast, have been minimal, largely achieved through administrative revisions in disability standards.

<sup>19</sup>J. HOLAHAN & J. COHEN, *supra* note 18. Medicaid covers about one-third of poor adults, one-half of poor children. *Id.* at 47. However, for various reasons, about one-third of Medicaid recipients have incomes *above* poverty levels. Conversely, the main reason so many poor people are not covered under Medicaid is the program's categorical nature; only certain categories of poor people can qualify. Notably, childless people and intact families are generally ineligible. *But see infra* notes 237, 239. Cutbacks among even eligible groups are also responsible. See J. HOLAHAN & J. COHEN, *supra* note 18.

<sup>20</sup>See, e.g., *Health Insurance for the Unemployed: Hearing Before the Subcomm. on Health of the Senate Comm. on Finance*, 98th Cong., 1st Sess. (1983); STAFF OF SUBCOMM. ON HEALTH AND THE ENVIRONMENT OF THE HOUSE COMM. ON ENERGY AND COMMERCE, 98TH CONG., 1ST SESS., *REPORT ON HEALTH BENEFITS: LOSS DUE TO UNEMPLOYMENT* (Comm. Print 1983).

<sup>21</sup>See, e.g., K. SWARTZ, *THE CHANGING FACE OF THE UNINSURED* (Urban Institute, May 1984); Friedman, *The Right Issue at the Wrong Time*, *CHA INSIGHT*, June 9, 1986, at 1; Friedman, *supra* note 17, at 126-27; see also *infra* note 45.

Moreover, even those who retained coverage at work in the 1980's often have found their coverage cut back. Cutbacks have taken the form of increased requirements for patient cost sharing, utilization review, and the like,<sup>22</sup> as well as decreased employer payment of insurance premiums, especially for dependents.<sup>23</sup>

What explains the lack of insurance among non-poor working adults? Obviously, their employers have not bought them insurance. Type of employment also matters, especially size of employment group, because insurance is much cheaper for large groups than for small ones or for individuals.<sup>24</sup> Beyond workplace characteristics comes individual willingness to pay for coverage; presumably nonbuyers either cannot afford coverage that is attractive to them or they do not appreciate its value.

One of the most discouraging findings of recent surveys is that households that contain at least one insured adult also contain many uninsured dependents. In fact, one third of all uncovered children—over 3 million children—came from such households.<sup>25</sup> Although direct causation is not established, presumably this lack of coverage reflects the worker's choice not to pay the additional amount necessary to obtain family coverage.<sup>26</sup>

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<sup>22</sup>See, e.g., J. CALIFANO, *AMERICA'S HEALTH CARE REVOLUTION: WHO LIVES? WHO DIES? WHO PAYS?* (1986); P. FOX, W. GOLDBECK & J. SPIES, *HEALTH CARE COST MANAGEMENT: PRIVATE SECTOR INITIATIVES* (1984).

<sup>23</sup>See, e.g., BUREAU OF LABOR STATISTICS, U.S. DEP'T OF LABOR, *EMPLOYEE BENEFITS IN MEDIUM AND LARGE FIRMS, 1985* (1986). Having to pay for dependents out of pocket, with after-tax dollars, is a major disincentive to buying coverage, especially when that coverage features increasingly higher deductibles and coinsurance.

<sup>24</sup>On economies of larger-scale insurance, see, e.g., Bovbjerg, *Insuring the Uninsured Through Private Action: Ideas and Initiatives*, 23 *INQUIRY* 403 (1986). On large versus small employers, see, e.g., Moyer & Cahill, *HHS Survey Illustrates Difference in Large, Small Employers' Health Plans*, *BUS. & HEALTH*, Nov. 1984, at 50. Unfortunately for insurance coverage, some two-thirds of new jobs are created in small firms, mainly in the service industry. See, e.g., *In Praise of Pizza Parlours*, *THE ECONOMIST*, May 17, 1986, at 75. See generally Monheit, Hagen, Berk & Farley, *The Employed Uninsured and the Role of Public Policy*, 22 *INQUIRY* 348 (1985) (characteristics of employment that affect coverage).

<sup>25</sup>Friedman, *supra* note 17, at 128.

<sup>26</sup>Two other possible reasons for a decline in insurance coverage deserve brief mention. For various reasons, the proportion of households headed by women has risen, and these households are less likely than male-headed ones to have coverage, especially given Medicaid acts. See *id.* at 128. Moreover, to an unknown extent, more individuals have probably become "uninsurable" in the private market, especially outside of large employment group plans. Such people include those with chronic conditions needing care or adverse medical histories that put them at high risk of significant expense; they cannot get ordinary coverage without major exclusions. See, e.g., Gottschalk, *People with Chronic Diseases Often Find Insurance Is Unaffordable—or Unavailable*, *Wall St. J.*, Aug. 12, 1986, at 29, col. 3. This phenomenon is an unfortunate side effect of progress; medical treatment now saves many who formerly would have died (e.g., through better emergency care or cardiac resuscitation) but who now survive with an adverse health history. Additionally, medical

Who are the uninsured? They fit no simple stereotype. Common expectations are that the uninsured are exclusively poor, unemployed, young, and nonwhite. Persons with any of those characteristics are indeed at higher risk of being uninsured, as Table 2 shows.

TABLE 2  
SOME CHARACTERISTICS THAT PUT PEOPLE AT HIGH RISK  
OF BEING UNINSURED (1984)

Group	Percentage Not Insured	Relative Risk
Entire under-65		
Population	15.2%	1.00
Unemployed Adults	33.6%	2.21
Income Below Poverty		
Line	33.8%	2.22
Age 18-24	29.0%	1.91
Children Age 0-18		
Below Poverty Line	34.1%	2.24
Blacks Age 18-64	25.0%	1.64
Never Married Males	30.6%	2.01
Married Female,		
Spouse Absent	36.0%	2.37
Children in Single-Parent		
Household	34.2%	2.25
Adults with No High		
School Diploma	25.5%	1.68

(computed from M. SULVETTA & K. SWARTZ, *supra* note 11, *passim*).

But, in fact, most of the uninsured have family incomes at least somewhat above the poverty line, are employed, are adults, and are white, as Table 3 shows. These people may thus seem less appealing for consideration as medical indigents; still, medical bills of a substantial size would clearly throw most of these people into the medically indigent category.

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diagnosis has improved physicians' ability to predict future problems and hence insurance expenses; the most glaring example is screening for antibodies to the acquired immune deficiency syndrome (AIDS) virus.

TABLE 3  
THE SHARE OF THE UNINSURED CONTRIBUTED BY GROUPS  
WITH CERTAIN CHARACTERISTICS (1984)

Characteristic	Percentages* of Under-65 Uninsured Who Are
Family Income (All Ages)	Below Poverty - 35.6%
	1 to 2x Poverty - 29.3%
	2 to 3x Poverty - 15.4%
	Over 3x Poverty - 19.7%
Employment Status (Adults, 18-64)	Employed - 56.5%
	Housekeeping - 15.2%
	School - 7.2%
	Unemployed - 12.1%
	Unable to work, early retirement - 8.9%
Age	0-17 - 33.0%
	18-24 - 23.6%
	25-44 - 27.4%
	45-64 - 16.0%
Race (Adults)	White - 79.3%
	Black - 17.3%
	Other - 3.5%

\*Percentages in each group may not add to 100.0% because of rounding.  
(adapted from M. SULVETTA & K. SWARTZ, *supra* note 11, *passim*).

### C. Problems Posed by Lack of Coverage

1. *Poor Access to Care and Poor Health for the Uninsured.*—Uninsured people get less medical care, for a combination of reasons: they seek less care on their own, they are referred less often for specialized care or hospitalization, or they are turned away or otherwise discouraged by some providers.<sup>27</sup> The uninsured are far more likely not to have a regular source of care and much less likely to use medical services than are the insured, as Table 4 indicates.

<sup>27</sup>See Aday & Andersen, *The National Profile of Access to Medical Care: Where Do We Stand?*, 74 AM. J. PUB. HEALTH 1331 (1984); see also Davis & Rowland, *Uninsured and Underserved: Inequities in Health Care in the United States*, 61 MILBANK MEM. FUND Q. 149 (1983); ROBERT WOOD JOHNSON FOUNDATION, UPDATED REPORT ON ACCESS TO HEALTH CARE FOR THE AMERICAN PEOPLE (Special report no. 1, 1983). For a more rousing portrait of the uninsured's problems, see Dallek, *Six Myths of American Medical Care: What the Poor Really Get*, HEALTH/PAC BULL., May-June 1985, at 9.

TABLE 4  
HOW INSURANCE STATUS AFFECTS MEDICAL CARE

Indicator of Medical Use	Insured	Uninsured
Physician visits per person under age 65 in 1977	3.7	2.4
Hospital patient days per 100 persons under age 65 in 1977	90.0	47.0
Families who needed care but did not receive it in 1982	4.8%	15.0%
Families who did not see a physician in 1982	17.1%	32.9%
People with no regular source of health care in 1982	9.7%	23.1%

(adapted from M. SULVETTA & K. SWARTZ, *supra* note 11, at 4 (citing Davis & Rowland, *supra* note 27; ROBERT WOOD JOHNSON FOUNDATION, *supra* note 27)).

It is undocumented to what extent reduced access to care hurts the health of the uninsured, but it is reasonable to assume that their health does suffer.<sup>28</sup> Thus, the uninsured are generally thought to be sicker than the insured, a difference probably reflecting not only reduced medical attention as such but also low income, inability to work, depression from unemployment, and possibly other factors as well.<sup>29</sup>

2. *Uncompensated Care for Providers.*—Much of the recent concern over lack of health coverage derives from hospitals' fears of "uncompensated care," which is a frequent result of treating uninsured persons.<sup>30</sup> Uncompensated care consists of both charity care (provided to the indigent with no expectation of payment) and "bad debts" (unpaid bills of those expected to pay).<sup>31</sup> In 1982, about five or six percent of total hospital charges went uncompensated.<sup>32</sup> Because aggregate hospital charges

<sup>28</sup>See generally Munding, *Health Service Funding Cuts and the Declining Health of the Poor*, 313 NEW ENG. J. MED. 44 (1985).

<sup>29</sup>Empirical evidence on this point is weak. *Cf. id.* (loss of access to medical care hurts health); Davis & Rowland, *supra* note 27, at 165-66 (15% of uninsured rate health as fair or poor, vs. 11% of insured; sick uninsured have 4.1 physician visits annually, vs. 6.9 for sick insured).

<sup>30</sup>See generally UNCOMPENSATED HOSPITAL CARE: RIGHTS AND RESPONSIBILITIES (F. Sloan, J. Blumstein & J. Perrin eds. 1986) [hereinafter UNCOMPENSATED HOSPITAL CARE].

<sup>31</sup>It does not include "contractual allowances" or "discounts" below charges or costs that some hospitals give to some insurers' patients by virtue of participation agreements (as for Blue Cross/Blue Shield plans in many areas) or special negotiations (as for "preferred provider" arrangements under which hospitals trade a discount for more insured patients). Sloan, Valvona & Mullner, *Identifying the Issues: A Statistical Profile*, in UNCOMPENSATED HOSPITAL CARE, *supra* note 30, at 16.

<sup>32</sup>M. SULVETTA & K. SWARTZ, *supra* note 11 at 25; Sloan, Valvona & Mullner, *supra* note 31, at 16, 19. The latter put 1982 uncompensated hospital care at \$6.2 billion, or 5 percent of charges, and 6 percent of total receipts; using different survey data, the former put the 1982 level at \$7.5 billion.

exceed costs or revenues, the percentage of uncompensated care is about a percentage point lower when expressed as a fraction of hospital budgets.<sup>33</sup>

The burden of uncompensated care is not spread evenly across providers. Public hospitals provide a vastly disproportionate amount of uncompensated care (40.1% of uncompensated charges, double their 19.0% share of total charges), as do major teaching hospitals (35.8% of uncompensated charges vs. 24.0% of total charges), and large city hospitals generally (49.1% of uncompensated charges vs. 39.1% of all charges).<sup>34</sup> Whether for-profit hospitals contribute their "fair share" relative to similar not-for-profit community hospitals is hotly debated.<sup>35</sup>

It is not reliably known what share of uncompensated hospital care goes to indigents. Charity is said to constitute about one third of uncompensated care,<sup>36</sup> but there is no single accepted operational definition of "charity care." Existing accounting practices allow hospitals discretion in applying classification standards for charity care, and reported charity varies by hospital.<sup>37</sup> Thus, there is no guarantee that reported hospital "charity" accords with social expectations or public desires with regard to the medically indigent.<sup>38</sup>

How is "uncompensated care" financed? After all, institutions like hospitals cannot give charity without themselves incurring costs. Individual professionals can donate "free" personal attention, time, and skill beyond normal working hours. But hospital care involves ancillary services, supplies, or multiple personnel which must be paid for with revenue from some source.

The conventional wisdom is that hospitals cross-subsidize nonpaying

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<sup>33</sup>See *supra* note 32. According to data collected by the American Hospital Association, this amount increases to 5.6% by 1984. See *infra* note 61.

<sup>34</sup>M. SULVETTA & K. SWARTZ, *supra* note 11, at 28, 31, 30.

<sup>35</sup>See generally FOR-PROFIT ENTERPRISE IN HEALTH CARE 97-126, 209-23, 225-32 (B. Gray ed. 1986) [hereinafter FOR-PROFIT-ENTERPRISE] (asserts that for-profit hospitals do not contribute enough). But see Sloan & Becker, *For-Profits v. Non-Profits: A Phantom Issue*, TECH. REV., April 1984, at 11.

<sup>36</sup>See, e.g., Cohodes, *America: The Home of the Free, the Land of the Uninsured*, 23 INQUIRY 227, 228 (1986) (charity care comprises one-third of uncompensated care); see also Sloan, Valvona & Mullner, *supra* note 31, at 19 (of 1982's \$6.2 billion in uncompensated charges, hospitals designated \$1.7 billion as charity, \$4.5 billion as bad debt).

<sup>37</sup>FOR-PROFIT ENTERPRISE, *supra* note 35, at 102; Sloan, Valvona & Mullner, *supra* note 31, at 19. More defined descriptions do exist for Hill-Burton purposes. See *infra* notes 121-31.

<sup>38</sup>In fairness to hospitals, it must be noted that there is little consistency in public programs' definition of indigency for purposes of eligibility determinations. One of few existing uniform standards is that established by the federal Department of Health and Human Services—belatedly, under pressure of repeated litigation—to measure hospitals' adherence to Hill-Burton requirements to deliver "free" care to indigents. See FOR-PROFIT ENTERPRISE, *supra* note 35, at 102. See also *infra* notes 121-28 and accompanying text.

patients largely with revenues earned from paying patients, especially those who pay hospital charges (or whose insurers do), since charges are higher than costs.<sup>39</sup> Lesser sources of revenue include philanthropic contributions, nonpatient revenues—both relatively minor for most hospitals—and, mainly for public institutions, direct public subsidies from tax funds.<sup>40</sup>

Alternatively, a hospital can subsidize uncompensated care from its own capital, incurring a deficit met largely by not funding depreciation. This last option obviously hurts the long-run viability of an institution and may impair its ability to raise operating capital as well. In 1980, fully one-third of the hospitals that provided a high volume of care to poor people were fiscally “stressed” in that they had deficits in operating and total accounts.<sup>41</sup>

Little is known about what care the uninsured indigent receive outside of hospitals, although it seems likely that non-hospital providers render relatively less uncompensated care than do hospitals.<sup>42</sup> For society at large, hospital service comprises some forty-six percent of personal health care spending (exclusive of public health activities, medical research, and construction); the balance goes to physicians, other professionals, drugs, nursing homes, and so on.<sup>43</sup> Hospitals, especially public ones, are the traditional “providers of last resort,” and their legal obligations to provide care are greater than those of other providers.<sup>44</sup> Moreover, hospital care is the most heavily insured, which traditionally has given hospitals more “third-party” revenues from which to cross-subsidize charity care.

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<sup>39</sup>See, e.g., FOR-PROFIT ENTERPRISE, *supra* note 35, at 106-07; Phelps, *Cross-Subsidies and Charge Shifting in American Hospitals*, in UNCOMPENSATED HOSPITAL CARE, *supra* note 30, at 108. It is often argued that cost-paying “insurers,” especially Medicare and Medicaid, do not contribute to this shift. See, e.g., J. MEYER, *PASSING THE HEALTH CARE BUCK: WHO PAYS THE HIDDEN COST?* (1983).

<sup>40</sup>FOR-PROFIT ENTERPRISE, *supra* note 35, at 100, Table 5.2, & 106 (public subsidy of \$1.9 billion in 1984).

<sup>41</sup>Hadley, Mullner & Feder, *The Financially Distressed Hospital*, 307 *NEW ENG. J. MED.* 1283 (1982). This study focused on hospitals for which uncompensated care plus Medicaid constituted 24% or more of charges.

<sup>42</sup>The only estimates of non-hospital charity with which the authors are familiar confirm this expectation. One estimate holds that physicians provided some \$2.9 billion of free care in 1982. See G. BAZZOLI, *HEALTH CARE FOR THE INDIGENT: LITERATURE REVIEW AND RESEARCH AGENDA FOR THE FUTURE* (1985). *But see* F. SLOAN, J. VALVONA & G. HICKSON, *ANALYSIS OF HEALTH CARE OPTIONS IN TENNESSEE: UNCOMPENSATED CARE* (Vanderbilt Univ. 1985) (Tennessee doctors provided only one-seventh the amount of uncompensated care as Tennessee hospitals).

<sup>43</sup>Levit, Lazenby, Waldo & Davidoff, *National Health Expenditures, 1984*, *HEALTH CARE FINANCING REV.*, Fall 1985, at 1, 9 [hereinafter *National Health Expenditures*] (in 1984, hospital care claimed \$157.9 billion out of \$341.8 of personal health care).

<sup>44</sup>See *infra* text accompanying notes 101-31.

Uncompensated care is clearly a multibillion dollar problem for hospitals, presumably a smaller one for other providers. It is likely to have totalled about \$10 billion in 1982 (assuming that two-thirds or three-quarters of it occurred in hospitals). The volume of uncompensated care has probably grown since then, as the next subsection discusses; certainly, the pressures on hospitals have increased.<sup>45</sup>

#### D. Growing Problems

Recent developments have made access to insurance and care more difficult for the medically indigent. Not only has the number of uninsured grown through 1984 (Table 1), but it is likely to continue to rise in the long run, despite a generally improved economy. A number of portents point in this direction. First, the normal, "structural" level of unemployment, below which the percentage of people looking for work is not apt to fall, even in good times, seems to have risen above the expected 3-4% of the 1970's to perhaps 5-6% or more. Few of the unemployed have employer-paid health coverage.<sup>46</sup> Second, employment patterns also seem to be undergoing a structural shift. To oversimplify, the United States is moving from manufacturing to service jobs, from unionized to nonunionized work forces, from mainly full-time to increasingly part-time workers, and from large employers to smaller ones—all moves from well-insured types of employment to less well-covered ones.<sup>47</sup>

Finally, the recent federal tax reform bill<sup>48</sup> reduces the incentives for companies and workers alike to shelter income in tax-free benefits like health insurance. Business in the aggregate will be paying considerably more federal income tax (although at a lower official marginal rate), which should make companies even more zealous about cutting corporate

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<sup>45</sup>Large as \$10 billion may seem, it is not large in relation to some 31 million uninsured people in 1982 (see *supra* Table 1). Per capita, that amounts to little more than \$300 for the year, far less than 1982's \$1,184 per capita spending for the general population. *National Health Expenditures*, *supra* note 43, at 16. It may be safely assumed that this amount of charity care did not meet all the medical needs of the medically indigent, given the extent to which the uninsured receive less care (see *supra* Table 4). Meeting those needs on a prepayment basis would be substantially more costly. See *infra* notes 257-58.

<sup>46</sup>See *supra* note 20.

<sup>47</sup>Black, *Comment on "The Employed Uninsured and the Role of Public Policy,"* 23 *INQUIRY* 209 (1986); Monheit, *supra* note 24. Black's and Monheit's observations rest mainly on 1977 data about employment and insurance coverage. Unpublished research on changes in insurance status during 1980-86 by Stephen M. Long and Jack Rodgers of the Congressional Budget Office disputes some of the details of these findings, arguing that long-term structural changes do not explain the rapid rise in the number of uninsured in the early 1980's.

<sup>48</sup>Tax Reform Act of 1986, Pub. L. No. 99-514, 100 Stat. 2085; *Summary of Conference Agreement on H.R. 3838*, TAX NOTES, Sept. 8, 1986, at 985.

health benefits than they have already been.<sup>49</sup> Individuals will pay less federal tax overall, and at lower marginal rates, especially at the high and low ends of the scale. High-income and low-income taxpayers alike will thus find tax-free health benefits considerably less attractive than before, compared with the alternative of higher cash income.

At the same time, the cost of offering workplace health benefits has been raised by numerous government requirements in the form of "mandated benefits," thus making insurance benefit packages richer for some<sup>50</sup> and more available to others, including the recently unemployed and divorced dependents.<sup>51</sup> These developments are helpful in some regard to those already in well-insured positions but, again, do not ease the difficulties of the marginal company and its workers in attempting to get affordable health coverage. All of these trends seem to indicate that the future will see more people without health coverage, not fewer.

Meanwhile, uncovered people also seem to face even greater problems in obtaining care—especially if they cannot prepay in cash, at least in part. The main reason is that the ability of hospitals to cross-subsidize care to the indigent seems to be declining. All providers, including hospitals, face increased price competition from their competitors as well as greater price resistance from their customers. Both developments have adverse implications for the uninsured, at least in the short run.<sup>52</sup>

Hospitals generally seem to manage the extent to which they provide uncompensated care in order to match their fiscal capacity.<sup>53</sup> It is safe to assume that they will cut back if increased price competition threatens their earnings or their ability to attract paying patients. Cutback strategies will include choosing locations and services attractive to insured rather than uninsured populations, avoiding services like obstetrics and emergency treatment of trauma that often go uncompensated, and screening out or transferring indigents or requiring deposits from them, at least for non-emergency care.<sup>54</sup>

Although almost all hospitals provide some level of charity care, in most locations the institutional provider of last resort, if one exists, is the public hospital. Anecdotal evidence indicates that the demand for

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<sup>49</sup>See *supra* notes 22 & 23.

<sup>50</sup>State laws regulating insurance have for a decade or more been altered to require insurance plans to include mental health benefits, among others. One estimate is that nearly 600 such statutes exist. Demkovich, *Covering Options Through Mandated Benefits*, BUS. & HEALTH, Jan./Feb. 1986, at 27 (more than 580 laws at the end of 1984, requiring coverage of everything from alcoholism services, in 38 states, to hospices, in 5 states, with an almost equal number of new bills pending).

<sup>51</sup>See *infra* note 207 on the federal "COBRA" entitlements allowing continuance as a group member even after layoff, divorce, or other separation from the group.

<sup>52</sup>See, e.g., Kinzer, *Care of the Poor Revisited*, 21 INQUIRY 5 (1984).

<sup>53</sup>Hadley, Mullner & Feder, *supra* note 41.

<sup>54</sup>FOR-PROFIT ENTERPRISE, *supra* note 35, at 104-05.

public hospital care has risen, in part as a result of transfers from other hospitals.<sup>55</sup> At the same time, state and local governments that traditionally have funded public hospitals' net deficits (after collections from Medicaid and other third-party payers) often have found themselves under considerable fiscal pressure, in the aftermath of recession and the "taxpayers' revolt."<sup>56</sup> Indeed, a number of public hospitals have closed since the late 1970's, perhaps most notably Philadelphia's,<sup>57</sup> and there is some movement toward "privatizing" others.<sup>58</sup>

For the future generally, some observers predict closures of as many as one thousand of today's six thousand short-term general hospitals, both public and private.<sup>59</sup> The remaining hospitals will have to be more concerned with competition for paying patients and less concerned about indigent care (which raises prices). Thus, in the 1990's, it is quite possible that the medically indigent will have less access to care than they do now, unless there are changes in public policy.

As a political matter, it seems undeniable that hospitals—not the indigent themselves—will continue to be largely responsible for making "uncompensated care/indigent care" a legislative issue.<sup>60</sup> The American Hospital Association has recently completed a report on indigent care, and almost every state has commissioned a task force on the topic.<sup>61</sup> In this way, hospitals can provide an effective political voice for their largely disenfranchised poor patients.<sup>62</sup>

For the moment, neither the administration nor the Congress seems inclined to assist in finding solutions, certainly not solutions that require

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<sup>55</sup>See, e.g., Schiff, *supra* note 5.

<sup>56</sup>See, e.g., *There's Life Yet in Tax Revolt*, THE ECONOMIST, Aug. 30, 1986, at 18.

<sup>57</sup>Reportedly, 111 nonfederal, short-term general hospitals, 19 of which were state or local institutions, closed between 1980 and 1982. Sloan, Valvona & Mullner, *supra* note 31, at 26.

<sup>58</sup>Bovbjerg, Held & Pauly, *Privatization and Bidding in the Health Care Sector*, 6 J. POL'Y ANALYSIS & MGMT. (1987) (forthcoming).

<sup>59</sup>See, e.g., Mullner & McNeil, *Rural and Urban Hospital Closures: A Comparison*, HEALTH AFF., Fall 1986, at 131.

<sup>60</sup>See, e.g., Richards, *Special Interests Push Indigent Care Solutions*, HOSPITALS, Oct. 16, 1984, at 106.

<sup>61</sup>AMERICAN HOSPITAL ASS'N, COST AND COMPASSION: RECOMMENDATIONS FOR AVOIDING A CRISIS IN CARE FOR THE MEDICALLY INDIGENT, REPORT OF THE SPECIAL COMMITTEE ON CARE FOR THE INDIGENT (1986). Most of the state studies consider their topic as much "uncompensated care" as "indigent care." For a summary of state studies during 1982-84, see J. LUEHRS & R. DESONIA, A REVIEW OF STATE TASK FORCE AND SPECIAL STUDY RECOMMENDATIONS TO ADDRESS HEALTH CARE FOR THE INDIGENT (1984) (responses of 21 states to survey); see also NAT'L CONF. OF STATE LEGISLATURES, 12 QUESTIONS: WHAT LEGISLATORS NEED TO KNOW ABOUT UNCOMPENSATED HOSPITAL CARE (undated, issued 1985).

<sup>62</sup>See, e.g., Law, *A Consumer Perspective on Medical Malpractice*, 49 LAW & CONTEMP. PROBS. 305, 307 (1986).

new federal funding.<sup>63</sup> As a result, states and localities are scrambling to find new ways to bear the burden of financing care for the medically indigent.<sup>64</sup> This Article next considers the legal obligations for providing or financing care and concludes with an examination of state policy options for aiding the medically indigent.

### III. LEGAL RIGHTS TO HEALTH CARE OR COVERAGE

#### A. *Rights and Responsibilities*

The supply of medical care for the medically indigent may be diminishing, but there is no shortage of statements that medical care is a basic human "right." Religious leaders, moral philosophers, politicians, and even some judges have been heard from on this score.<sup>65</sup> Existing commentary on the subject is voluminous<sup>66</sup> and will not be reviewed here. Many arguments about rights occur on an abstract, philosophical plane. One underlying ethical-legal issue is whether society or medical

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<sup>63</sup>In post-Gramm-Rudmann Washington, concern over reducing the massive federal deficit seems to preclude new funding initiatives. The administration has repeatedly attempted to cut existing indigent health programs like Medicaid, *see* R. BOVBJERG & J. HOLAHAN, *supra* note 18, and community health centers, *see* G. PETERSON, R. BOVBJERG, B. DAVIS, W. DAVIS, E. DURMAN & T. GULLO, *THE REAGAN BLOCK GRANTS: WHAT HAVE WE LEARNED* (1986) [hereinafter G. PETERSON]. Congress has protected the basic scope of Medicaid and some other existing programs, but seems unwilling to fund new ones. It will consider mandates for employer or state contributions, but not new federal taxes. Thus, COBRA requires employers to offer group insurance continuation benefits. *See infra* note 207. "Risk pool" legislation seriously considered but not passed would have required states to help pay for "insurance of last resort" for the otherwise uninsured. Access to Health Care Bill, S. 2402, 99th Cong., 2d Sess., 132 CONG. REC. S5218 (1986) discussed *infra* at note 290.

<sup>64</sup>*See supra* notes 7 & 61; *infra* note 136.

<sup>65</sup>*See, e.g.*, The Labor Day Statement of Cardinal John J. O'Connor on "The Right to Health Care" ("Every person has a basic right to health care which flows from the sanctity of life and the dignity of human persons" (citing 1981 Pastoral Letter on Health Care from American Catholic Bishops)), *excerpted in* HEALTH/PAC. BULL., July/Aug. 1985, at 6-7; Williams, *The Idea of Equality*, in PHILOSOPHY, POLITICS, AND SOCIETY 121-22 (P. Laslett & W. Ronciman eds. 1962) (It is a "necessary truth" that "the proper ground of [medical] treatment is need"); E. KENNEDY, IN CRITICAL CONDITION (1972) (especially Chapter 10, Good Health Care: A Right for All Americans); *Memorial Hosp. v. Maricopa County*, 415 U.S. 250, 259 (1974) (dictum) ("[M]edical care is as much 'a basic necessity of life' to an indigent as welfare assistance. And . . . of greater constitutional significance. . . .").

<sup>66</sup>*See, e.g.*, PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE, VOLUME TWO: APPENDICES, SOCIOCULTURE AND PHILOSOPHICAL STUDIES (1983) (twelve articles on access and right to it, each referencing various literatures); Fried, *Equality and Rights in Medical Care*, in IMPLICATIONS OF GUARANTEEING MEDICAL CARE 3 (J. Perpich ed. 1975).

providers owe the same care to all or whether charitable obligations are limited to some "decent minimum" of care.<sup>67</sup> Legal and policy analysis must consider how any such rights are determined and what, if any, corresponding responsibility attaches.

The most fundamental right to health care would be one derived from federal constitutional provisions. The constitutional authority of the federal government to fund health care for the medically indigent is indisputable,<sup>68</sup> and the federal-state Medicaid program is tangible evidence of that authority.<sup>69</sup> The government may assume by statute an obligation to fund medical care, but it has no general constitutional duty to do so. For example, the government may cut back previously offered Medicaid benefits<sup>70</sup> and may refuse to fund certain care, even care considered by some to be medically necessary.

The abortion cases well illustrate the distinction between a patient's right to receive care and a public obligation to pay for it. A patient's right to receive an abortion cannot be unduly restricted by government, but this limited right carries no corresponding funding obligations.<sup>71</sup> Government may even deny funds for abortions while paying for similar treatments under Medicaid or other programs.<sup>72</sup>

Two limited exceptions prove this rule. First, people involuntarily confined to mental institutions may have a "right to treatment" grounded in substantive due process or even in the eighth amendment's prohibition of cruel and unusual punishment. A number of lower federal courts have so held in cases of involuntary civil commitment.<sup>73</sup> The remedy for institutionalization without adequate treatment is not easily framed,

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<sup>67</sup>Compare, e.g., PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL RESEARCH, SUMMING UP: FINAL REPORT ON STUDIES OF THE ETHICAL AND LEGAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIOR RESEARCH 29-30 (1983) ("The Commission proposes a standard of 'an adequate level of care' for all, not 'a right to health care' that offers patients access to all beneficial care, to all care that others are receiving, or to all that they need—or want.") and Fried, *supra* note 66 ("decent standard of care for all") with, e.g., E. KENNEDY, *supra* note 65 (especially chapter 10, Basic Right of Access for All to Quality Care).

<sup>68</sup>U.S. CONST. Preamble ("promote the general welfare . . .").

<sup>69</sup>Social Security Act, tit. XIX, 42 U.S.C. §§ 1396 *et seq.* (1982 & Supp. 1985).

<sup>70</sup>Generally, states, rather than the federal government, are sued for implementing cutbacks, because most cutbacks have historically been undertaken at state discretion rather than by federal mandate. See, e.g., *Alexander v. Choate*, 469 U.S. 287 (1985) (Tennessee cut of hospital coverage to 14 inpatient days held valid). In contrast, federal eligibility cutbacks in 1981 received no judicial challenge.

<sup>71</sup>*Beal v. Doe*, 432 U.S. 438 (1977); *Roe v. Wade*, 410 U.S. 113 (1973).

<sup>72</sup>*Harris v. McRae*, 448 U.S. 297 (1980).

<sup>73</sup>See, e.g., *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974); *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966), *appeal after remand*, 387 F.2d 241 (D.C. Cir. 1967); *Wyatt v. Stickney*: RETROSPECT AND PROSPECT (L. Jones & R. Parlour eds. 1981). See generally D. WEXLER, *MENTAL HEALTH LAW: MAJOR ISSUES* (1981).

but courts generally require either deinstitutionalization, sometimes also with treatment,<sup>74</sup> or improved institutional care, going beyond the merely custodial.<sup>75</sup> Determining precisely what care is required and at what cost proves rather difficult in practice.<sup>76</sup> The Supreme Court has given only limited support to even this narrow concept of a right to mental health treatment,<sup>77</sup> and the recent trend seems to disfavor such litigation.<sup>78</sup>

The second exception entitles incarcerated prisoners to adequate health care. Traditionally, what little health care was available in jails and prisons was very poor.<sup>79</sup> A series of lawsuits has established that prison inmates must be given at least that level of care that prevents their medical situation from being cruel and unusual punishment.<sup>80</sup> Again, precisely what level of care meets the constitutional minimum is not clear, nor is the extent to which a prisoner must contribute toward his own care.<sup>81</sup>

These two exceptions are readily understood. Both institutionalized mental patients and prisoners are individually made wards of the state. It is an easy step to hold that the act of taking away their liberty (and with it their capacity to help themselves or to seek private charity) requires the government to give them in return a reasonable level of medical care, along with humane treatment in other regards.<sup>82</sup> These

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<sup>74</sup>Callahan v. Carey, N.Y.L.J., Dec. 11, 1979, at 10, col. 5 (N.Y. Sup. Ct. Dec. 10, 1979).

<sup>75</sup>See, e.g., *Wyatt v. Stickney*: RETROSPECT AND PROSPECT, *supra* note 73.

<sup>76</sup>See *id.*; see also Miller, *The "Right to Treatment": Can The Courts Rehabilitate and Cure?*, 46 THE PUBLIC INTEREST 96 (1977).

<sup>77</sup>See, e.g., *McNeil v. Director, Patuxent Inst.*, 407 U.S. 245 (1972) (holding that the state of Maryland could not confine appellant indefinitely on basis of administrative referral for observation under "defective delinquent" law; dictum noted remarkable rarity of litigation to set "substantive constitutional limitations on this [civil commitment] power").

<sup>78</sup>See, e.g., *Jones v. United States*, 463 U.S. 354 (1983) (civil commitment of convicted criminal upheld despite not meeting standards for independent civil commitment); *Youngberg v. Romeo*, 457 U.S. 307 (1983) (constitutional "right to habilitation" grounded on deprivation of personal freedom and safety, not on extent of available medical treatment); *Pennhurst State School v. Halderman*, 451 U.S. 1, 18 (1982) (poorly treated mentally retarded patients not entitled to redress against the state under federal handicapped statute; Congress did not intend to require states "to assume the high cost of providing 'appropriate treatment' " in exchange for federal funds).

<sup>79</sup>See, e.g., S. GOLDSMITH, *PRISON HEALTH: TRAVESTY OF JUSTICE* (1975).

<sup>80</sup>See generally Neisser, *Inmate Welfare Funds: Reassessing Prisoner Assessments*, in *PRISONERS AND THE LAW* 16-1, 16-18 through 16-20 (I. Robbins ed. 1985); Neisser, *Is there a Doctor in the Joint? The Search for Constitutional Standards for Prison Health Care*, 63 VA. L. REV. 921 (1977).

<sup>81</sup>In *City of Revere v. Massachusetts General Hospital*, 463 U.S. 239 (1983), the Supreme Court carefully refrained from deciding to what extent the hospital could collect from the patient, who was granted bail while hospitalized with wounds received during arrest, stating that this was a matter of state law. *Id.* at 245-46.

<sup>82</sup>*Cf.* *Wyatt v. Aderholt*, 503 F.2d 1305, 1312 (5th Cir. 1974) (treatment is "the *quid pro quo* society [has] to pay as the price of . . . denial of individuals' liberty").

exceptional cases do not support a fundamental *positive* "right to health care," but there may be a fundamental *negative* right allowing a sort of "free exercise." Thus, whereas certain aspects of medical practice are subject to restrictions under licensure or economic regulation,<sup>83</sup> courts have recognized the importance of professional freedom<sup>84</sup> and patients' free choice,<sup>85</sup> even the choice not to receive care of any sort.<sup>86</sup>

However, for the most part, the medically indigent have only those entitlements that have been voluntarily enacted, in whole or in part, to help them.<sup>87</sup> Each statute—Medicare, veterans' coverage, maternal and child health, and so on—carries with it greater or lesser entitlements to a more or less defined population. The negative implication of each program of special assistance is that no general federal obligation exists.

Beyond basic federal law, there are three other possible sources of indigent rights. These are the duties of providers, of states and localities, and of health insurers.

## B. Obligations of Health Care Providers

1. *Physicians. a. Duty to treat.*—Although physicians may voluntarily provide charity care to the indigent, they have no affirmative legal duty to do so. Like anyone else, physicians are free not to render aid even in an emergency.<sup>88</sup> Any assistance that a physician may gratuitously render is considered the act of a "good samaritan."<sup>89</sup> This same view has been echoed by numerous courts across the nation, and stands unchanged by statute.<sup>90</sup>

Most legal doctrine on the subject arises from malpractice law, enforced through tort suits for damages. Doctors are remarkably free of legal duty to treat anyone, paying customers and the impecunious alike. The classic statement of this non-duty comes from *Hurley v.*

<sup>83</sup>See, e.g. IND. CODE §§ 25-22.5-1-1 *et seq.* (1982).

<sup>84</sup>*Cf.* *Roe v. Wade*, 410 U.S. 113, 163 (1973) (importance of noninterference with doctors' judgment).

<sup>85</sup>The malpractice rule that patients must give "informed consent" is based on the importance of personal sovereignty. See generally J. KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984).

<sup>86</sup>*In re Quinlan*, 70 N.J. 10, 355 A.2d 647 (1976), is the seminal case. For a full discussion, see PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DECIDING TO FORGO LIFE-SUSTAINING TREATMENT: ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS* (1983).

<sup>87</sup>On federal medical programs, see generally F. WILSON & D. NEUHAUSER, *HEALTH SERVICES IN THE UNITED STATES* 137-228 (2d ed. 1982).

<sup>88</sup>See RESTATEMENT (SECOND) OF TORTS § 314 comment c (1965).

<sup>89</sup>State law typically protects such medical samaritans from ordinary negligence actions. See, e.g., IND. CODE §§ 34-4-12-1 to -2 (1982).

<sup>90</sup>See e.g., *Harper v. Baptist Medical Center-Princeton*, 341 So. 2d 133 (Ala. 1976); *Childers v. Frye*, 201 N.C. 42, 158 S.E. 744 (1931); *Lyons v. Grether*, 218 Va. 630, 239 S.E.2d 103 (1977).

*Eddingfield*,<sup>91</sup> a turn-of-the-century case in which the Indiana Supreme Court ruled that a physician had no duty to treat anyone. The court saw no common law duty, even though the doctor was not otherwise occupied, the would-be patient was very sick (he later died), was a former patient of the refusing physician, and tendered payment in advance. The court rejected any medical analogy with the common law duty of innkeepers to serve all comers as well as the argument that the then recently enacted state regulatory scheme of physician licensure had created such a duty. This minimalist legal view of physicians' obligations to would-be patients has long been an accepted tenet of organized medicine as well as of the law.<sup>92</sup> The traditional rule that physicians are free to reject anyone as a patient may have been tempered somewhat by civil rights legislation,<sup>93</sup> but medical indigency is not a protected civil rights category.

A physician's legal duty to treat a patient arises only from mutual consent—by express contract or by one implied by the parties' behavior. Whether this contractual physician-patient relationship exists is a factual question that turns upon whether the physician accepted the case and whether the patient accepted the physician's professional services.<sup>94</sup> Under certain circumstances, some courts have inferred a duty to treat even absent specific consent. For example, an Arizona court ruled that a physician on the staff of a hospital who agreed to be an "on-call" emergency room doctor could no longer refuse treatment to an individual seeking emergency care.<sup>95</sup> A New York court found a physician-patient relationship based solely on a telephone conversation between a hospital physician and an emergency room visitor, even though the physician was said mainly to have directed the patient to see his own doctor.<sup>96</sup> For the most part, however, mutual consent remains a requirement.

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<sup>91</sup>156 Ind. 416, 59 N.E. 1058 (1901).

<sup>92</sup>AM. MED. ASS'N, PRINCIPLES OF MEDICAL ETHICS § 6 (1985); cf. Relman & Reinhardt, *An Exchange on For-Profit Health Care*, in FOR-PROFIT ENTERPRISE, *supra* note 35, at 209 (lack of duty to serve shows profit orientation of physicians).

<sup>93</sup>See generally NAT'L HEALTH LAW PROGRAM, MANUAL ON STATE AND LOCAL GOVERNMENT RESPONSIBILITIES TO PROVIDE MEDICAL CARE FOR INDIGENTS 163-71 (M. Dowell ed. 1985) [hereinafter STATE AND LOCAL GOVERNMENT RESPONSIBILITIES] (Chapter IV, "Access to Health Care and Civil Rights Legislation").

<sup>94</sup>*Lyons*, 218 Va. 630, 239 S.E.2d 103; see also 61 AM. JUR. 2D *Physicians, Surgeons, and Other Healers* § 96 (1972).

<sup>95</sup>*Hiser v. Randolph*, 126 Ariz. 608, 617 P.2d 774 (Ariz. Ct. App. 1980), *overruled on other grounds*, *Thompson v. Sun City Community Hosp., Inc.* 141 Ariz. 597, 688 P.2d 605 (Ariz. 1984) (The court in *Thompson* also distinguished *Hiser* on the issue of the physicians' duty to treat in emergency situations). *But see, e.g.*, *Wilmington Gen. Hosp. v. Manlove*, 54 Del. 15, 174 A.2d 135 (1961); *Richard v. Adair Hosp. Found. Corp.*, 566 S.W.2d 791 (Ky. Ct. App. 1978). See *infra* discussion at notes 112-20 on emergency care and duty to serve.

<sup>96</sup>*O'Neill v. Montefiore Hosp.*, 11 A.D.2d 132, 202 N.Y.S.2d 436 (1960).

*b. Standard of care and extent of treatment.*—Once a patient-physician relationship has been established, the physician must exercise the same standard of care—customary skill and diligence<sup>97</sup>—regardless of whether the patient is an indigent or a paying customer. Even when physicians render their services gratuitously, their potential liability for negligence or malpractice remains the same as in treating any other patient.<sup>98</sup>

Having once begun treatment, a physician must continue treatment as long as medical care is necessary or face a possible malpractice action for abandonment if actionable damage occurs.<sup>99</sup> Physicians may safely withdraw from a case only when services are no longer needed, when the patient voluntarily terminates the relationship, when referral is made to an equally qualified practitioner, or when the patient has a reasonable opportunity to see another physician.<sup>100</sup>

*2. Hospitals. a. Duty to treat.*—As a general matter, private hospitals, like physicians, have no legal duty to accept all potential patients seeking care, except perhaps in emergency situations.<sup>101</sup> Public hospitals, by statute, by charter, or by tradition, generally are obligated to accept all patients, at least in emergencies,<sup>102</sup> but the “right” of admission to public hospitals for non-emergency cases is not absolute.<sup>103</sup>

Even more than that of physicians, hospitals’ discretion to refuse patients is limited by civil rights provisions,<sup>104</sup> but in general, ability to pay can be considered in deciding whether to treat. Indeed, absent an emergency, a hospital may require a cash deposit as a condition of admission.<sup>105</sup> Significantly, in only about half of the states are hospitals

<sup>97</sup>The classic article is McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549 (1959); see also A. HOLDER, *MEDICAL MALPRACTICE LAW* 40-43, 53-55 (1975).

<sup>98</sup>See, e.g., *Rule v. Cheeseman*, 181 Kan. 957, 317 P.2d 472, 477 (1957) (the fact that the patient was a charity patient was immaterial in determining the surgeon’s negligence); see also 70 C.J.S. *Physicians and Surgeons* § 52 (1951).

<sup>99</sup>See, e.g., A. HOLDER, *supra* note 97, at 374-402.

<sup>100</sup>*Lyons v. Grether*, 218 Va. 630, 239 S.E.2d 103 (1977); see also Annotation, *Liability of Physician Who Abandons Case*, 57 A.L.R.2d 432, 439 § 3 (1958).

<sup>101</sup>See, e.g., *Birmingham Baptist Hosp. v. Crews*, 229 Ala. 398, 157 So. 224 (1934) (physician in emergency room diagnosed child’s advanced diphtheria and began treatment but hospital denied admission because the disease was contagious; held no liability for later death); *Hill v. Ohio County*, 468 S.W.2d 306 (Ky. 1971), *cert. denied*, 404 U.S. 1041 (1972) (pregnant woman had no right to hospital admission, absent emergency); see also A. SOUTHWICK, *THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION* 161-62 (1978).

<sup>102</sup>See *Wilmington Gen. Hosp. v. Manlove*, 54 Del. 15, 174 A.2d 135 (1961) (dictum on public hospital duty); A. SOUTHWICK, *supra* note 101, at 162-64.

<sup>103</sup>See A. SOUTHWICK, *supra* note 101, at 163.

<sup>104</sup>See STATE AND LOCAL GOVERNMENT RESPONSIBILITIES, *supra* note 93, at 163-71.

<sup>105</sup>*Joyner v. Alton Ochsner Medical Found.*, 230 So. 2d 913 (La. App. 1970) (auto accident victim given emergency treatment but refused admission).

legally required to have emergency rooms.<sup>106</sup>

As with physicians, once a hospital begins to provide diagnosis and treatment for an indigent patient, it is held to the same standard of care as for any other patient.<sup>107</sup> Particularly when financial considerations prompt an early discharge of a patient, the hospital may be found liable for damages in a tort suit for abandonment.<sup>108</sup>

However, tort actions constitute an abysmal enforcement tool for achieving access to care. Only those emergency refusals that result in compensable damages are normally actionable, and severe damage is usually needed to justify the expense of a suit. Indigents are also disadvantaged because their economic damages are likely to be low and they may have poor access to legal assistance.<sup>109</sup> Moreover, if indigents are receiving public assistance, they may not be allowed to keep much of any recovery.

Malpractice doctrine is, therefore, of little help to indigents seeking care.<sup>110</sup> Indeed, if anything, malpractice law may actually hurt indigents' access to private care, because offering any care may make a provider, especially a hospital, liable to provide all needed care, perhaps entirely without recompense. It is precisely this concern that presumably prompts "dumping."

One way to reduce the malpractice incentive to dump patients would be to grant immunity from tort actions to providers that conform to the coverage and utilization requirements of any applicable indigent care program. The existing federal Professional Review Organization (PRO) legislation provides such immunity with regard to the appropriateness

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<sup>106</sup>About half of states directly or indirectly require certain categories of hospitals to have emergency facilities. A. SOUTHWICK, *supra* note 101, at 183-84. See, e.g., ILL. ANN. STAT. ch. 111 1/2, para. 86, 87 (Smith-Hurd 1977 & Supp. 1986) (private and public hospitals providing general medical or surgical services); PA. STAT. ANN. tit. 62, § 443.3 (Purdon 1986) (all hospitals receiving payments from Department of Public Welfare). STATE AND LOCAL GOVERNMENT RESPONSIBILITIES, *supra* note 93, provides a table of emergency care laws; on tax rules, see *id.* at 489-90.

<sup>107</sup>HOSPITAL LAW MANUAL ¶ 1-3 (1981).

<sup>108</sup>See e.g., *Meiselman v. Crown Heights Hosp.*, 285 N.Y. 389, 34 N.E.2d 367 (1941) (hospital discharged patient when open wounds were still draining); *Jones v. City of New York, Hosp. for Joint Diseases*, 134 N.Y.S.2d 779 (N.Y. Sup. Ct. 1954), *rev'd on other grounds*, 286 A.D. 825, 143 N.Y.S.2d 628 (1955) (transfer of a stabbing victim who later died was for hospital convenience rather than necessity and thus actionable).

<sup>109</sup>The last point is not self-evident, given free legal assistance as a free point of entry and the wide availability of the private, contingent-fee personal injury bar. No direct evidence on this point seems to exist. The only major empirical analysis of medical malpractice, however, provides *indirect* evidence, that the incidence of claims does not vary by differences in per capita income or in the proportion of people on welfare among states. P. DANZON, *MEDICAL MALPRACTICE: THEORY, EVIDENCE, AND PUBLIC POLICY* 75 (1985).

<sup>110</sup>See Law, *supra* note 62, at 306-15; Rosenblatt, *Rationing "Normal" Health Care: The Hidden Legal Issues*, 59 TEXAS L. REV. 1401, 1410-15 (1981).

of treatment when Medicare has denied payment.<sup>111</sup> However, a broader immunity provision could apply equally to coverage issues as well as to issues of appropriateness. Under such a provision, a hospital would be immune from suit if it failed to provide uncompensated care beyond that covered under the indigency care program.

Of course, there are other ways to discourage providers from transferring patients, at least emergency patients, inappropriately. New federal legislation specifically addresses inappropriate transfers.

*b. Emergency room as a source of duty to treat.*—Under 1986 federal legislation, hospitals that operate emergency rooms and that participate in the Medicare or Medicaid programs must follow certain protocols in assessment, treatment, and transfer of emergency patients (including patients arriving in active labor).<sup>112</sup> The duty applies to all patients, not merely to public program beneficiaries.<sup>113</sup>

This legislation was passed in response to growing concern over refusals of care and “dumping” of patients on public facilities.<sup>114</sup> Basically, affected hospitals must examine all patients and then either accept them for full treatment or at least stabilize their condition so that they can be safely transferred. Unstabilized patients may be transferred only with their express consent or when the transfer is certified to be in their own interest.<sup>115</sup> The federal act specifically states that it does not preempt state rules except when they are plainly inconsistent with federal requirements.<sup>116</sup> Clearly the state remains free to enforce more stringent standards.

The federal act was in many ways modeled upon landmark Texas legislation that took effect the week before the federal action.<sup>117</sup> Under the Texas law, a physician must examine all emergency patients within

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<sup>111</sup>42 U.S.C. § 1320c-6(c) (1982). This little known and little used provision was also included in the predecessor PSRO legislation. It applies to Medicare, and to Medicaid as well where the state elects to use the PRO to perform Medicaid review.

<sup>112</sup>Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 82, 164 *et. seq.* (COBRA, approved Apr. 7, 1986). Almost all hospitals participate in one or both of these programs, and many have emergency rooms. *See supra* note 106.

<sup>113</sup>The legislation’s constitutionality might be challenged on the ground that no legitimate purpose is served by requirements for non-Medicare persons as well as for Medicare beneficiaries. In defense, one could argue that it is unwise, in emergency circumstances, to make distinctions among various patients according to their insurance status.

<sup>114</sup>*See supra* notes 4 & 5.

<sup>115</sup>Specifically, transfers before stabilization or during active labor may occur only at the request of the patient or upon certification of the physician that the medical benefits expected from transferring outweigh the risks of effecting the transfer. In addition, transfers may be made only to facilities with available space and qualified personnel who have agreed to accept the transfer and to provide appropriate medical treatment.

<sup>116</sup>Consolidated Omnibus Budget Reconciliation Act of 1985, Pub. L. No. 99-272, § 9121, 100 Stat. 82.

<sup>117</sup>Texas Indigent Health Care and Treatment Act, TEX. REV. STAT. ANN. art. 4438f (Vernon Supp. 1986). *See Chershov, Texas Transfer Law Still Spurs Controversy, HOSPITALS*, May 5, 1986, at 160.

twenty minutes of their arrival. Patients are to be stabilized before any transfer, and the receiving hospitals and physicians must agree to the transfer.

In the absence of applicable statutory enactments, emergency treatment and transfer is governed mainly by malpractice law. In this connection, many state courts have held that operating an emergency room creates a duty to treat emergency cases regardless of payment.<sup>118</sup> However, not all courts have accepted the emergency room exception to the general no-duty rule,<sup>119</sup> and some have rejected it.<sup>120</sup>

c. *The Hill-Burton Act as a source of duty to treat.*—In the past, many hospitals have accepted federal capital grants or loans under the Hill-Burton program.<sup>121</sup> The terms of these grants obligate hospitals to provide a “reasonable volume” of free or below-cost services to persons unable to pay for hospital care. Until the 1970’s, it was unclear exactly how much care hospitals were required to provide (i.e., what was a “reasonable volume”) and to whom they were to provide it. In 1970, a federal district court found that a private civil action could be implied under the Hill-Burton Act because the Act was designed in part to benefit directly those persons unable to pay for medical services.<sup>122</sup> Upon review, the circuit court held that individual hospitals could not be expected to supply all the services needed by indigents in their states.<sup>123</sup>

Accordingly, the Secretary of Health, Education, and Welfare (now, the Secretary of Health and Human Services) issued clarifying regulations on what amount of uncompensated services provided by a hospital would constitute compliance with the “reasonable volume” requirement of the Hill-Burton Act. Even with continued litigation in the 1970’s and the revised regulations,<sup>124</sup> the Hill-Burton Act has proven difficult to enforce.<sup>125</sup> Although the regulations and cases tend to interpret the Hill-

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<sup>118</sup>See e.g., *Hiser v. Randolph*, 126 Ariz. 608, 617 P.2d 774 (Ariz. Ct. App. 1980); *Wilmington Gen. Hosp. v. Manlove*, 54 Del. 15, 174 A.2d 135 (1961); *Mercy Medical Center of Oshkosh, Inc. v. Winnebago County*, 58 Wis. 2d 260, 206 N.W.2d 198 (1973).

<sup>119</sup>See, e.g., *Campbell v. Mincey*, 413 F. Supp. 16 (N.D. Miss. 1975) (dictum noting that *Manlove* not universally followed; held, no emergency, so hospital not liable under own rules).

<sup>120</sup>See, e.g., *Perth Amboy Gen. Hosp. v. Board of Chosen Freeholders*, 158 N.J. Super. 556, 386 A.2d 900 (1978); *Fabian v. Matzko*, 236 Pa. Super. 267, 344 A.2d 569 (1975). Compare K. WING, *THE LAW AND THE PUBLIC’S HEALTH* 234-45 (2d ed. 1985) (hospital duty in emergency not settled law) with A. SOUTHWICK, *supra* note 101, at 185-89 (“[m]ost observers” think holding that emergency room creates duty “should now be accepted as the rule.” *Id.* at 187).

<sup>121</sup>42 U.S.C. § 291(c)(e) (1982) (The Hospital Survey and Construction Act of 1946).

<sup>122</sup>*Cook v. Ochsner Found. Hospital*, 319 F. Supp. 603 (E.D. La. 1970), *aff’d*, 559 F.2d 968 (5th Cir. 1977).

<sup>123</sup>*Cook*, 559 F.2d at 971.

<sup>124</sup>42 C.F.R. § 124.503 (1979).

<sup>125</sup>*Cf.* Blumstein, *Court Action, Agency Reaction: The Hill-Burton Act as a Case Study*, 69 IOWA L.REV. 1227 (1984); Wing, *The Community Service Obligation of Hill-Burton Health Facilities*, 23 B.C.L. REV. 577 (1982).

Burton Act as creating entitlements for specific classes of patients,<sup>126</sup> no individual patient has a claim to free services.<sup>127</sup> Furthermore, even though the regulations define persons "unable to pay," each hospital may develop its own plans for distributing charity care.<sup>128</sup>

Some \$571 million of free care met Hill-Burton obligations in 1984,<sup>129</sup> a figure well below the uncompensated care burden<sup>130</sup> and dwarfed by apparent need. Even this amount of charity care is likely to diminish in the future because Hill-Burton "free care" obligations normally last for twenty years and the grant program was virtually eliminated in 1974.<sup>131</sup>

### C. *Obligations of States and Localities*

All states and a great many political subdivisions (counties, towns, or cities) voluntarily provide or finance a variety of health services. The largest program by far is the federal-state Medicaid program. Participating states, by federal requirement, must cover certain categorically eligible poor people and must provide certain mandatory benefits. Additional coverage may be added at a state's option within the limits of federal financial participation.<sup>132</sup> Medicaid's contribution to preventing medical indigency is well known. Medicaid programs have by and large ceased to expand to cover many additional people.<sup>133</sup> Consequently, this Article does not further describe Medicaid at this point.

All levels of government provide many specialized health services for the general population and general services for specialized populations. Classic examples are treatment or immunizations for communicable diseases and care for handicapped children.<sup>134</sup> Poor people often receive

<sup>126</sup>Blumstein, *supra* note 125.

<sup>127</sup>*Newsom v. Vanderbilt Univ.*, 653 F.2d 1100, 1121 (6th Cir. 1981).

<sup>128</sup>42 C.F.R. § 124.507 (1979).

<sup>129</sup>STATE AND LOCAL GOVERNMENT RESPONSIBILITIES, *supra* note 93, at 35.

<sup>130</sup>Sloan, Valvona & Mullner, *supra* note 31, at 19 (\$1.7 billion of hospital-denominated charity care is included in the \$6.2 billion of uncompensated care).

<sup>131</sup>U.S. OFF. OF MGMT. & BUDGET, THE BUDGET OF THE UNITED STATES GOVERNMENT, FISCAL YEAR 1975, APPENDIX 415 (1974).

<sup>132</sup>See generally R. BOVBERG & J. HOLAHAN, *supra* note 18.

<sup>133</sup>See generally J. HOLAHAN & J. COHEN, *supra* note 18. An exception is limited expansions targeted at needy children and young mothers, including expectant mothers, authorized by 1986 federal legislation. See *infra* note 224.

<sup>134</sup>See generally F. GRAD, PUBLIC HEALTH LAW MANUAL (1973); ROLE OF STATE AND LOCAL GOVERNMENTS IN RELATION TO PERSONAL HEALTH SERVICES (S. Jain ed. 1981) [hereinafter ROLE OF STATE AND LOCAL GOVERNMENTS] (reprinted from 71 AM. J. PUB. HEALTH 1 (Supp. Jan. 1981)). STATE AND LOCAL GOVERNMENT RESPONSIBILITIES, *supra* note 93, cites statutory authority for many of these programs. The Association of State and Territorial Health Officials (ASTHO), through its Public Health Foundation, publishes several annual compilations of data on public health activities reported by 57 state health agencies and estimated for some 3,000 local health departments. See, e.g., PUBLIC HEALTH FOUNDATION, 1984 PUBLIC HEALTH CHARTBOOK (1986).

particular emphasis in such programs, but they are not the focus. Moreover, this type of public health activity tends to be quite restricted, both in the scope of the care provided and in the level of financing made available.<sup>135</sup> Consequently, this Article also skips over programs such as these to consider in depth only direct efforts to curb medical indigency.

1. *Sources of State Power to Provide Indigent Health Care.*<sup>136</sup>—All but three states either authorize or require state or county governments to provide for “relief and support” of the poor.<sup>137</sup> Many of these laws date from 19th century “poor laws.”<sup>138</sup> The older statutes do not always expressly mention medical care, but several have been interpreted to cover at least some level of medical services.<sup>139</sup> State authority to provide or finance health care is derived from the general police power.<sup>140</sup> Counties (or other substate jurisdictions) have such power by virtue of delegation from their states.<sup>141</sup>

2. *Types of Local Indigent Health Programs.*—Existing indigent care programs can be divided into four different types: The first is the public hospital model, most typically run by counties or cities, sometimes with state aid. States using this approach operate hospitals themselves or authorize counties to do so. These public hospitals are generally required to serve the poor free or at a discount.<sup>142</sup> In 1984, there were

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<sup>135</sup>In fiscal year 1984, for example, state and local public health spending totaled some \$6.5 billion. PUBLIC HEALTH FOUNDATION, *supra* note 134, Fig. 1. A few state health agencies administer Medicaid in their states, but the latter expenditures are not included. By way of comparison, federal-state expenditures for Medicaid in 1984 totalled \$34.5 billion (provider payments only). J. HOLAHAN & J. COHEN, *supra* note 18, at 9.

<sup>136</sup>The following discussion owes much to three legal and programmatic compilations of information on assistance for the medically indigent. Butler, *Legal Obligations of State and Local Government for Indigent Health Care*, in ACADEMY FOR STATE AND LOCAL GOVERNMENT, ACCESS TO CARE FOR THE MEDICALLY INDIGENT: A RESOURCE DOCUMENT FOR STATE AND LOCAL OFFICIALS 13-44 (R. Curtis & S. White eds. 1985) [hereinafter ACADEMY] provides the most readable review. STATE AND LOCAL GOVERNMENT RESPONSIBILITIES, *supra* note 93, thoroughly documents existing programs from the perspective of legal enforcement; it gives numerous state-by-state listings, extracts and commentaries. INTER-GOVERNMENTAL HEALTH POLICY PROJECT, GEORGE WASHINGTON UNIV., STATE PROGRAMS OF ASSISTANCE FOR THE MEDICALLY INDIGENT (1985) [hereinafter IHPP] also gives state-by-state profiles from the program point of view, as well as some fiscal data. This Article would not have been possible without the kind of background provided by such data sources.

<sup>137</sup>Kentucky, North Carolina, and Tennessee have no unit of government legally responsible for indigent health care. Butler, *supra* note 136 at 17, Table I.

<sup>138</sup>New Hampshire's General Assistance program, for example, originated from English Poor Laws. *Baker-Chaput v. Cammett*, 406 F. Supp. 1134, 1137 (D.N.H. 1976). See also R. STEVENS & R. STEVENS, WELFARE MEDICINE IN AMERICA (1974).

<sup>139</sup>*E.g.*, *Jerauld County v. St. Paul-Mercury Indem. Co.*, 76 S.D. 1, 71 N.W.2d 571 (1955); see, *e.g.*, Butler, *supra* note 136, at 16.

<sup>140</sup>*Jacobson v. Massachusetts*, 197 U.S. 11 (1905); *Industrial Comm'n v. Navajo County*, 64 Ariz. 172, 167 P.2d 113 (1946); *Jerauld County*, 76 S.D. 1, 71 N.W.2d 571.

<sup>141</sup>*Jacobson* 197 U.S. 11; F. GRAD, *supra* note 134.

<sup>142</sup>States that have used this method include Arkansas, Colorado, Florida, Iowa, Maine, Michigan, Missouri, Nevada, North Carolina, South Carolina, West Virginia, and Wisconsin. Butler, *supra* note 136, at 19 n.25.

some 1,622 state and local government hospitals, of a national total of 5,759 community hospitals.<sup>143</sup> These hospitals are important not merely for inpatient care but also for outpatient care in emergency rooms and outpatient clinics, especially in the nation's large urban areas.

A second approach is for government to contract for indigent care with specific private providers, mainly hospitals and community health centers but occasionally individual practitioners as well. Several levels of government may share financing.<sup>144</sup> Contracting is common for public health and mental health services and is sometimes used for general health care to the indigent.<sup>145</sup> States that have used this approach include Colorado, Delaware, Florida, Idaho, and Indiana.

The third and fourth methods are both more insurance-style medical programs, under which eligible indigent enrollees can get specified services from many providers, not merely one or a few contracting providers. Model number three is a rather limited "vendor-payment" program under which eligibles do not enroll in advance. Medical providers bill the county or state for care to the indigent and are reimbursed at some rate on a case-by-case basis.<sup>146</sup> The benefits available and the indigency standards for such programs vary greatly from place to place. Often, only hospital care is covered.

Model four is the more familiar style of insurance program that resembles Medicaid or private insurance: Once eligible persons enroll, they may seek any covered service (typically well beyond hospital care) from any participating provider. A few states provide full Medicaid benefits to the medically indigent, wholly at their own expense, without federal matching support.<sup>147</sup> More commonly, these insurance-style programs for indigent care are far more restricted than Medicaid, both in

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<sup>143</sup>AM. HOSP. ASS'N, HOSPITAL STATISTICS 7, Table 1 (1985) (data from 1984 survey). An additional 700-odd institutions were federal or long-term hospitals. Although state and local hospitals thus constituted 28% of the total, they contributed a smaller share of total hospital beds, some 20% in 1984. On public hospitals' contributions to indigent care, see e.g., Dallek, *The Continuing Plight of Public Hospitals*, 16 CLEARINGHOUSE REV. 97 (1982); Feder, Hadley & Mulliner, *Poor People and Poor Hospitals*, 9 J. HEALTH POL. POL'Y & L. 237 (1984).

<sup>144</sup>Community health centers often receive a mix of federal block grant, state, and local funding to supplement earnings from charges to patients and their insurers, if any. See, e.g., G. PETERSON, *supra* note 63; R. PRICE, *HEALTH BLOCK GRANTS* (1981).

<sup>145</sup>On public health contracting, see, e.g., Jain, *supra* note 134. Iowa contracts with the University of Iowa Hospitals and Clinics to provide non-Medicaid indigent health care statewide. IHPP, *supra* note 136, at 139. For a list of citations to states using this approach, see Butler, *supra* note 136, at 20 nn.28-30.

<sup>146</sup>See Butler, *supra* note 136, at 28-30; STATE AND LOCAL GOVERNMENT RESPONSIBILITIES, *supra* note 93.

<sup>147</sup>Maryland's indigent care program is its Medicaid program, for example. IHPP, *supra* note 136, at 157.

benefits and in provider payment levels.<sup>148</sup> Eligibility for these indigency programs may be tied to receipt of state "general assistance" (welfare), just as Medicaid categorical eligibility is based on welfare (Aid to Families with Dependent Children or Supplemental Security Income Assistance). This subtype of insurance program is often called a "GA-medical" program.<sup>149</sup> Administrative and funding responsibilities for these insurance-style programs are often shared among state and local authorities.<sup>150</sup>

This brief discussion illustrates how widely the method of providing indigent care and coverage varies nationwide. In addition, the states differ in the amount of discretion they give to the financing or administrative agency. Some programs provide little administrative structure and few operational guidelines, whereas others are quite detailed and specific, and their diversity is enormous.<sup>151</sup>

From the point of view of the otherwise uninsured medically indigent, what matters about these state and local efforts is how much access to care they provide. The medical access that a program achieves depends on its legal requirements, the funding provided, and the administrative discretion given to allow funding to be matched to indigents' requirements. The administrator's discretion may be guided only by general statutory principles; or specific statutory or administrative provisions may govern eligibility, benefits, and level of provider payments.

3. *Nature of State-Local Duty.*—Although almost all states have statutes permitting publicly provided indigent health coverage or care,<sup>152</sup> few seem to mandate such aid. It has been argued that two states' constitutions require those states to provide for the poor, while three others require counties and hospital districts to do so.<sup>153</sup> But even these apparent constitutional mandates are open to interpretation about the nature of duty created.<sup>154</sup> In addition to constitutional provisions, some state statutes purport to impose duties on the state,<sup>155</sup> but these apparent "mandates" seem binding only so long as the state voluntarily accepts that duty. The state remains free to repeal a statute, even if by its terms it does not seem to allow administrative or budgetary cutbacks. Thus,

<sup>148</sup>*Id. passim.*

<sup>149</sup>*Id.* at 26 (also called general relief, home relief, or poor relief).

<sup>150</sup>Butler, *supra* note 136, at 19.

<sup>151</sup>IHPP, *supra* note 136, at 67-292; *see also* STATE AND LOCAL GOVERNMENT RESPONSIBILITIES, *supra* note 93.

<sup>152</sup>*See, e.g.*, LA. REV. STAT. ANN. § 40:2017 (West 1977) (state department of health "may" provide for indigent care in private hospitals).

<sup>153</sup>Butler, *supra* note 136, at 16 nn.8, 9 (citing ALA. CONST. art. IV, § 88, KAN. CONST. art. 7, § 4, MONT. CONST. art. XII, § 3(3), N.Y. CONST. art. VIII, § 1 (states); TEX. CONST. art. 9, §§ 4,5,9. (counties or districts)).

<sup>154</sup>*See, e.g.*, MONT. CONST. art. XII, § 3 (state must establish institutions but only such as the public interest *may* require).

<sup>155</sup>*See, e.g.*, DEL. CODE ANN. tit. 31, § 505(6) (1985) (general assistance program).

it seems fair to conclude that there is no fundamental state right to health care; some courts have so held.<sup>156</sup>

On the other hand, state statutory mandates on lesser jurisdictions can be truly binding.<sup>157</sup> Some state courts have interpreted even ostensibly permissive statutes to mandate local government to fund care for the indigent. The Arizona Supreme Court, for example, read two statutes authorizing counties to care for the sick as imposing a duty to provide medical care for the indigent sick.<sup>158</sup> The obligation to provide some variety of indigent medical care may even appear in a city charter<sup>159</sup> and may apply even though an area is otherwise granted "home rule."<sup>160</sup> In some thirty-seven states, counties or towns are to some degree responsible for indigent care (often shared among levels of government); in four other states, counties are responsible for care only if they operate county hospitals.<sup>161</sup>

Public hospitals are generally required to serve the poor at a discount or at no charge. An interesting issue arises where administration of the public hospital is contracted out to a private firm (as increasingly occurs for cost containment reasons) or where the entire hospital is sold to private interests. Of course, the private administrators or new owners may be obligated by contract to provide some level of indigent care. North Carolina has gone even further, enacting a provision requiring both purchasers and lessees of public hospitals to continue indigent care.<sup>162</sup> In any event, enforcement of any such obligation may pose a problem.<sup>163</sup>

4. *Extent of State-Local Duty.*—Exactly what limits exist or may be set on any public duty or undertaking to provide or finance care is not settled by current case law.<sup>164</sup> If a provision is not mandatory, the government can revoke it by ceasing to provide or to finance care.

<sup>156</sup>See, e.g., *Mary Lanning Memorial Hosp. v. Clay County*, 170 Neb. 61, 101 N.W.2d 510 (1960).

<sup>157</sup>See, e.g., IND. CODE §§ 12-2-1-1 through -39 (1982 & Supp. 1986) ("Township trustee must promptly provide medical and surgical attendance for all the poor . . . not . . . in public institutions.").

<sup>158</sup>*Industrial Comm'n v. Navajo County*, 64 Ariz. 172, 167 P.2d 113 (1946); see also *Memorial Hosp. v. Maricopa County*, 415 U.S. 250, 252 (1974) (notes "mandatory" duty of counties).

<sup>159</sup>See, e.g., F. GRAD, *supra* note 134.

<sup>160</sup>See, e.g., ILL ANN. STAT. ch. 34, para. 5011-5029 (Supp. 1986) (Cook County is obligated to finance care for poor).

<sup>161</sup>Calculated from Butler, *supra* note 136, at 17, Table I. See also STATE AND LOCAL GOVERNMENT RESPONSIBILITIES, *supra* note 93.

<sup>162</sup>N.C. GEN. STAT. § 131E-13 (Supp. 1985).

<sup>163</sup>Andrulis, *Survival Strategies for Public Hospitals*, BUS. & HEALTH, June 1986, at 31, 34.

<sup>164</sup>Interestingly, most cases are brought not by the poor themselves but by hospitals that have provided care to indigents and are requesting compensation for that care.

Courts generally will not obligate a government to undertake a function that is permissive rather than mandatory.<sup>165</sup>

Occasionally, a state or county may operate an indigent health care program simply by appropriating funds without a statutory mandate or even express statutory authority. When such appropriated funds are exhausted, the state or local agency would seem to have no lingering obligation to continue covering care for the indigent.<sup>166</sup>

Where specific statutory language governs indigent care, budgetary discretion may be more circumscribed. Programs vary widely in the discretion granted to control the scope of support through eligibility, benefits, and payment provisions. For example, Iowa gives its county boards of social services broad control over the form and amount of support.<sup>167</sup> California also gives broad discretion to its county supervisors to determine eligibility for, amount of, and conditions attached to indigent relief.<sup>168</sup> However, a county's exercise of discretion must remain consistent with the language and purpose of California's General Assistance statutes.<sup>169</sup> Other states have given local authorities much less discretion. For example, Michigan's GA-medical program sets very precise standards and fixes the local share of resultant spending.<sup>170</sup> Even when counties are given broad administrative discretion, state courts have held that county regulations must bear a reasonable relationship to the intended purpose of the state statute.

A county's obligation to deliver indigent health care does not necessarily change if the state establishes an additional program, such as Medicaid.<sup>171</sup> Similarly, establishing a public medical facility within the county does not necessarily relieve the county's responsibility for indigent care rendered elsewhere. The Nevada Supreme Court, for example, held a county responsible for emergency care rendered at a private hospital even though the county operated its own facility.<sup>172</sup> In contrast, California courts have held that counties were responsible only for care given at

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<sup>165</sup>See, e.g., *Perth Amboy Gen. Hosp. v. Board of Chosen Freeholders*, 158 N.J. Super. 556, 386 A.2d 900 (1978) (statute which *authorized* counties to make payments to hospitals providing care to indigents did not *require* counties to do so).

<sup>166</sup>See generally *Butler*, *supra* note 136, at 18.

<sup>167</sup>*Collins v. Hoke*, 705 F.2d 959 (8th Cir. 1983).

<sup>168</sup>*City & County of San Francisco v. Superior Court*, 57 Cal. App. 3d 44, 47, 128 Cal. Rptr. 712, 714 (1976).

<sup>169</sup>*Bay Gen. Community Hosp. v. County of San Diego*, 156 Cal. App. 3d 944, 203 Cal. Rptr. 184 (1984); *Patten v. San Diego County*, 106 Cal. App. 2d 467, 235 P.2d 217 (1951).

<sup>170</sup>MICH. COMP. LAWS ANN. § 400.66a (West 1976); see *IHPP*, *supra* note 136, at 171-74.

<sup>171</sup>*Madera Community Hosp. v. County of Madera*, 155 Cal. App. 3d 136, 201 Cal. Rptr. 768 (1984); *Hall v. County of Hillsborough*, 122 N.H. 448, 445 A.2d 1125 (1982).

<sup>172</sup>*Washoe County v. Wittenberg*, 100 Nev. 143, 676 P.2d 808 (1984).

a county facility or by a provider already under contract with the county.<sup>173</sup>

5. *Funding Limitations and Obligations.*—The state of Washington statutorily limits public obligations to the appropriated amounts,<sup>174</sup> whereas Ohio positively obligates the county to appropriate needed funds.<sup>175</sup> Some states have given counties specific authority to levy taxes in order to care for the indigent. Idaho, for example, allows counties to levy an ad valorem tax on property.<sup>176</sup> Nevada allows indigent health spending to raise county property taxes above an otherwise binding ceiling percentage on assessments.<sup>177</sup> A public hospital or clinic or a private contractor may simply reach the limit of its resources and then shut down certain services or turn away certain people (or postpone serving them). Presumably, in so doing, it would use accepted principles of medical triage, serving the medically neediest first. Whether a disappointed patient or the provider can then sue the responsible jurisdiction(s) for more than the budgeted funds is not clear.<sup>178</sup> Presumably, a great deal would turn on the precise statutory wording of the institution's duty and the extent of discretion authorized.

6. *Specific Terms of Assistance.*—Any program of medical assistance requires some operating definitions as to (a) eligible recipients, (b) benefits available (including which providers and what services are covered), and (c) payment levels. As for other aspects of program administration, local administrators generally are given broad discretion, although courts have sometimes limited the exercise of this discretion.<sup>179</sup> For example, a New Jersey court held that a municipality must conform to statewide rules and regulations of public assistance.<sup>180</sup> In a case from

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<sup>173</sup>*Bay Gen. Community Hosp.*, 156 Cal. App. 3d 944, 203 Cal. Rptr. 184; *Union of Am. Physicians & Dentists v. County of Santa Clara*, 149 Cal. App. 3d 45, 196 Cal. Rptr. 602 (1983).

<sup>174</sup>WASH. REV. CODE ANN. § 74.09.035 (Supp. 1987); see also GA. CODE ANN. § 31-8-36(b) (1985).

<sup>175</sup>*St. Thomas Hosp. v. Schmidt*, 62 Ohio St. 2d 439, 406 N.E.2d 819 (1980); OHIO REV. CODE ANN. § 5101.161 (Anderson Supp. 1985).

<sup>176</sup>IDAHO CODE § 31-3503 (1983); see also *Idaho Falls Consol. Hosp. Inc. v. Bingham County Bd. of County Comm'rs*, 102 Idaho 838, 642 P.2d 553 (Idaho 1982).

<sup>177</sup>NEV. REV. STAT. § 428.050 (1985).

<sup>178</sup>Some courts have held that counties may not be liable for indigent health care beyond their budgets. See, e.g., *Board of Directors of Memorial Gen. Hosp. v. County Indigent Hosp. Claims Bd.*, 77 N.M. 475, 423 P.2d 994 (N.M. 1967); *Board of Comm'rs v. Ming*, 195 Okla. 234, 156 P.2d 820 (1945); *Cache Valley Gen. Hosp. v. Cache County*, 92 Utah 279, 67 P.2d 639 (1937). Other courts have held that obligations must be met even if they exceed the county's budget limitations. *City & County of San Francisco v. Superior Court*, 57 Cal. App. 3d 44, 128 Cal. Rptr. 712 (1976); *Hall v. County of Hillsborough*, 122 N.H. 448, 445 A.2d 1125 (1982).

<sup>179</sup>See *supra* text accompanying notes 167-70.

<sup>180</sup>*Ricker v. Lawson*, 155 N.J. Super. 536, 382 A.2d 1183 (1977).

New Hampshire, a United States district court held that a town must administer its assistance program pursuant to written, objective, and ascertainable standards.<sup>181</sup>

To determine eligibility, administrators of indigent health care must define "indigent." The majority of states do not provide a definition within the statute itself, although some statutes include a very general definition. For example, New Hampshire defines those who are entitled to free health care as those who are "poor" and unable to support themselves.<sup>182</sup> Idaho defines the medically indigent as "persons needing hospital care without income or resources sufficient to pay for necessary medical care."<sup>183</sup> Some states have included within their statutes more precise definitions of "indigent." Arizona, for example, establishes specific income and resource standards.<sup>184</sup> Oklahoma defines an indigent as a person with income under the federal poverty level, with resources insufficient for self care, and with a need for hospital care.<sup>185</sup>

Where statutes have provided no definition of indigency or only a general definition, state courts have often played an active role in interpreting the statute. The Supreme Court of Montana, for example, held that the counties must have flexible eligibility standards that take into consideration not only income but also family debts and outstanding medical bills.<sup>186</sup>

In defining indigency, most state statutes contain residency or citizenship requirements. However, in 1974, the United States Supreme Court held that an Arizona statute requiring a year's residence in a county as a condition of indigent care was unconstitutional under the equal protection clause.<sup>187</sup> Since this ruling, several state courts have invalidated other similar durational residency requirements. More recent statutes simply require the indigent to be domiciled in the state with an intent to reside there.<sup>188</sup> This type of residency requirement would seem to answer the equal protection concerns stated by the Supreme Court.<sup>189</sup>

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<sup>181</sup>Baker-Chaput v. Cammet, 406 F. Supp. 1134 (D.N.H. 1976).

<sup>182</sup>N.H. REV. STAT. ANN. § 165:1 (Supp. 1986).

<sup>183</sup>IDAHO CODE § 31-3503 (1983).

<sup>184</sup>ARIZ. REV. STAT. ANN. § 36-2905 (Supp. 1986).

<sup>185</sup>OKLA. STAT. ANN. tit. 56, § 58 (West Supp. 1987).

<sup>186</sup>Saint Patrick Hosp. v. Powell County, 156 Mont. 153, 477 P.2d 340 (1970); see also Hall v. County of Hillsborough, 122 N.H. 448, 445 A.2d 1125 (1982); Sioux Valley Hosp. Ass'n v. Davison County, 319 N.W.2d 490 (S.D. 1982).

<sup>187</sup>Memorial Hosp. v. Maricopa County, 415 U.S. 250 (1974).

<sup>188</sup>See, e.g., MONT. CODE ANN. § 53-3-315 (1985).

<sup>189</sup>In 1982, the United States Supreme Court held unconstitutional a Texas statute which prohibited illegal aliens from enrolling in public schools. Plyler v. Doe, 457 U.S. 202 (1982). This case would seem to indicate that states could not deny indigent health care to undocumented aliens. However, language in the opinion can be interpreted as limiting the holding to educational rights of minor children.

States have differed in their treatment of undocumented aliens. The New Mexico Supreme Court held undocumented aliens were "residents" for purposes of the indigent care statute.<sup>190</sup> However, a California court recently held that counties were not required to reimburse private hospitals for care of undocumented aliens because the statute required indigents to be "lawful" residents.<sup>191</sup>

Most state statutes do not specify which providers or what services are covered under their indigent health care laws.<sup>192</sup> Thus, the counties often have considerable discretion in determining the type of care covered and who may be paid as providers. Although state courts generally have upheld this broad discretion, California courts have held that a county has no obligation to pay for indigent care delivered at a facility other than its own or one with which it has contracted.<sup>193</sup> In contrast, the Idaho Supreme Court required an Idaho county to pay a hospital that was neither under contract nor even within the state.<sup>194</sup> (The case involved an Idaho resident's going to nearby Salt Lake City, a logical and common pattern; query whether more distant hospitals would be paid.) Even those states that require a contractual relationship with the provider often allow recovery by noncontractors in emergency situations.<sup>195</sup>

The particular services covered by indigent health care programs also vary widely from state to state.<sup>196</sup> Most state indigent statutes cover at least emergency care. Some states cover a broader range of health care needs. Arizona, for example, provides for hospitalization and medical care, including long-term care and home health services.<sup>197</sup>

Judicial interpretations of coverage provisions have been important. The Indiana courts, for example, have construed an Indiana provision that covers indigents suffering from a "disease, defect, or deformity" to exclude normal pregnancy.<sup>198</sup> In a later case interpreting the same

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<sup>190</sup>*Perez v. Health & Social Servs.*, 91 N.M. 334, 573 P.2d 689 (1977).

<sup>191</sup>*Bay Gen. Community Hosp. v. County of San Diego*, 156 Cal. App. 3d 944, 203 Cal. Rptr. 184 (1984).

<sup>192</sup>*See, e.g.*, CAL. WELF. & INST. CODE § 17000 (West 1980); CAL. GOV'T CODE § 29606 (West 1968). California's statute directs counties to "relieve and support" the incompetent, poor and indigent, and "necessary expenses" incurred in this support are charged to the county. *See also* NEB. REV. STAT. § 68-104 (1984). Nebraska's statute directs counties to provide "medical and hospital care" to "the poor".

<sup>193</sup>*E.g.*, *Bay Gen. Community Hosp.* 156 Cal. App. 3d 944, 203 Cal Rptr. 184.

<sup>194</sup>*University of Utah Hosp. & Medical Center v. Bethke*, 101 Idaho 245, 611 P.2d 1030 (1980).

<sup>195</sup>*County Dep't of Public Welfare v. Trustees of Indiana Univ.*, 145 Ind. App. 392, 251 N.E.2d 456 (1969); *Washoe County v. Wittenberg*, 100 Nev. 143, 676 P.2d 808 (1984).

<sup>196</sup>*See generally* IHPP, *supra* note 136, at 67-292 (state-by-state profiles).

<sup>197</sup>ARIZ. REV. STAT. ANN. § 11-291 (Supp. 1986).

<sup>198</sup>*Lutheran Hosp. of Fort Wayne, Inc. v. Department of Public Welfare*, 397 N.E.2d 638 (Ind. Ct. App. 1979) (construing IND. CODE § 12-5-1-1 (1982)).

statute, an Indiana court held that a county may not restrict the number of inpatient days.<sup>199</sup>

Few indigent care programs set the type of particularized limits or conditions on services that have become common in conventional private group health insurance and in Medicaid, such as pre-admission screening for nonemergency hospital admissions.<sup>200</sup> Indigent programs that are integrated with Medicaid present an exception.<sup>201</sup> Thus, the validity of controls of this kind seems not to have been litigated.

Program specifications, or the lack thereof, also govern payment levels, an important indirect influence on access to care. Medicaid-integrated programs generally pay Medicaid rates, and contractual providers receive the contracted-for amounts. Many older-style indigent vendor-payment programs, however, pay hospitals flat, per-day amounts.<sup>202</sup> Two older state statutes oddly prohibit price setting through bids<sup>203</sup>—quite contrary to recent innovations in practice, notably in Arizona and California.<sup>204</sup> One early Nebraska case disqualified counties' prepayment for services as "insurance,"<sup>205</sup> but this holding seems obsolete in light of recent trends toward prepayment in Medicare and Medicaid.

Most states or counties have established varied procedural requirements that providers or patients must follow to receive payment for indigent health care. Many states require prior governmental approval or a contractual agreement before a provider renders care to an indigent. However, this requirement may be waived in emergency situations.<sup>206</sup>

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<sup>199</sup>*Welborn Memorial Baptist Hosp., Inc. v. County Dep't of Public Welfare*, 442 N.E.2d 372 (Ind. Ct. App. 1982).

<sup>200</sup>*See, e.g., J. CALIFANO, supra note 22; P. Fox, W. GOLDBECK & J. SPIES, supra note 22; J. HOLAHAN & J. COHEN, supra note 18.*

<sup>201</sup>Maryland, for example, simply includes indigents not eligible for federal Medicaid assistance within the same state-federal Medicaid program, but wholly at state expense. *See IHPP, supra note 136, at 157-59.*

<sup>202</sup>*See, e.g., Massachusetts Gen. Hosp. v. Cambridge*, 347 Mass. 519, 198 N.E.2d 889 (1964) (hospital rate for voluntarily treated indigents is purely statutory and can be below actual incurred expenses); DEL. CODE ANN. tit. 29, § 7204 (1983); *see also Springfield Hosp. v. Comm'r of Public Welfare*, 350 Mass. 704, 216 N.E.2d 440 (1966) (hospital rate for old age assistance patient below actual cost is valid; hospitals are "greatly affected with the public interest" and have a "civic obligation" to serve patients).

<sup>203</sup>CONN. GEN. STAT. ANN. § 17-274 (West Supp. 1986); UTAH CODE ANN. § 17-5-55 (Supp. 1986).

<sup>204</sup>*See, e.g., J. CHRISTIANSON & D. HILLMAN, HEALTH CARE FOR THE INDIGENT AND COMPETITIVE CONTRACTS: THE ARIZONA EXPERIENCE* (1986); L. JOHNS, R. SERZAN & M. ANDERSON, SELECTIVE CONTRACTING FOR HEALTH SERVICES IN CALIFORNIA, FINAL REPORT (1985).

<sup>205</sup>*Hustead v. Richardson County*, 104 Neb. 27, 175 N.W. 648 (1949) (counties not authorized to engage in business of insurance).

<sup>206</sup>*University of Utah Hosp. & Medical Center v. Bethke*, 101 Idaho 245, 611 P.2d 1030 (1980).

#### D. Obligations of Private Health Insurers

Would-be insureds have no general legal right to private health coverage, and there is little tradition of providing free or below-cost insurance as there has long been for providing hospital care. Insurance is a private contract, only partially regulated, available to those who can afford it and not to others. Several qualifications to this "no rights" generalization deserve mention.

First, if workers or their dependents are covered through a workplace group and they cease to be group members, because of layoff or widowhood, for example, they are entitled to continue on the group policy at their own expense for a certain period.<sup>207</sup>

Second, in most states, Blue Cross/Blue Shield plans in theory must allow open enrollment in their nongroup plans.<sup>208</sup> This is one regulatory stricture that can be seen as a public quid pro quo for granting the Blues tax exemption. Moreover, such nongroup Blues rates may be kept low by direct or indirect subsidy from the Blues' group business if their group market share is strong enough to permit this;<sup>209</sup> they also often use a version of "community rating" principles. Community rating charges all insureds in a large pool the same price (based on the pool's average cost), rather than basing rates on the specific experience of subgroups. Pooling experience arguably helps the poorest and sickest, whose experience is the worst, at the expense of lower-risk insureds.<sup>210</sup>

Finally, ten states now guarantee otherwise uninsurable people the right to conventional insurance at a subsidized rate.<sup>211</sup> Coverage is rea-

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<sup>207</sup>This "continuation" privilege (or the ability to "convert" to a relatively generous individual policy) arose first through industry custom, then through state and federal law. On custom, see HEALTH INS. ASS'N OF AM., GROUP HEALTH INSURANCE 1-17 (1976); for state rules as of Spring 1985, see IHPP, *supra* note 136, at 294-95; for new federal rules from COBRA legislation, extending the right to coverage to a period up to three years in some cases, see Bovbjerg, *supra* note 24, at 405-06 nn. 12 & 13.

<sup>208</sup>See, e.g., IND. CODE § 27-8-11-3 (Supp. 1986). It is thought that in recent years, the Blues' commitment to open enrollment has waned under competitive pressure. Cf. U.S. GEN. ACCT. OFF., PUB. NO. HRD-86-110, HEALTH INSURANCE: COMPARING BLUE CROSS AND BLUE SHIELD PLANS WITH COMMERCIAL INSURERS (July 1986) (Blues' differences from commercials described as minor).

<sup>209</sup>In Massachusetts, for example, by order of the Insurance Commissioner, one percent of group premiums helps defray nongroup expenses. Indirect subsidies may be achieved by regulatory accounting rules that attribute the same administrative loading factor to group coverage as to nongroup, when in fact group practice could normally be expected to achieve economies of scale in sales and operations. Cf. Bovbjerg, *supra* note 24, at 409.

<sup>210</sup>Under competition from more experience-rated policies, largely in the group market, community rating pools tend to fragment, as low-risk groups insure on their own rather than remain in the community pool. For a description of how such competition ended early community rating in the group market, see P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 329-31 (1982).

<sup>211</sup>In one of the ten, Connecticut, the pool is not restricted to persons rejected by conventional insurers. See Bovbjerg & Koller, *State Health Insurance Pools: Current*

sonably generous by non-group standards, but enrollments are very low, even as a fraction of the tiny percentage of uninsurables.<sup>212</sup> Even with considerable subsidy, policies cost 150% or more of the price of standard coverage.

These various insurance rules all help would-be insureds, but do require them to pay for their own coverage, albeit at relatively favorable rates. Thus, they probably do not reach many or most of the medically indigent, who are relatively poor or unemployed or both. They may, however, help prevent medical indigency among the nonpoor caused by large medical bills that exceed ability to pay.

One common type of state insurance regulation tends to make insurance relatively less affordable, namely "mandatory benefits" rules that require all health insurance policies to cover certain services, notably mental health care. Mandated benefits "upgrade" insurance protection for those who can afford it, but disproportionately burden poorer insureds and their employers and tend to make it more difficult for those less able to pay to buy any coverage at all.<sup>213</sup>

#### IV. PRIVATE AND PUBLIC APPROACHES TOWARD IMPROVEMENT

##### A. *Introduction: Where We Stand*

The problems of the uninsured and of the uncompensated care they generate are increasing. Legally, there is tenuous support for a right to care or coverage in the constitutional or statutory sense, as just noted. Most of the obligations are conditional: that is, if a provider, an insurer, or the government assumes to provide care or coverage for someone, then it must provide care or coverage of a certain standard. In any event, this branch of the law appears to be poorly developed in terms of the jurisprudence of rights. Indeed, for the most part, cases on indigent coverage do not even cite one another. As a result, the body of case law provides little guidance.

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*Performance, Future Prospects*, 23 INQUIRY 111 (1986) (experience of six pools operating before 1984). The states are Connecticut, Florida, Indiana, Iowa, Minnesota, Montana, Nebraska, Ohio, Rhode Island, Tennessee, and Wisconsin. As of late 1986, ten states now have risk pool legislation, according to the National Governors' Association. G. CLAXTON, CONCEPT PAPER: FACILITATING HEALTH CARE COVERAGE FOR THE WORKING UNINSURED 14 (Nat'l Governor's Ass'n, Pre-Conference Draft, Dec. 1986).

<sup>212</sup>Bovbjerg & Koller, *supra* note 211. About one percent of the population is thought to be uninsurable. *Id.* See also *supra* note 26 and accompanying text.

<sup>213</sup>See Demkovich, *supra* note 50. Such rules disproportionately burden small group and nongroup coverage because large workplace groups very often "self-insure" precisely so as to escape such state insurance mandates and achieve other economies. See Bovbjerg, *supra* note 24, at 408. Over half of large employment groups are now thought to self-insure. See *infra* note 273.

Any effective solution will require at least some government involvement, although the nature of that involvement may vary considerably according to circumstances. Past political responses to the problems of the poor have varied enormously, and there is considerable disagreement about the approach that should be taken.

### B. *Private Sector Approaches*

“Leave it to the private sector” is the understandable response of many people to medical indigency. After all, most of the progress in past generations was due to the astonishing success of private group health coverage. It is largely responsible for bringing health coverage to approximately ninety percent of American workers and their dependents.<sup>214</sup> Moreover, “mainstream” employment group coverage prepays for most typical medical and dental services from almost any licensed provider at little out-of-pocket cost to the insured—thus guaranteeing access to care while also protecting against poverty-inducing catastrophe.<sup>215</sup>

The spread of workplace group insurance, however, seems to be reaching its natural limit.<sup>216</sup> Under current economic conditions, it appears that a relatively high level of “structural uninsurance” will remain. Of course, this level will vary from place to place depending upon economic conditions, the employment structure of the economy, existing tax incentives, and so on.

Relying on private efforts to increase insurance can only partly address the problem of medical indigency. Private coverage can reach only those with the wherewithal to pay for coverage. It thus bypasses the indigent, although more coverage would tend to prevent the type of medical-financial catastrophe that can cause people to become medically indigent.

Most employed people who do not have “proper” coverage and who might expect to benefit from private solutions are in small employment groups. Of employees in larger groups (100 or more employees), nearly 100% have coverage, whereas fewer than half of the people in smaller employment groups have health coverage.<sup>217</sup> The plain fact is that existing forms of coverage sold through existing organizational arrangements simply cost more than many of these workers and their

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<sup>214</sup>See, e.g., Moyer & Cahill, *supra* note 24; see also *supra* notes 12-15 and accompanying text.

<sup>215</sup>Medicare and Medicaid are similar to private coverage in this regard; they have essentially adopted the workplace model of middle class style coverage for their particular populations.

<sup>216</sup>See *supra* text accompanying notes 46-52.

<sup>217</sup>See, e.g., Moyer & Cahill, *supra* note 24. The problem is thought to be still worse for very small groups, those with twenty, ten, or fewer employees.

employers are willing to pay. For smaller, poorer workplaces and for individuals, covering the same medical expenses costs more per capita in absolute terms, costs much more as a relative share of earnings, and receives considerably less government "subsidy" in forgone taxes.<sup>218</sup>

For large groups, medical experience is more predictable (and hence more insurable), and economies of scale make coverage cheaper to sell and to administer. Relative costs of sales, administration, claims settlement, and regulation all rise as group size declines; and many of the economizing methods of large groups are not available to smaller ones, at least not to the same degree—including, for instance, self-insurance, sophisticated protocols for screening and reviewing care, and negotiating favorable rates with medical providers. Smaller groups can combine into larger ones, but artificially created large groups do not act like naturally existing groups.<sup>219</sup> Finally, the tax-free status of workplace health benefits provides a greater benefit to higher income workers than to poorer ones because income taxes are progressive. Those working poor most in need of assistance pay no income tax at all but likewise receive no tax benefit from buying medical care through workplace coverage, unlike their middle class counterparts.

Some private initiatives offer opportunity for improvement, notably in underwriting and pooling smaller groups and in developing attractive plans with better cost-containment features.<sup>220</sup> Attitudes about the importance of insurance may also change. However, substantial changes in the extent of purely private coverage look implausible in the near future. Clearly, more fundamental changes will require more government involvement, either through direct or indirect subsidies or through some form of mandates or coercion. Again, this should not be surprising. If the poor and near poor cannot or do not cover themselves voluntarily, someone else must pay for their care, at least in part.

### C. Public Sector Approaches

Any model of coverage and care for the medically indigent must address four basic questions: who should be eligible; what should be the nature of the product or program; how should it be financed; and how should it be administered.<sup>221</sup> This Article next examines a number

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<sup>218</sup>On the problems of small versus large groups in insurance markets, see Bovbjerg, *supra* note 24.

<sup>219</sup>Differences stem mainly from adverse selection, increased sales and administrative expenses, and instability over time. See generally *id.*

<sup>220</sup>*Id.*

<sup>221</sup>There are many ways to characterize options for indigent coverage and care, and each author tends to develop his own. These four issues cover the fundamental choices. For somewhat different categorizations, see, e.g., IHPP, *supra* note 136; STATE AND LOCAL GOVERNMENT RESPONSIBILITIES, *supra* note 93; Bartlett, *Overview of Public Policy Options*

of models and the different ways they attempt to answer these questions.

1. *Eligibility for Assistance.*—The uncertain nature of medical indigency makes it difficult to determine who should be eligible. One problem is the difficulty of deciding what constitutes “need.” Taxpayers and the political systems that represent them are unwilling to finance unlimited amounts of everything called “medical care” for all those who cannot or do not provide for themselves. From a policy perspective, it is clearly inappropriate to undercut incentives for self-help and to promote “free riding” by many people who would normally insure themselves but who would happily take free public assistance instead.

Another problem with defining eligibility in advance is that relevant circumstances are not fixed: employment status changes, and people’s incomes go up and down, as does their medical spending. The inability to foresee such changes complicates the operation of an insurance-style program, which contemplates coverage for a defined population over a preset time period. The uninsured, in notable contrast, are a constantly shifting and unstable grouping.

Nonetheless, some eligibility guidelines must be created, using income, assets, medical status, and other characteristics of potential eligibles. One way to deal with shifting circumstances is to allow administrators discretion to reevaluate eligibility on a continuous basis (for each hospital admission, for example). A major *legal* question is to what extent administrators will be allowed discretion to grant or deny eligibility for unusual circumstances; indeed, existing medical indigency programs often have extremely vague standards. These standards could be difficult to sustain against an attack on due process grounds.<sup>222</sup> A major *practical* concern is that constant reconsideration is not only expensive for public administrators but also a deterrent to private actors who may be at risk as a result of a finding of non-eligibility. Vagueness makes it difficult for both eligibles and providers who deal with them to know where they stand; this uncertainty must hurt access to care for these uncertain eligibles.

At any given level of public spending, there is a clear trade-off between covering more people and providing more benefits: the more people covered, the higher the expense. Indeed, of any design decision, eligibility has the greatest impact on total program spending. The quickest way to increase or decrease spending is to add to or subtract someone

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*to Improve Access for the Medically Indigent*, in ACADEMY, *supra* note 136, at 47; Butler, *supra* note 136; Hughes, *Local Anesthetics: A Look at States' Programs for the Uninsured*, HEALTH/PAC BULLETIN, November 1986, at 11; Lewin & Lewin, *Health Care for the Uninsured*, BUS. & HEALTH, September 1984, at 9; Wilensky, *Underwriting the Uninsured: Targeting Providers or Individuals*, in UNCOMPENSATED HOSPITAL CARE, *supra* note 30, at 148.

<sup>222</sup>See Butler, *supra* note 136; STATE AND LOCAL GOVERNMENT RESPONSIBILITIES, *supra* note 93, at 19-22.

from the rolls. Other program adjustments have a much smaller fiscal impact than completely dropping or adding an additional person.

One way to avoid having to make an all-or-nothing eligibility decision is to require people to contribute something on their own on an income-related basis, even if they receive public assistance. Public assistance then subsidizes self-help rather than wholly replacing it. This can be done in advance by making beneficiaries share in premium payments, or after the fact, by making them co-pay for incurred medical expenses. Nevertheless, requiring even partial payments from poor people in need of care is distasteful to many; cost sharing under Medicaid has met with considerable political reluctance.<sup>223</sup> Moreover, it has often proven difficult for providers to be very vigorous or effective in collecting their unpaid share of bills from a relatively poor population.

Another possibility is to target specific groups seen as fiscally or medically needier than others or those for whom the public investment in care is perceived to have the largest benefit. The most obvious group on both these counts is composed of low-income children and expectant and recently delivered mothers. Numerous states are beginning to target Medicaid expansions in this manner; the same could hold true for other public efforts to aid the indigent.<sup>224</sup>

Of course, setting eligibility standards to aid the medically indigent is more easily described in the abstract, as here, than actually implemented. As already noted, the concept of medical indigency is itself not easy to define.<sup>225</sup> Numerous programmatic problems arise in defining what support to provide to people at what levels of income and assets: For example, over what period of time is income measured? What assets count, including those of family members, and how are they to be valued? What "spend down" of income or assets (to meet large, uncovered medical bills) makes an otherwise non-indigent person eligible?<sup>226</sup> Once an operational definition of medical indigency is created, including

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<sup>223</sup>Traditionally, Medicaid programs have not been allowed to charge co-payments, although this has changed somewhat of late. See *Cost Sharing by Recipients*, 3 Medicare & Medicaid Guide (CCH) ¶ 14,731 (March 1983).

<sup>224</sup>See, e.g., Dallek, *States Study Health Care for the Uninsured Poor*, 18 CLEARINGHOUSE REV. 740, 743 (1984); Kosterlitz, *Concern About Children*, NAT'L J., Sept. 20, 1986, at 2255 (state task forces have recommended special attention to children in Colorado and Texas, for example). Recent federal legislation has allowed expanded coverage. See *infra* note 237.

<sup>225</sup>See *supra* note 9.

<sup>226</sup>Medicaid has of course had to create numerous rules and administrative mechanisms to decide eligibility; eligibility is generally conceded to be the most complex and difficult part of Medicaid to describe or understand. See, e.g., Joe, Meltzer & Yu, *Arbitrary Access to Care: The Case for Reforming Medicaid*, HEALTH AFF., Spring 1985, at 59. Complexities make it difficult even to know how many people are eligible for any Medicaid program at a particular time; hence reliable program statistics focus on the number of known "recipients" of covered care. See, e.g., J. HOLAHAN & J. COHEN, *supra* note 18, at 45.

of necessity lack of adequate health insurance, it becomes difficult to avoid "free riding" by eligible beneficiaries who, absent public aid, would cover themselves through their own or their employers' efforts. Even many low-income people have some insurance. Various strategies exist to address this problem, but none is perfect.<sup>227</sup>

2. *The Product: Hospital Payment vs. Insurance.*—What is to be provided to those who are eligible? Should public aid focus only on hospital services, or should it instead provide for broader availability of medical services, typically through an insurance-like mechanism? Either approach can use public or private hospitals or insurance plans.

a. *Hospital-based programs.*—Three basic program models focus on hospitals. The first is to operate a public hospital or, increasingly, to contract with a private entity to operate it. Under the public hospital model, the hospital not only provides services but also determines eligibility and benefits, since it is typically left to the hospital to decide whom to serve, in what order, and how much care to give. It can be difficult to establish good public budgetary control over these hospital choices. Public hospitals have been an important source of care for the medically indigent, but the trend is toward reducing rather than increasing the public role in this area.<sup>228</sup>

A second possibility is to contract with a number of hospitals, public and private, for the delivery of particular care to a particular population. This model is often followed for small, specific public health programs,<sup>229</sup> but is less often used for general medical care for the medically indigent.<sup>230</sup> Its use could be expanded. A major advantage of contracting over the public hospital approach is that it may provide some competition among hospitals for the contract(s). In any event, in many areas there is no public hospital, and the contract approach offers a simple way to pay for care.

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<sup>227</sup>Eligibility standards can be set very stringently to cover only the desperately poor, who can seldom contribute to their own coverage in any case. But this eliminates the working poor, with some income, who contribute large numbers of uninsured. A "sliding scale" of income-related assistance is a promising alternative, but requires ongoing administrative complexity either to bill beneficiaries for their share of public premiums or to give them "vouchers" to buy private coverage. Another mechanism is to offer assistance to only the "hard core" uninsured, for example, by requiring that beneficiaries have gone two years without any private coverage. This discourages free riding but again leaves uncovered many otherwise deserving potential eligibles. Requiring "maintenance of effort" in terms of employers' buying private insurance is another possibility, but is administratively complex: monitoring and enforcement for hundreds of thousands of small workplaces would be needed, more if individual self-help were required.

<sup>228</sup>See *supra* notes 57, 58, 142 & 143 and accompanying text.

<sup>229</sup>See *supra* note 145 and accompanying text.

<sup>230</sup>An exception is Iowa where, with state funds, the University of Iowa Hospital and Clinics provide "free" care to all county-certified indigents (up to a preset quota) from all over the state. See IHPP, *supra* note 136, at 139.

A third model, already in use in many states, is to cover a group of qualifying hospitals under a "vendor payment" program.<sup>231</sup> Under this model, eligibility standards may be defined by the program, with hospitals put at risk to obtain verification of patients' eligibility before delivering nonemergency services.

These options have been aggregated under the rubric of hospital-based approach because by far the bulk of such programs' spending normally goes to hospitals. A limited amount of non-hospital outpatient care could also be provided through direct dealings with non-hospital providers, primarily those affiliated with public health systems. Public health systems provide various primary, preventive, and other medical services through public health clinics operated by local governments and staffed with public health nurses, doctors, and others.<sup>232</sup>

The major advantage of the hospital-based approach is that it builds on the existing system. After all, hospitals deliver the most crucial care, receive the bulk of current spending on the medically indigent, and provide the most uncompensated care. The other advantage of a hospital-oriented approach is its relative ease of operation and finance. The number of hospitals, especially public hospitals, is relatively small, which facilitates dealing with them. It would be far more difficult to deal on the same basis with physicians or other more numerous providers.

*b. Medicaid and lesser "insurance" programs. (i.) Advantages of insurance.*—The second basic approach is not hospital-oriented but rather recipient-oriented—in short, insurance or something very much like it. Insurance-style programs cover a broader spectrum of care and determine eligibility not merely for one hospital episode, but for a set period of time, much as private insurance enrolls people for a year or for some other term of coverage.

Paying only for hospital care means covering only the most expensive care and forgoing whatever possibilities exist to treat medical problems before they become sufficiently serious to warrant institutionalization. It also delegates to hospitals considerable control over who is to receive care and to what extent. Moreover, if only public hospitals or a limited number of private hospitals specialize in care to the poor, a hospital-oriented approach also fails to promote quality competition, which may be important in assuring that poor people get adequate care. There is also some danger that any hospitals designated under a hospital-only approach would be at least perceived as being lower quality, welfare-style hospitals and hence would be shunned by the insured middle class.

In contrast, an insurance entitlement empowers the patient rather

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<sup>231</sup>See, e.g., Butler, *supra* note 136, at 19-20; see *supra* text accompanying notes 146 & 147.

<sup>232</sup>See, e.g., ROLE OF STATE AND LOCAL GOVERNMENTS, *supra* note 134; PUBLIC HEALTH FOUNDATION, *supra* note 135.

than the provider.<sup>233</sup> Giving people control over their own insurance money gives them a measure of dignity in contrast to shunting them to a "charity" hospital. It also allows both patients and providers to plan for medical care to a greater extent. Moreover, giving people the resources with which to "shop around" may promote desirable quality competition.

Quality is also enhanced by hospitals' and doctors' serving the medically indigent alongside better funded and possibly more demanding patients. Covering more than hospital services promotes health maintenance and thus avoids some needs for inpatient care. This method may or may not save money overall, but it certainly makes people better off.<sup>234</sup> Finally, under an insurance plan, a partial public subsidy is more feasible because the beneficiaries' share is collected in advance, when they are more likely to be healthy and employed. Collecting at the time of medical need or thereafter, as with the hospital-based plans described above, is more difficult. For all of these reasons, this Article strongly supports insurance-style programs for the medically indigent, to the fullest extent that they are politically and economically feasible.

Economic feasibility is, of course, the Achilles' heel of this insurance approach. Broad coverage can be far more expensive than simply relying on public hospitals, both because the price per unit of service may be higher and because a great deal more care may be delivered and consumed.<sup>235</sup> The great challenge, then, for those who favor an insurance-style approach is to find ways to provide coverage that is less expensive than conventional approaches or to persuade the electorate that expansion of existing programs is fiscally prudent and a good medical value.

(ii.) *Options for expanding Medicaid.*—The best known and by far the largest insurance-style approach is Medicaid. Indeed, the most straightforward way to expand coverage for the medically indigent would be to cover more poor people under Medicaid. For states, Medicaid is a good insurance "buy" because the federal government pays half or more of program spending on an open-ended basis. Medicaid coverage could be expanded by raising the income standards for eligibility, by choosing to cover people in optional categories such as two-parent families or children aged 18-21 or by operating "medically needy" programs that allow people to "spend down" to eligibility.<sup>236</sup> Additional expansions

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<sup>233</sup>For one view of the importance of empowering patients, see Bovbjerg & Held, *Ethics and Money: The Case of Kidney Dialysis and Transplantation*, TOPICS IN HOSP. L., Sept. 1986, at 55.

<sup>234</sup>It is poorly appreciated that much so-called "preventive" medical care is not cost-effective, that is, does not save a dollar in prevented care for every dollar invested in prevention. See generally L. RUSSELL, *IS PREVENTION BETTER THAN CURE?* (1986).

<sup>235</sup>People without insurance now get much less care even though they are sicker. Giving those people coverage can thus be expected at least to double the amount of care that they get in hospitals and perhaps similarly for outpatient services. See *supra* Table 4 & note 27.

<sup>236</sup>Few states maximize federal financial participation in Medicaid by setting the highest allowable income limits and covering all optional eligibility categories. See generally J.

would be possible if federal requirements for categorical eligibility as well as low income were eased.<sup>237</sup> However, the fact that states have not expanded Medicaid eligibility indicates that they think it is too expensive to cover more people in this way—even with federal subsidies.<sup>238</sup> The one major area of program expansion in recent years has been to add coverage for poor children and their mothers.<sup>239</sup> Of course, states are free to cover others as they please, without federal assistance.

(iii.) *New economizing options.*—If Medicaid and other traditional programs are perceived as too expensive, what alternatives exist? The keys to economizing are to hold down the price and utilization of medical care. This must be accomplished without leaving uncovered large expenses for catastrophic care, a central goal of good coverage. It is especially important to limit expensive hospital care, through some combination of provider and patient incentives, prescreening of admissions, reviews of care given, and judicious substitution of outpatient for inpatient care.

The other critical element is to lower prices paid to providers, particularly hospital payments.<sup>240</sup> From the standpoint of the hospitals,

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HOLAHAN & J. COHEN, *supra* note 18. This is one reason that only about 40% of poor people are Medicaid eligible. *Id.* For a good short review of Medicaid eligibility options, see Reymer, *Medicaid Eligibility Options*, in *AFFORDING ACCESS TO QUALITY CARE I* (R. Curtis & I. Hill eds. 1986).

<sup>237</sup>Recent federal amendments have taken a first step toward easing categorical requirements by allowing coverage of expectant mothers and poor children not receiving AFDC cash assistance. See Consolidated Omnibus Budget Reconciliation Act of 1985, PUB. L. No. 99-272, §§ 9501, 9511, 100 Stat. 82, 201, 212; Omnibus Budget and Reconciliation Act of 1986, Pub. L. No. 99-509, 100 Stat. \_\_\_\_; see also Kosterlitz, *Breaking Medicaid's Link with AFDC*, NAT'L J., Sept. 20, 1986, at 2256. But more significant expansions seem unlikely. The current administration has sought to *cap* federal Medicaid obligations rather than allowing states to expand them yet further. R. BOVBJERG & J. HOLAHAN, *supra* note 18, at 7-10, and budget deficits make congressional initiative unlikely as well. See also *supra* note 63.

<sup>238</sup>The number of Medicaid recipients has remained stable in the 1980's, despite increased need for coverage. See *supra* notes 18-19 and accompanying text. See also J. HOLAHAN & J. COHEN, *supra* note 18, at 40-43.

<sup>239</sup>The 1981 Medicaid amendments gave states the authority to target children's care without having to provide full medically needy benefits for the elderly and disabled, who consume far greater resources for less obvious returns in avoiding other long term medical costs. R. BOVBJERG & J. HOLAHAN, *supra* note 18, at 33-35. In the case of children, it is possible to provide cost-effective care by expanding preventive and prenatal services and thus to avoid many of the very large bills which can accompany difficult deliveries and disabled or crippled children. Subsequent federal changes have both required and allowed more coverage of children. See *supra* note 237.

<sup>240</sup>Of course, a key feature of any such program for the indigent would be a requirement that the provider accept payment from the program as payment in full, except perhaps for specified cost sharing by patients. That is currently done in both Medicare and Medicaid with regard to hospitals. See *Admissions and Quality Review*, 1 Medicare & Medicaid Guide (CCH) ¶ 4227 (Nov. 1984); and *Reimbursement in General*, 3 Medicare & Medicaid Guide (CCH) ¶ 14,723 (Oct. 1984) (Medicare); *Limitations on Charges to Beneficiaries*, 3 Medicare & Medicaid Guide (CCH) ¶ 20,883Q (Oct. 1985); and *Acceptance of State Payment as Payment in Full*, 4 Medicare & Medicaid Guide (CCH) ¶ 21,833 (June 1985) (Medicaid).

this may not be disadvantageous if it helps reduce the total amount of uncompensated care and increase the number of paying patients. Of course, one must take care not to reduce payments so far as to deny beneficiaries desired access to care.<sup>241</sup> Prices can be held down either by setting prices administratively for public programs, by regulating prices of providers, or by using bidding or negotiation to select providers who are willing and able to accept lower prices for a higher volume of patients.<sup>242</sup> Benefits redesign—better targeting of benefits to needs—may also be helpful; the optimal mix of benefits is probably not provided in the traditional insurance policy.<sup>243</sup>

What new arrangements embody these principles? Perhaps the best known example is the Health Maintenance Organization (HMO). HMO's use restricted panels of physicians and hospitals to deliver care and are thought to be less costly than conventionally provided insurance on a fee-for-service basis with open access to all providers of the patient's choice.<sup>244</sup> Many state Medicaid programs now promote HMO's for their eligible participants; programs in California and Michigan have long advocated this approach.<sup>245</sup> Unfortunately, HMO's do not exist in all parts of the country.

Using HMO's to care for the medically indigent presents other problems as well. First, existing HMO's would want to be prepaid on a monthly basis and guaranteed enrollment for six months or more, as is possible under Medicaid.<sup>246</sup> However, the medically indigent can be a floating population; some are transient, others are only intermittently uncovered by private insurance or Medicaid. Second, HMO's are geared to provide comprehensive, high quality care at a price not unlike that charged by private conventional insurance. As a result, HMO's cost considerably more per capita than what a state might pay for a public hospital or for a limited vendor payment program.

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<sup>241</sup>The same holds true for physicians: It is desirable not to overpay physicians, but if physicians are underpaid, they will not provide enough of the services needed to keep people healthy and out of hospitals. This has been an endemic problem for states' Medicaid programs. Low physician payment often results in people going to hospital emergency rooms or outpatient departments for primary care that would have been much more cheaply provided in physicians' offices. See generally J. HOLAHAN & J. COHEN, *supra* note 18, at 62.

<sup>242</sup>See generally Bovbjerg, Held & Pauly, *supra* note 58; *infra* text accompanying notes 253-56.

<sup>243</sup>Long distance transportation (e.g., to less expensive outlying institutions) or non-traditional providers for chronic-care services are two services not conventionally covered but which could be cost-effective if implemented on a controlled basis.

<sup>244</sup>The extent of HMO savings has long been debated. It is clear that people in HMO's use significantly less hospital care than others. H. LUFT, HEALTH MAINTENANCE ORGANIZATIONS: DIMENSIONS OF PERFORMANCE (1981). It is not clear to what extent this is due to HMO economies rather than to self-selection by enrollees.

<sup>245</sup>R. BOVBJERG & J. HOLAHAN, *supra* note 18, at 57.

<sup>246</sup>*Id.* at 58.

Another possibility is the so-called Preferred Provider Organization (PPO).<sup>247</sup> Using existing hospitals and doctor practices, PPO's operate like a cross between conventional insurance, covering all providers, and HMO's, with a limited list of covered providers. PPO's encourage enrollees to use one of a selected group of so-called preferred providers, who have agreed to hold down spending either by discounting their normal fees or by agreeing to utilization reviews or other cost-containment measures.

PPO beneficiaries have fewer cost sharing requirements for using preferred providers than for using other providers, who are still covered but at a lower rate. Both beneficiaries and preferred providers profit from this approach. Beneficiaries receive full benefits from a restricted list of providers, yet retain the ability to go to anyone at some additional expense. Preferred providers benefit, despite lower fees or restrictions, because they can expect to receive additional patients from the PPO or at least to retain patients they might otherwise have lost. Since their inception in the early 1980's,<sup>248</sup> PPO's have grown rapidly, but have only recently expanded their marketing to include small groups and individuals. It is not known whether any states or localities have attempted to contract with private PPO's to enroll the medically indigent. As with HMO's, PPO's currently compete primarily in the employment group market and provide relatively complete benefit packages and high quality care.

Another cost containment approach, which can be used in conjunction with either conventional insurance or alternative systems like HMO's and PPO's, involves "managed care." Management means increased control over care by physician or nonphysician reviewers. One common approach is "case management" by a primary care physician, an internist, or a family physician. These physicians act as the patient's point of entry for all care, controlling referrals to specialists and hospitals and often reviewing the latter's care and charges. Traditional medical practice has long been conceived as similarly beginning with a primary care provider who then makes appropriate referrals, but in practice, many patients have gone directly to high-priced specialists or hospital care on their own. Moreover, even transfers from primary care physicians have not normally involved fiscal management, although some medical follow-up may exist. In contrast, case managers act like true "gatekeepers" by controlling access to and use of care on both economic and medical grounds. Various models exist, not all of which have been successful.<sup>249</sup>

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<sup>247</sup>See, e.g., Gabel & Ermann, *Preferred Provider Organizations: Performance, Problems, and Promise*, HEALTH AFF., Spring 1985, at 24.

<sup>248</sup>See Bovbjerg, *supra* note 24.

<sup>249</sup>It is possible, for example, to put financial risk on managing physicians, or merely to reward them for being parsimonious in their patients' use of medical resources.

A number of areas are experimenting with case management as a way of holding down medical costs while providing broad access to well integrated medical care. Thus, management can potentially have positive effects on health as well as on spending. The state of Kansas, for example, has made some progress in using case management for the medically indigent population,<sup>250</sup> as has the state of Michigan through its Medicaid program.<sup>251</sup>

Outside reviewers can also "manage" care indirectly through such mechanisms as prescreening of hospital admissions, concurrent evaluations of the necessity for prolonged hospital stays, or retrospective review of utilization and claims. These practices are now common in large private health insurance plans, but less so in public plans.<sup>252</sup>

Of course, achieving improvements through case management depends on there being something to manage. Savings are possible where disjointed and perhaps over-generous coverage has led to previous overspending, so that cutbacks are not deleterious. But the main problem for the uninsured is prior *lack* of care, not over-service. One could implement managed care for a previously uncovered population, but the manager must be able to provide a minimum set of benefits—both primary care and necessary specialists, in addition to hospital care—well beyond what is currently available to many or most of those now medically indigent. Such management should make coverage less expensive than traditional open access insurance, but it will almost surely cost more than the patchwork of care now available to the uninsured—because more care will be delivered.

Mention should be made of two other major cost-containment ideas: provider and patient incentives to economize. Providers can be motivated to reduce their use of medical resources if they are prepaid some fixed amount, rather than being "reimbursed" for their incurred costs or charges as under the traditional practice of Medicare, Medicaid, and private plans alike. The 1980's have seen a virtual "buyer's revolution" of refusal to accept provider-dictated spending.<sup>253</sup>

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<sup>250</sup>See Hansen, *Kansas' Medical Coverage Programs for the Poor: A Targeted Approach Through State-Financed and State-Administered Programs*, in ACADEMY, *supra* note 136, at E-1.

<sup>251</sup>See, e.g., McDonald & Fairgrieve, *Michigan's Experiment with Case Management*, 20 CLEARINGHOUSE REV. 423 (Special issue, Summer 1986).

<sup>252</sup>For private developments in managing health spending, see, e.g., J. CALIFANO, *supra* note 22; P. FOX, W. GOLDBECK & J. SPIES, *supra* note 22. Efforts are too numerous and varied to catalog here; many are reported regularly in such newsletters as COALITION REPORT (U.S. Chamber of Commerce, Clearinghouse on Business Coalitions for Health Action, Washington, D.C.) and MEDICAL BENEFITS (Kelly Communications, Charlottesville, Va). For public-plan developments, see, e.g., AFFORDING ACCESS TO QUALITY CARE, *supra* note 236, especially chapter 5 at 127 (Bartlett, *The Management of Medicaid Inpatient Hospital Expenditures*) and Chapter 8 at 201 (Neuschler, *Alternative Financing and Delivery Systems: Managed Health Care*).

<sup>253</sup>See, e.g., J. CALIFANO, *supra* note 22.

Prepayment can result from several approaches. First, plans may simply set prices administratively and offer them to providers on a "take it or leave it" basis, as does Medicare with its prospective payment system for hospitals based on Diagnosis Related Groups (DRG's).<sup>254</sup> Alternatively, preset prices can be arrived at voluntarily through bidding or negotiation, or set on a mandatory basis by economic regulation, as are hospital rates in a number of states.<sup>255</sup> Referral or admitting physicians can also be encouraged to economize on specialists' treatment or hospital care by sharing savings with them.<sup>256</sup> One concern about economizing incentives is naturally that providers may *underserve*, just as generously rewarded fee-for-service practitioners may *overserve*.

Finally, patients may be encouraged to save in similar fashion—either by having to share in spending (cost-sharing through deductibles, co-payments, or co-insurance) or by being allowed to share in savings below expected amounts. However, as previously discussed, patient-oriented strategies are generally considered less desirable for poverty populations than for the insured middle class. A payment requirement to pay X dollars per visit may help insured patients weigh the cost versus the value of care without preventing them from proceeding; for poor people, the burden looms larger relative to their other needs and may deter them from getting care altogether.

3. *Financing. a. Fiscal requirements.*—How much financing is needed to cover the medically indigent? That obviously depends on one's definition of the problem and on how generous one is in addressing it. The potential range is \$5-50 billion, with \$15-20 billion a reasonable estimate for moderate initiatives. A minimal program might cover only the cost of non-elective, uncompensated hospital care that is already provided to "charity" patients. Such care totalled about \$4-5 billion in 1986.<sup>257</sup> Funding such care through a public program would be the

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<sup>254</sup>See, e.g., Bovbjerg, Held & Pauly, *supra* note 58.

<sup>255</sup>See, e.g., *id.*

<sup>256</sup>Some case management strategies do this, as noted *supra* notes 249-52. Similarly, some HMO's give their doctors performance bonuses. And some hospitals prepaid by Medicare have sought to reward physicians for holding down hospital spending. See U.S. GEN. ACCT. OFF., PUB. NO. HRD-86-103, MEDICARE: PHYSICIAN INCENTIVE PAYMENTS BY HOSPITALS COULD LEAD TO ABUSE (1986). Congress has acted to ban under Medicare and Medicaid any payment incentives to physicians from hospitals or risk bearing HMO's to reduce or limit services to patients. Omnibus Budget Reconciliation Act of 1986, Pub. L. No. 99-509, § 9313, 100 Stat. \_\_\_\_\_, \_\_\_\_\_.

<sup>257</sup>The figure is the authors' rough estimate, with the following assumptions: The 1986 cost of uncompensated hospital care is \$13 billion. Cohodes, *supra* note 36 (citing estimates by American Hosp. Ass'n). About one-third of such care goes to charity patients, as designated by hospitals themselves. Sloan, Valvona, & Mullner, *supra* note 31, at 19. Approximately two-thirds of such care is for non-elective services. Cf. *id.* at 30 (fully 42% of relevant hospital charges comes from two categories, childbirth and accidents — both non-elective services). Note that the estimate of \$4-5 billion does not allow for an *increase* in hospital service generated by the knowledge among hospitals and indigents

minimal response to the problems of the medically indigent.

The highest reasonable estimate comes from assuming coverage for all of the uninsured and underinsured for a broad range of services to a very high level of medical spending—on the ground that in-depth coverage for all is needed to prevent catastrophic medical expenses from rendering anyone medically indigent. Full coverage implemented on a national basis could easily cost \$50 billion dollars more a year than is now spent, depending on how rich a benefit package were provided.<sup>258</sup> This approach would constitute national health insurance, although it might not closely resemble the ambitious federal plans of the 1970's in design or implementation.

More reasonable estimates of a program to cover the medically indigent surely lie between the \$5 and \$50 billion extremes. As a rough guess, spending \$50 a month only for those now uninsured who are below the poverty line would cost "only" about \$6 billion the first year, whereas spending \$80 a month for those with family incomes under two

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alike that more funds were available to cover charity care. Depending on the eligibility and payment rules applied under a new system, such an increase could be substantial.

<sup>258</sup>The \$50 billion figure derives from assuming that an equivalent of 30 million uninsured person-years currently exist, with an additional 20 million underinsured (i.e., not protected against catastrophe). Benefits are estimated at \$100 per month for the uninsured, half that for the underinsured:  $(\$100/\text{month}/\text{person} \times 12 \text{ months}/\text{year} \times 30 \text{ million person-years}) + (\$50/\text{month}/\text{person} \times 12 \text{ months}/\text{year} \times 20 \text{ million person-years}) = \$48 \text{ billion}$ . No allowance is made for increased spending due to people cutting their own coverage to rely on government help. Discussion: Some 35 million people were uninsured in March 1984, probably two-thirds of them for the entire year, one-third for part of the year, perhaps averaging six months, for a total of about 30 million person-years. Calculated from M. SULVETTA & K. SWARTZ, *supra* note 16, at 3. At least an additional 20 million are underinsured. This estimate is from the finding that in 1977 24%-37% of population was underinsured overall, *id.* at 19, whereas only 11% was uninsured at the time of survey, *id.* at 3. See also Farley, *supra* note 11. The \$100 and \$50 figures are reasonable guesses for moderate coverage. Average per capita personal health spending for the entire population for 1986 is estimated at \$146 per month. Calculated from data in Arnett, McKusick, Sonnefeld & Cowell, *Projections of Health Care Spending to 1990*, HEALTH CARE FINANCING REV., Spring 1986, at 1, 3, 12. Spending of course varies greatly according to characteristics of the insured and of the benefits covered. See, e.g., *id.* at 20-32. Medicare, for an aged and disabled population, currently spends some \$180 per month for each beneficiary, not counting beneficiaries' own spending. U.S. OFFICE OF MANAGEMENT & BUDGET, THE UNITED STATES BUDGET IN BRIEF 46-47 (1986) (\$67 billion in federal fiscal 1986 for some 31 million beneficiaries). Medicaid spends about \$159 per month per recipient overall, although nearly half goes to a small fraction of eligible recipients receiving long term care. *Id.* at 44 (\$23.7 billion federal, \$19.3 billion state for 22.5 million FY 1986 recipients). Not all of these people are covered for the entire year, so the estimate is biased low. Federal spending in 1986 for the Federal Employees Health Benefits Plan averaged fully \$221 per month per covered employee (each with an unknown number of dependents), not counting employees' share of premiums (about 25% of the total or 33% more than the federal share) or required cost sharing. U.S. OFFICE OF MANAGEMENT & BUDGET, BUDGET OF THE UNITED STATES GOVERNMENT, Appendix, Fiscal Year 1986 I-V 7 (1986) [hereinafter U.S. BUDGET].

times the poverty level would cost some \$20 billion.<sup>259</sup> In practice, it would not be sensible to cover everyone below some arbitrary level for 100% of the cost and no one above it at all. Such abrupt breaking points (or “notches,” as they are often called) are unfair to those just above them, discourage beneficiaries from earning more (or reporting earnings), and encourage non-beneficiaries to drop to covered levels. An intermediate method is to provide graduated support in the boundary zone (often called “sliding scale” support), which probably would increase spending.

In comparison, states now spend about \$20 billion a year in Medicaid,<sup>260</sup> and almost all are working hard to cut back its scope.<sup>261</sup> Moreover, states spent an additional \$24 billion on hospitals and other health care in 1985.<sup>262</sup> Cities and counties together contributed somewhat less, about \$18 billion on health care in 1984.<sup>263</sup> New funding for the indigent could displace some existing spending; this small “savings” would likely be overwhelmed by new spending generated by almost any new entitlement.

*b. Funding sources and limitations. (i.) State taxes and federal preemption.*—States and localities have numerous funding options through taxation or mandates on individuals, employers, providers, and insurers. In principle, any existing state tax could be used to fund programs for the medically indigent, whether they were public programs, like Medicaid, or private programs, like those considered in the next subsection. Traditionally, these taxes include the state income tax (for most states), city, county, and state property taxes, and sales and excise taxes. Any or all could be used for these purposes. States could appropriate general fund monies or they could dedicate a particular tax levy to help meet the needs of the medically indigent. Because state budgets are already hard pressed, new revenues are probably needed, and many people prefer to raise new revenue in some way related to health—by raising so-called “sin taxes” on tobacco and alcohol, for example. Nevertheless, it is clear that such taxes by themselves probably will not produce sufficient

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<sup>259</sup>About one-third of the uninsured are uncovered only during part of the year, Farley, *supra* note 11, so that they would not need new assistance for the full year. Also, the estimates do not include newly uninsured people taking advantage of new assistance.

<sup>260</sup>See U.S. BUDGET, *supra* note 258.

<sup>261</sup>See generally AFFORDING ACCESS TO QUALITY CARE, *supra* note 236; J. HOLAHAN & J. COHEN, *supra* note 18.

<sup>262</sup>U.S. BUREAU OF THE CENSUS, SERIES No. GF84, No. 3, STATE GOVERNMENT FINANCES IN 1984, at 2 (1985). Not all of such spending covers medical indigents, of course; much goes to particular classes of patients not based on income, e.g., victims of tuberculosis, crippled children.

<sup>263</sup>U.S. BUREAU OF THE CENSUS, SERIES No. GF84, No. 4, CITY GOVERNMENT FINANCES IN 1983-84 (1985) and SERIES No. GF84, No.8, COUNTY GOVERNMENT FINANCES IN 1983-84, at 2 (1985).

revenue,<sup>264</sup> and there is, of course, considerable political resistance to general tax increases.<sup>265</sup>

Therefore, funding that does not require direct taxation of individuals attracts considerable interest. Public funding can be provided, in part, by a tax or assessment on hospitals not providing a specified minimum amount of charity care. Under this approach, all hospitals could be required to provide a certain percentage of, say, their gross revenue as charity care. Hospitals providing less would be required to pay the difference into the fund.<sup>266</sup> Public policy makers may find such taxation by regulation attractive because it is "off budget," or at least off *their* budgets.

Adopting this concept would have the added benefit of eliminating "dumping" of non-paying patients as a way to hold down prices in the increasingly competitive hospital market. Although expensive, it would promote access to inpatient care for poor people, and the expense would be spread among paying hospital patients, largely insured patients. Of course, a standard definition of charity care, as compared to uncompensated care, would be needed to exclude bad debts of those capable of paying. And administration of this "program" would have to be left mainly to hospitals themselves.<sup>267</sup>

One might also attempt to reduce the number of uninsureds generally—not only the medically indigent—by mandating that employers provide health insurance to their employees. The state of Hawaii currently has such a program. However, a legal obstacle prevents other states from enacting similar programs. The federal Employee Retirement Income Security Act of 1974 (ERISA) interferes with state options through its regulation of employee benefit plans, both pension plans and welfare benefit plans.<sup>268</sup>

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<sup>264</sup>See Bartlett, *State Level Policies and Programs*, in ACADEMY, *supra* note 136, at 54, 60-61.

<sup>265</sup>See *supra* note 56.

<sup>266</sup>The Ohio task force dubbed this the "care or share" approach. GOVERNOR'S COMMISSION ON OHIO HEALTH CARE COSTS: FINAL REPORT (July 1984) (summarized in J. LUEHRS & R. DESONIA, *supra* note 61, at 37-38). Hospital taxes could also be based on net revenues, number of licensed or occupied beds, or other measures. Pooling similar to that described in the text already occurs within hospital rate-setting states and in Florida, where it helps fund an expanded Medicaid program. *E.g.*, Perkins, Dallek, Dowell & Waxman, *State-Based Financing of Indigent Health Care: Promise and Problems* 20 CLEARINGHOUSE REV. 372, 372-75 (Special Issue, Summer 1986).

<sup>267</sup>Such charity pooling seems impractical to extend to providers other than hospitals because there are so many of them.

<sup>268</sup>29 U.S.C. §§ 1001 *et seq.* (1982). Welfare benefit plans covered under ERISA include those that provide for medical, sickness, accident, and other non-pension fringe benefits. 29 U.S.C. § 1002(1) (1982). It should be noted that nothing in ERISA regulates the contents of welfare benefit plans; only reporting and disclosure requirements were enacted, according to conventional wisdom because Congress expected national health insurance soon to supercede all existing health plans.

Intending to make regulation of employee benefit plans exclusively a federal concern, ERISA expressly preempts state regulation of employee benefit plans.<sup>269</sup> One exception to this ERISA preemption of state law is that states may continue to tax and regulate insurance, that is, insurance companies and insurance contracts.<sup>270</sup> The Supreme Court has upheld such state regulation that mandates benefits to be covered in health insurance contracts, for example.<sup>271</sup> However, the Court noted that ERISA prohibits state regulation of an employer's benefit plan that is "self-insured" rather than placed with an insurance company, as this would not fall under the "insurance law" exception to the federal preemption.<sup>272</sup> Increasingly, especially in large employment groups, health benefits are self-funded.<sup>273</sup>

Given that ERISA prohibits state regulation of employee benefit plans other than through the avenue of insurance regulation, it would seem, a fortiori, that states cannot mandate that such plans exist.<sup>274</sup> Thus, the state of Hawaii is able to maintain its program only because of specific amendments to ERISA that "grandfather" the Hawaii Prepaid Health Care Act.<sup>275</sup> Of course, ERISA could be further amended to grant states the authority to require private insurance coverage.

It might be possible for states to achieve similar "insurance" goals through their power to tax employers. Clearly ERISA would not prohibit states from taxing all employers to fund care or coverage for the uninsured, for example, through a general payroll tax. Whether an income tax, because it is related to ability to pay, or a payroll levy, because it is related to the number of employees, is the more equitable method is open to debate. A payroll tax would, of course, tax employers already providing coverage in order to help those not now providing coverage, and could thus considerably hurt incentives to insure, especially in in-

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<sup>269</sup>29 U.S.C. § 1144(a) (1982).

<sup>270</sup>29 U.S.C. § 1144(b) (1982).

<sup>271</sup>*Metropolitan Life Ins. Co. v. Massachusetts*, 105 S. Ct. 2380, 2393 (1985).

<sup>272</sup>ERISA expressly provides that self-insured plans are not to be considered "insurers" or "insurance companies" for the purposes of state regulation. 29 U.S.C. § 1144(b)(2)(B) (1982).

<sup>273</sup>See, e.g., Etheredge, *The World of Insurance: What Will the Future Bring?*, *BUS. & HEALTH*, Jan./Feb. 1986, at 5 (describes growth of self-insurance); *Self Insurers Out-number Fully Insured Among Larger U.S. Corporations*, *COALITION REP.*, April 1985, at 1.

<sup>274</sup>*But see* *Director of Bureau of Labor Standards v. Fort Halifax Packing Co.*, 510 A.2d 1054 (Me. 1985), *prob. juris. noted sub. nom* *Fort Halifax Packing Co. v. Coyne*, 107 S. Ct. 430 (1986). In this case, Maine's Supreme Judicial Court held that because a Maine statute requiring severance pay was only operative when a benefit plan was not in existence, the statute did not "relate to" an employee benefit plan and thus was not preempted by ERISA.

<sup>275</sup>Pub. L. 97-473, § 302, 96 Stat. 2605 (1982) (codified at 29 U.S.C. § 1144(b)(5) (1982)).

dustries where many companies already provide no insurance. To maintain insurance incentives, employers could be allowed to deduct from the amount of payroll tax due any amounts contributed to health benefit plans (insured or self-insured) for their employees.

Would such provisions be impermissible regulation under ERISA? Perhaps so. Some courts have interpreted certain state plans of taxation as prohibited regulation and therefore ruled them preempted by ERISA. For example, a federal district court in Connecticut found a statute that imposed a 2.75% annual tax on employee benefit plans to be void and unenforceable because of ERISA preemption of state regulation.<sup>276</sup> Moreover, in protecting Hawaii's Prepaid Health Care Act in 1983, Congress specifically provided that Hawaii's ERISA exemption did not affect the status of "any state tax law relating to employee benefit plans."<sup>277</sup> Courts have interpreted this language to indicate that Congress intended to preempt all state tax laws insofar as they relate either directly or indirectly to employee benefit plans.<sup>278</sup>

Despite these rulings, a state may still be able to enact a payroll tax with deductions for health coverage such as the one outlined above. The rationale behind the deduction would be that these employers are already doing their part toward financing health care by providing some reasonable form of coverage. The legal argument runs as follows: First, the tax is analogous to a state corporate income tax that allows deductions for an employer's expenses incurred in maintaining employee benefit plans. Clearly, such state income taxes with such deductions have not yet been found to "relate to" employee benefit plans for purposes of ERISA preemption. A payroll tax with similar offsets should be afforded similar status.

Second, such a payroll tax does not "relate to" employee benefit plans because the employer is taxed, not the benefit plan itself. Moreover, unlike the voided Connecticut statute, the amount of deduction would not discriminate between insured and self-insured health benefits—the very distinction ERISA has been held to maintain.<sup>279</sup> For these reasons,

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<sup>276</sup>National Carriers' Conference Comm. v. Heffernan, 454 F. Supp. 914 (D. Conn. 1978). Connecticut's tax on premiums received by insurance companies was 2%, which meant that the tax structure operated as an incentive to use traditional insurance rather than ERISA-exempted plans. The court found this discrepancy (2% vs. 2.75%) to be "illustrative of the potential use of taxation as a means of regulation." *Id.* at 917-18.

<sup>277</sup>29 U.S.C. § 1144(b)(5)(B)(i) (1982).

<sup>278</sup>See, e.g., Northwest Airlines, Inc. v. Roemer, 603 F. Supp. 7 (D. Minn. 1984); General Motors Corp. v. California State Bd. of Equalization, 600 F. Supp. 76 (C.D. Cal. 1984). See Shaw v. Delta Airlines, Inc., 463 U.S. 85 (1983); Alessi v. Raybestos-Manhattan, Inc., 451 U.S. 504 (1981).

<sup>279</sup>See *supra* notes 271-72 and accompanying text. Taxing self-insurance for the purpose of funding the deficits of state high-risk pools has also been invalidated on ERISA grounds. See generally Bovbjerg & Koller, *supra* note 211.

a combination payroll tax and coverage credit may not be considered as regulating employee benefit plans.

Similarly, states are also free to tax the insurance-like alternative plans such as HMO's and PPO's; again, they may offset charitable care these entities provide. Indeed, to some extent, states already do so through the imposition of insurance premium taxes.

The calculation of such taxes as well as set-offs for indigent coverage or care involve complex administrative questions. Nevertheless, such taxes could provide a useful basis for funding, and could equalize the burden imposed on competing financing and delivery alternatives—insurance companies, self-insurers, and alternative plans like HMO's and PPO's.

Mandates or taxes on insurers, on medical providers, or on employers may have more current political appeal than taxes on individual taxpayers. Indirect funding through mandates for individuals to insure themselves is another "off-budget" option for states to consider. It would be foolish to replace efficient group purchasing of health coverage by employers with more expensive individual policies; however, it might be sensible to fill in some gaps with individual mandates. One such mechanism is auto insurance, with a long tradition of individual requirements.<sup>280</sup> Automobile owners or drivers could be required to provide evidence of adequate health insurance as a condition of licensure, especially to cover the very large bills that often result from accidents and which contribute disproportionately to uncompensated care in hospitals.<sup>281</sup>

(ii.) *Private revenue.*—States can also seek to attract voluntary funding from individuals themselves (or their employers, if any) by mandating, or themselves running, subsidized insurance plans for some of the uninsured. The basic idea here is to encourage insurance coverage with subsidies while holding down costs with private contributions to premiums. This strategy presupposes that potential eligibles (or their employers) can afford to make a contribution, so it does not address the impoverished "hard core" of the uninsured. The approach would nonetheless address two groups who may be considered medically indigent—the uninsured working poor and the medically uninsurable. Public assistance could take the form of subsidizing eligibles' purchase of private coverage with cash, vouchers, or tax benefits; alternatively, governments could create publicly underwritten plans or insurance pools that eligibles could "buy into" at below-market rates.<sup>282</sup> It would be difficult, but

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<sup>280</sup>See, e.g. Widiss, *Introduction: Background and Perspective*, in *NO-FAULT AUTOMOBILE INSURANCE IN ACTION: THE EXPERIENCES IN MASSACHUSETTS, FLORIDA, DELAWARE AND MICHIGAN* (A. Widiss, J. Little, R. Clark & T. Jones eds. 1977).

<sup>281</sup>See *supra* note 257 on the contribution of accidents.

<sup>282</sup>Assistance to the working poor could readily take the form of providing a tax credit for workplace purchase of insurance, which would assist low and high income workers alike, rather than today's tax exclusion, which disproportionately assists upper-

perhaps not impossible, to structure such a new subsidy to aid those at high risk of failing to insure themselves, without having to subsidize too many otherwise similar people who already have coverage. This approach is experimental but merits close attention.

A second category of potential eligibles also needs public help to obtain coverage but can contribute themselves. These are nonpoor people otherwise uninsurable because of pre-existing adverse health conditions. In a number of states, state-run comprehensive insurance risk pools help these people buy standard policies at a surcharged rate.<sup>283</sup> The pools help a small fraction of even the uninsurable, and still fewer of the uninsured generally, and they do so at a high cost because even the surcharged premiums must be subsidized to meet high medical bills. Moreover, as now run, the pools do not help the indigent, but only those with the wherewithal to pay high premiums themselves. Although states may move toward targeted subsidies to help the low income uninsurable, high risk pools will provide only limited general help to the medically indigent.

4. *Administration.*—Any of the strategies just discussed can be implemented with varying degrees of public involvement. An entire public system can be created, using public funds and employees. Alternatively, government may specify what model(s) are desired and contract with private companies to administer the plan(s). Or government may help currently uninsured people “buy into” existing private plans, including those run privately for public employees.<sup>284</sup> Beneficiaries may be required to choose among multiple alternatives, e.g., HMO, PPO, private fee-for-service plan, public fee-for-service plan. Any of these alternatives may be funded with a mix of public and private revenues.

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bracket taxpayers. *See generally* Enthoven, *Health Tax Policy Mismatch*, HEALTH AFF., Winter 1985, at 5. The self employed could also be given tax benefits equivalent to those of group employees, as proposed in the Improved Access to Health Care Bill, H.R. 4742, S.2402-S.2403, 99th Cong., 2d Sess. (1986). Such major federal tax changes seem unlikely, given that comprehensive reforms have just been legislated. *See supra* note 48.

<sup>283</sup>*See supra* notes 11 & 26 for description of uninsurables; on the operation of state pools, see Bovbjerg & Koller, *supra* note 211.

<sup>284</sup>The state of West Virginia, for example, has a unique multi-employer group plan for public employees that already covers about 1 state resident in 8. The plan began at the state level, then expanded to cover local employees. The state is seeking foundation funding to study the feasibility of opening the plan to small, private employers as well. Remarks of Robert Chehig, West Virginia Public Employees Insurance Board, at Conference on Facilitating Health Care Coverage for the Working Uninsured: Alternative Strategies, Center for Policy Research, National Governors' Association, in Rosemont, Illinois (December 16, 1986). The two main implementation problems are how to prevent free-riding by small employers who would have bought coverage anyway and how to prevent adverse selection by high-utilizing new enrollees that would drive up the cost of the plan for all participants. Some judgmental underwriting (exclusion of bad risks) appears to be required. On the problems of pooling small groups, see generally Bovbjerg, *supra* note 24.

The state of Arizona, for example, has brought a number of these different methods together in the Arizona Health Care Cost Containment System.<sup>285</sup> AHCCCS, as it is known, is a comprehensive program of medical services provided to the medically indigent on a prepaid basis. Arizona runs the program with federal financial participation in lieu of conventional Medicaid. The program is privately administered under a state contract set by competitive bidding. The private contractor in turn contracts with local health plans for the provision of care, again on a prepaid basis through competitive bidding. HMO's, PPO's, and others are eligible to bid if they provide the requisite services in the designated areas. All providers are required to use primary care gatekeepers.

Currently, AHCCCS is being run as a demonstration project with federal Medicaid waiver authority, and results are not complete. The results on quality and access are not yet in, and there is some concern that people are not being well enough served.<sup>286</sup> However, the state itself is encouraged that it is delivering good quality care to a broad section of the medically indigent at a price less than that which prevails for Medicaid in somewhat comparable sunbelt states.<sup>287</sup> The state plans to expand AHCCCS to include non-Medicaid eligibles, including the working poor. This approach would mix public and private roles both in funding and in administration.

Numerous other initiatives incorporating these economizing ideas are under way at the state and local level, mainly initiated by public or quasi-public entities. The Robert Wood Johnson Foundation has sought to stimulate such trials with technical assistance and modest "seed money."<sup>288</sup>

As a matter of public administration, the need to implement controls over medical spending points toward local control because most medical markets are local. It is difficult to relate individually to providers or patients from a distance. Moreover, integrating new medical assistance with public hospital care might also occur more readily at a local level. Public "tastes" in welfare spending also vary considerably from place to place, certainly among states, and even within them. Some areas are well known for high taxes and high benefits, while other areas are known for the opposite.

Local control would also result in more experimentation than a national or even a state approach, assuming that the responsible localities

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<sup>285</sup>*E.g.*, J. CHRISTIANSON & D. HILLMAN, *supra* note 204.

<sup>286</sup>Kirkman-Liff, *Refusal of Care: Evidence from Arizona*, HEALTH AFF., Winter 1985, at 15.

<sup>287</sup>D. SCHALLER, ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM: ANNUAL REPORT, JULY 1984-JUNE 1985, at 91-118 (March 1986).

<sup>288</sup>ROBERT WOOD JOHNSON FOUNDATION, HEALTH CARE FOR THE UNINSURED PROGRAM (1985) (grant solicitation materials).

<sup>289</sup>*See generally* P. FOX, W. GOLDBECK & J. SPIES, *supra* note 22.

are large enough to support professional management. It is no accident that changes in private-sector health insurance occur market area by market area, through new entry by HMO's and PPO's and aggressive benefits management by large employers, third-party administrators, and business coalitions.<sup>289</sup> On the other hand, medical indigence is greatly affected by state-level decisions on welfare, Medicaid, hospital licensure, and insurance regulation, as well as by federal ERISA, Medicaid, and Medicare rules. Moreover, the ability of jurisdictions to raise revenues varies, so a broader approach also makes sense.

Given the current administration's attitude, the federal government appears to be out of the funding picture, although federal legislation continues to seek state and private solutions. For example, bills apparently to be reintroduced in the 100th Congress would require subsidized state high-risk pools, as well as revenue pooling for essential hospital care on behalf of those who cannot pay.<sup>290</sup> In any event, the short-term political reality, along with tradition and legal theory, suggest that combined state-local programs will be the dominant approach in the future as in the past.<sup>291</sup> Such approaches can combine state strengths in financing, pooling, regulation, and managerial expertise (available directly or through technical assistance to localities) with local virtues of provider and patient relations and flexible tailoring of programs to local desires and needs.

##### V. AFFORDING DECENT COVERAGE FOR THE MEDICALLY INDIGENT

Conventional medical care is expensive, as is the insurance needed to cover it. One reason that it costs so much is the widespread belief that only the best will suffice (especially when care is heavily insured). Such attitudes seem to be changing, and certain economizing measures have become acceptable.<sup>292</sup> However, no "magic bullets" exist that can make the same conventional care or coverage affordable for all without considerable public subsidy or coercion.<sup>293</sup> Even with new economies, additional efforts to help the medically indigent will cost more than the current patchwork of assistance through Medicaid, public hospitals, regulatory requirements, and private charity, and society seems unwilling to contribute enough money, individually or collectively.<sup>294</sup>

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<sup>290</sup>In the 99th Congress, these bills were S.2402, S.2403, and H.R. 4742, The Access to Health Care Act; see also *supra* notes 63 & 282.

<sup>291</sup>See discussion of existing programs, *supra* notes 132-213 and accompanying text.

<sup>292</sup>The "buyers' revolution" in health financing has necessitated the acceptance of limits on insurance coverage and on patients' and medical providers' discretion to order ever more and more expensive health care. See, e.g., J. CALIFANO, *supra* note 22.

<sup>293</sup>See Bovbjerg, *supra* note 24, at 416 (same conclusion, for private coverage, voluntarily purchased).

<sup>294</sup>The most obvious demonstration of unwillingness to pay for medical indigents is states' reluctance to expand Medicaid to cover as many medical indigents as that program

Improvements seem to require one or both of two interrelated developments—greater willingness to pay or increased acceptance of new health “products” that offer lower but still decent levels of protection that people will be willing to finance. One major obstacle impedes both developments—professional and political desires (and legal expectations) for high quality medicine within a so-called single-tier system of health care for all, even the medically indigent.

With regard to willingness to pay, several trends offer some encouragement:

(1) More information about the plight of uninsured indigents should increase willingness to help them.

(2) Ordinary, middle-class people are increasingly at risk of medical indigency—because many have lost well-insured jobs, because many are beginning to work in small, less-insured workplaces, because high medical spending can exceed what was once a reasonable extent of coverage, and because more people are developing adverse medical histories that hamper obtaining insurance. Funding an adequate social safety net should appeal to those concerned about these risks.

(3) Finally, new mechanisms are being found to control medical spending,<sup>295</sup> offering the eventual prospect that a politically attractive, streamlined “product” will indeed emerge.

New products, the second needed development, must be able to implement sensible restrictions on the amount of care available and the prices paid in order to maximize the number of people who can be covered, even if this means somewhat more restricted access to less elaborate care. For those who now have no protection at all, some care is better than none. Indeed, existing medically indigent programs are experimenting with restricting access to providers, as are many middle-class plans.

Likewise, strong utilization control over the services delivered seems reasonable, and it may prove appropriate to insist on less expensive, nontraditional providers to cover certain services. It definitely makes sense to keep people out of the hospital wherever possible. Something like the Arizona AHCCCS program, perhaps with even a lesser package of benefits, may be appropriate depending on the local situation. Of course, any restrictions on providers or coverage can prove difficult to implement. Further experimentation is needed here.

This ongoing search for a decent, even if bare-bones, level of coverage is significantly hampered by ethical, professional, and legal reluctance to *allow* lower levels. Anything less than equal care for all is often castigated as “rationing” or unethical “second class” care. It faces legal impediments as well.

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will reach, even though the federal government pays half or more of the cost. *See supra* notes 236-39 and accompanying text.

<sup>295</sup>*See supra* notes 240-54 and accompanying text.

All the permutations of ethical-professional concern cannot be successfully addressed here. In brief, insisting on single-tier medicine for all in practice means eliminating any assistance for many of the least fortunate, because currently society demonstrably will not provide unlimited funds. Perfection is the enemy of the good here, even in the opponents' own ethical frame of reference.<sup>296</sup> Society accepts dual standards for other charity, whether public or private charity, even with regard to fundamental needs like food, housing, and clothing; why not in medical care?<sup>297</sup> Moreover, although today many politicians and providers pay lip service to the notion of "nothing but the best" for all, the reality differs. There are different delivery systems for the insured middle class, for veterans, for Indians, and for people using public hospitals. Accepting different programs for the medically indigent does not seem unthinkable.<sup>298</sup> Certainly, Medicaid pays less for physicians than do private insurance programs and thus buys much lower access for Medicaid patients. Yet, even with Medicaid, those within the eligible categories are clearly better off than non-eligibles in otherwise similar economic circumstances.

On a more philosophical level, it is notable that opponents seem to like to invoke the spectre of "rationing"<sup>298</sup> because it connotes denying people something to which they are entitled and could get, absent a meddling government.<sup>299</sup> However, labeling lower but decent care or coverage "rationing" is conceptually misleading and politically unhelpful. In the case of indigent medical care or coverage, the real argument concerns the nature and level of any entitlement; the "rationing" no-

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<sup>296</sup>As argued by one respected academic and advocate of public health programs: "[F]inally, the argument is advanced that special programs for poor people are fated to become poor programs—always the first for recissions. That argument has served too long as the refuge for neglecting poor people altogether." Miller, *The Role of Health Planning in the Provision of Complex and Not-So-Complex Services*, in *THE ROLE OF HEALTH PLANNING IN THE COMPETITIVE ERA* 43 (F. Sloan, J. Blumstein & J. Perrin eds. forthcoming 1987).

<sup>297</sup>For example, although it needs to be safe and fit for habitation, public housing need not supply middle class space or amenities. Food stamps cover a minimal diet at best, and no specific allowance at all is made for clothing. With regard to private charity, people seem to donate used clothing rather than new, and soup kitchens hardly offer cuisine competitive with many restaurants. It is true that some health care more immediately involves life and death than do food or housing, but access to true emergency care is not what needs to be limited. *See also supra* note 67.

<sup>298</sup>*Compare, e.g.,* Rosenblatt, *Rationing 'Normal' Health Care: The Hidden Legal Issues*, 59 *TEXAS L. REV.* 1401 (1981) with Blumstein, *Rationing Medical Resources: A Constitutional, Legal, and Policy Analysis*, 59 *TEXAS L. REV.* 1345 (1981).

<sup>299</sup>Thus, for instance, gasoline rationing means queues for all, not merely for the poor. *Cf. Bovbjerg & Held, supra* note 233 (prefer "resource allocation" to "rationing" as descriptive term). "Rationing" as a term makes more sense if read in its older meaning of "offering limited quantities" (as in sailors' "rations" of rum), but the usual connotation of the expression is wholly different.

menclature merely assumes entitlement to full equality without demonstrating it or convincing taxpayers or others to fund it.

Hence, there are both practical and theoretical reasons for accepting separate programs for the poor. Beyond the ethical-political arguments lie practical legal problems. The law also contemplates equality of care for all, at least in that where care is provided, the same malpractice "standard of care" applies regardless of the patient's ability to pay.<sup>300</sup> Thus, where care is limited and a bad outcome occurs, providers (and insurers, as well) face possible liability.<sup>301</sup> In practice, legal exposure may reduce coverage because providers and funding jurisdictions may prefer to offer no nonemergency service rather than limited service or coverage with a liability risk.

How might liability rules protect the medically indigent without threatening willingness to help serve them at an affordable price? Precedents are not encouraging. Under malpractice law, a "reasonable minority" of practitioners may practice differently from the mainstream,<sup>302</sup> but the rule is grounded mainly in medical uncertainty, not differences in patients' ability to pay. The traditional locality rule, although now much eroded, is a second possibility.<sup>303</sup> The rule recognized local variation in the extent of medical talent and resources available. Some cases similarly hold it unnecessary for outlying hospitals to have the latest equipment available.<sup>304</sup> Such cases, however, focus on geographic rather than economic differences. More to the point is the distinction between specialists and general practitioners; specialists have a higher standard because they hold themselves out to patients as being more qualified (and, presumably, charge more as a result).<sup>305</sup> Public coverage that held itself out as only a decent minimum might seem analogous, but indigent patients have no real alternative, so the rationale is not really comparable.

Another relevant line of legal thinking—now quite academic and somewhat heretical—holds that malpractice law should govern only in the absence of contractual agreements specifying desired care (and dispute resolution procedures).<sup>306</sup> This approach suggests that different people

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<sup>300</sup>See *supra* notes 97-98, 107-08 and accompanying text. Cf. Atiyah, *Medical Malpractice and the Contract/Tort Boundary*, 49 *LAW & CONTEMP. PROBS.* 287, 292-98 (Spring 1986) (desire for egalitarianism a reason for tort, not contract, to govern malpractice).

<sup>301</sup>See, e.g., *Wickline v. State*, 183 Cal. App. 3d 1175, 228 Cal. Rptr. 661, *rev. granted*, 231 Cal. Rptr. 560, 727 P.2d 753 (1986) (issue of liability for bad outcome after hospital stay cut short under third-party coverage rules).

<sup>302</sup>E.g. A. HOLDER, *supra* note 97, at 55-57.

<sup>303</sup>E.g., Comment, *Standard of Care for Medical Practitioners—Abandonment of the Locality Rule*, 60 *KY. L.J.* 209 (1971).

<sup>304</sup>E.g., *Pederson v. Dumouchel*, 72 Wash. 2d 73, 431 P.2d 973 (1967).

<sup>305</sup>*Naccarato v. Grob*, 384 Mich. 248, 180 N.W.2d 788 (1970).

<sup>306</sup>E.g., Havighurst, *Private Reform of Tort Law Dogma: Market Opportunities and Legal Obstacles*, 49 *LAW & CONTEMP. PROBS.* 143 (Spring 1986).

can choose different levels of care for themselves. It could be argued that public beneficiaries had voluntarily accepted the restrictions in the program, so long as those restrictions were fully disclosed. However, this approach is not fully developed as a conceptual matter, much less as an accepted rule of law, and its relevance to poor people with few real choices is questionable.<sup>307</sup>

Perhaps the very notion that malpractice law should set the standard of care, in the sense of what care should be given, is over-broad. Partly through an unfortunate linguistic coincidence, the legal standard of "care," which originally meant the degree of carefulness required to be non-negligent, has come to mean also what services themselves are appropriate. Some rethinking seems called for here. The fact that a given insurance program or a given provider simply does not cover long-term care, mental health, or transplants—or for that matter, certain hospitalizations or hospitals—does not seem to be a failure of "care." It seems rather a personal or social judgment about the appropriate use of limited resources.

Malpractice rules and judicial process seem better suited to determining whether a technical mistake or oversight occurred than to deciding broader coverage issues. Thus, one solution to the problem might be to establish a program that defines and is limited to specific medical services and gives malpractice immunity to those who carefully provide those services. Whether the jurisdiction(s) establishing such a program can immunize themselves is another question.

## VI. CONCLUSION

The main problem for the medically indigent is that they do not have enough money. And the main problem with health coverage for the indigent is that neither they themselves, their employers, nor their government(s) have bought them adequate protection. Medical providers have limited ability to provide charity care. Consequently, the medically indigent are disadvantaged in their access to medical care.

This Article has discussed various ways of organizing and financing coverage or care for the medically indigent. More public and private resources must be raised through some combination of taxation, regulation, and increased voluntary payment. The effort needed for even medium-level assistance is significant, perhaps \$15-20 billion in the first year, or as much as states already spend on Medicaid.

If society in its various components is not willing to fund universal coverage of a conventional kind—and it currently is not—then society must settle for less, but in a constructive fashion. It must define a lesser but decent health "product," preferably in a subsidized, insurance-like

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<sup>307</sup>Atiyah, *supra* note 300.

form that offers beneficiaries choice among competing providers. Providers who participate in improving care for the indigent deserve praise, not malpractice suits for delivering only the care that is covered. They should receive protection from tort claims of misfeasance when they have in fact carefully complied with social norms of adequacy as reflected in coverage rules.

The need is urgent and the time to begin is now. It is better to start with a reasonable minimum, with the hope of later expansion, than to hold out for optimal plans that may never come to pass. Further arguing about "rationing" of care to the poor or the ethics of "two-tier" medicine merely postpones difficult coverage decisions, to the clear disadvantage of the medically indigent.

