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The Economics and Politics of Emergency Health Care for the Poor: The Patient Dumping Dilemma

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"When you're well, you lose the sense of how really hard it is to be sick."¹

All I can say is this: it looks as if we are all we have. Given what we know about ourselves and each other, this is an extraordinarily unappetizing prospect; looking around the world, it appears that if all men are brothers, the ruling model is Cain and Abel. Neither reason, nor love, nor even terror, seems to have worked to make us "good," and worse than that, there is no reason why anything should.²

I. INTRODUCTION

Claudia Thomas was nineteen years old and eight months pregnant.³ She was unemployed and had a two-year-old son, Eric, at home. Her husband, Steven, worked periodically, but none of his jobs offered health benefits for him, let alone Claudia and the kids. For this reason, Claudia had not seen a

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1. *Talk of the Town*, NEW YORKER, May 13, 1991, at 29-30.
2. Arthur A. Leff, *Unspeakable Ethics, Unnatural Law*, 1979 DUKE L.J. 1229, 1249.
3. This "story" represents an amalgamation of several real incidents (which culminated in litigation) involving uninsured pregnant women who were "dumped" on public institutions in spite of life-threatening medical conditions. See, e.g., *Owens v. Nacogdoches County Hosp. Dist.*, 741 F. Supp. 1269 (E.D. Tex. 1990); *Thompson v. St. Anne's Hosp.*, 716 F. Supp. 8 (N.D. Ill. 1989).

doctor during the entire length of her pregnancy.

One morning Claudia began having cramps and nausea that seemed worse than usual. By noon she knew that something was wrong. She called her mother to ask her to watch Eric while she went to the clinic, but her mother was not available. She decided to wait until evening when Steven came home. By the time Steven arrived her contractions were painful, even though she was a month away from her due date.

Claudia was bleeding and went to the emergency room of a nearby private hospital. Before she could see a doctor, she was asked to fill out several forms and answer questions about her insurance coverage and about her medical treatment during the pregnancy. Once it became obvious to the admitting nurse that Claudia did not have health insurance, another nurse was called in. She told Claudia that she would be "better off" at the county hospital, which was some 15 miles distant. Claudia demanded to see a doctor, saying that something was wrong and she was worried about the baby.

Finally, she was led back and told to wait for the doctor. After 15 minutes, Claudia saw a doctor who told her that she would not be admitted because she had not dilated sufficiently. However, he decided to run some tests to make sure the baby was all right. Although the tests suggested that the baby was experiencing some distress, the doctor assured Claudia that there was plenty of time before the baby would be born, and that the best place, for a case like hers, was County Hospital. Despite Claudia's protests, the doctor refused to admit her. Reluctantly, she departed for County Hospital by taxi. On the way to the hospital she delivered a premature baby girl in the taxi. The infant died shortly thereafter of cardiac and respiratory complications. The doctor who treated her at County Hospital believes that if she had been admitted to the private hospital and received the proper care the baby would have survived. Claudia believes that she would have been admitted to the private institution had she had medical insurance or other proof of ability to pay.

As the numbers of uninsured mount⁴ because of job

4. The estimates vary. See Erik Eckholm, *Health Benefits Found to Deter Switches in Jobs*, N.Y. TIMES, Sept. 26, 1991, at A1, B12 ("[T]he uninsured [are] now estimated at about 34 million Americans."); David Orentlicher & Kristen Halkola, *The Growing Inaccessibility to Prenatal Care for Poor and Minority Women: A Crucial Problem for Makers of National Health Policy*, in ONE NATION,

dislocations, exhaustion of benefits, and unaffordably high premiums, the incidence of "dumping" by private hospitals is, predictably, on the rise. Dumping occurs when a hospital, in violation of federal or state law, transfers an emergency patient to another (usually public) hospital or simply refuses any treatment based on the patient's inability to pay.⁵ In addition to the completely uninsured, favorite dumping targets include Medicare and Medicaid patients, AIDS patients, and cancer patients whose therapy may cost more than the maximum reimbursement under private insurance.

Dumping is merely a part of what is commonly referred to as the "health care crisis" which, in turn, is really a crisis involving two related, but distinct, issues: access and cost. There are two common themes to the complaints about health care voiced by consumers, insurers, providers, and politicians. These are (1) its high (and growing) cost and (2) the fact that millions have no access to good, consistent care because they are uninsured. Dumping is a blatant example of the difficulties the under- and uninsured face in securing access to health care.

All dumped patients represent potentially significant, uncompensated costs to the hospital that decides to refuse treatment.⁶ And, as health care costs have risen⁷ the problem

INDIVISIBLE: THE CIVIL RIGHTS CHALLENGE FOR THE 1990S, at 216, 228 (Reginald C. Govan & William L. Taylor eds., 1989) ("In 1988, thirty-seven million people, or about 15 percent of the total population in the United States, went without health insurance.").

5. See Emily Friedman, *The "Dumping" Dilemma: The Poor Are Always With Some of Us*, HOSPITALS, Sept. 1, 1982, at 51, 52; Karen J. Treiger, Note, *Preventing Patient Dumping: Sharpening the COBRA's Fangs*, 61 N.Y.U. L. REV. 1186, 1186-87 (1986).

6. As one observer has noted:

As economic pressures on hospitals grow and hospital managers are encouraged—or forced—to act like businessmen concerned primarily with profit margins, more and more patients will be denied access to urgently needed care simply because they cannot pay for it. In theory, all private hospitals, whether investor-owned or voluntary, acknowledge an obligation to provide emergency care for any acutely ill indigent patients brought to their doors—at least until such patients can be 'stabilized' (whatever that means) and safely transferred to a public hospital. That sounds reassuring, but in practice many very sick patients are denied adequate care.

Arnold S. Relman, *Economic Considerations in Emergency Care: What Are Hospitals For?*, 312 NEW ENG. J. MED. 372, 372 (1985).

7. Since 1980, health care expenditures in the United States have risen each year. Amounts spent per year, in billions of dollars: 1980-249.1; 1981-288.6; 1982-

has become acute. While the incessant rise in health care costs has been variously blamed on ever-changing, expensive technologies,⁸ malpractice liability, an increasingly older population, and physician greed,⁹ it has been suggested that many of the current problems can be traced to Reagan-era developments.¹⁰

It is important to keep in mind, though, that dumping is not a new phenomenon. As Emily Friedman has noted:

[A] historian at the University of Pennsylvania, Philadelphia, points out that

in the period from 1850 to 1870, the scandal of which voluntary hospitals were most afraid was that resulting from the death of a patient in an ambulance during a transfer to a municipal hospital. The newspapers would reveal the transfer, and because everyone assumed that private hospitals had public responsibilities, it would be seen as inhumane. But from the beginning of the nineteenth century, when voluntary hospitals were first

323.8; 1983-356.1; 1984-387.0; 1985-420.1; 1986-452.3; 1987-492.5; 1988-544.0; 1989-604.1. BUREAU OF THE CENSUS, STATISTICAL ABSTRACT OF THE U.S. 1991 Table 136 (11th ed. 1991). 1990 expenditures were \$666.2 billion. David A. Ridenour, *Compared to Canada, Health Care in the U.S. Is a Bargain*, SEATTLE TIMES, Feb. 13, 1992, at A11. Estimates for 1991 and 1992 were \$737.9 billion and \$817.0 billion respectively. Mark A. Hofmann, *Health Care Spending to Rise 10.7% in '92, Government Predicts*, BUS. INS., Jan. 6, 1992, at 3.

For general background and discussion of health care economics, see VICTOR R. FUCHS, *THE HEALTH ECONOMY* (1986); *HEALTH CARE FINANCIAL MANAGEMENT IN THE 1980S: TIME OF TRANSITION* (J.B. Silvers et al. eds., 1983); *ISSUES IN HEALTH ECONOMICS* (Roice D. Luke & Jeffrey C. Bauer eds., 1982); PHILIP JACOBS, *THE ECONOMICS OF HEALTH AND MEDICAL CARE* (1980); HERBERT E. KLARMAN, *THE ECONOMICS OF HEALTH* (1965); JOHN RAPOPORT ET AL., *UNDERSTANDING HEALTH ECONOMICS* (1982); *RESEARCH IN HEALTH ECONOMICS* (Richard M. Scheffler ed., 1979); MICHAEL D. ROSKO & ROBERT W. BROYLES, *THE ECONOMICS OF HEALTH CARE* (1988); *THE PRICE OF HEALTH* (George J. Agich & Charles E. Begley eds., 21 *Philosophy & Medicine*, 1986); KENNETH E. WARNER & BRYAN R. LUCE, *COST-BENEFIT AND COST-EFFECTIVENESS ANALYSIS IN HEALTH CARE* (1982).

8. Blayne Cutler, *Health Scare*, AMERICAN DEMOGRAPHICS, July 1990, at 11, 11 ("As medical techniques become more sophisticated, costs soar").

9. Dennis L. Breo, *Tough Talk from the President's Physician*, 262 JAMA 2742, 2744-45 (1989) (Dr. Burton J. Lee III, President Bush's physician, believes that in order to control medical costs, the United States must "cut[] out the waste, some of which is motivated by physician greed.").

10. See, e.g., Chris Black, *Increase in Homeless Families Linked to Worsening of Poverty*, BOSTON GLOBE, Apr. 30, 1989, at 12; Robert Pear, *Studies of Welfare Cuts Assess Harm to Elderly*, N.Y. TIMES, Mar. 19, 1982, at 20; *Reagan's Medicare Plan Is Cruel Hoax, Offers Little Help*, CHIC. TRIB., Mar. 9, 1987, at C15; Rebecca Trounson, *Convention '92, Bush: The Record, Race and Poverty*, HOUSTON CHRON., Aug. 20, 1992, at B1; *infra* note 20.

established, they had the ability to define which patients they did not want to treat: the chronic and incurable, the "morally unworthy," alcoholics, patients with venereal disease. Many of them would not take children, either, or pregnant women seeking hospital rather than home care, because they were usually prostitutes. It has been a strange symbiosis between the public and private sectors.¹¹

Thus, private hospitals in the United States have a long tradition of avoiding, when they can, economically undesirable patients. Given the existence of taxpayer-supported public hospitals whose principal task is to care for public patients at public expense, some have suggested that public hospitals are the appropriate places for the poor:

[W]e see many patients who self-refer, because they know they will be treated here if they do not have insurance. We also receive referrals from physicians' offices of patients who do not have insurance. I do not consider either of these to be "dumping." That's what we receive tax support for; that's part of our mission.¹²

In the early 1980s many states tightened up eligibility requirements for Medicaid in response to federal cuts and dramatic increases in the cost of running the program.¹³

11. Emily Friedman, *Problems Plaguing Public Hospitals: Uninsured Patient Transfers, Tight Funds, Mismanagement, and Misperception*, 257 JAMA 1850, 1850 (1987).

12. *Id.*

13. Medicaid came into existence when President Lyndon Johnson signed Public Law No. 89-97 in 1965. It is jointly subsidized by federal and state governments, providing funding for selected health care services for the blind, disabled, and families receiving aid to dependent children. Emily Friedman, *Medicare and Medicaid at 25*, HOSPITALS, Aug. 5, 1990, at 38.

Although Medicaid has brought many uninsured Americans into the fold of coverage of health care expenses, it does not cover all expenses; nor are benefits consistent between states. By 1972, 17.6 million Americans were covered under the program; by 1977, 22.9 million; by 1988, 22.9 million remained covered; by 1989, the number of covered Americans dipped to 21.6 million. *Id.* Beneficiaries, however, face major out-of-pocket expenses, and what expenses they find covered varies from state to state. Medicaid is a state-level entitlement which has led to patchwork coverage within certain limits between states in terms of services, eligibility, and payment. *Id.* at 38-46.

Over the years, state government responsibility for public health expenditures has varied from about 12 to 14%, while federal government responsibility has varied from about 11 to 30%. *See id.* at 50. This has led to a power struggle between the national and state governments in terms of who will pay what, who

However, by 1983, when Medicare began to curtail payments as well, finding a solution to the dumping problem took on new urgency. In that year Congress passed Social Security amendments¹⁴ creating the diagnostic related group (DRG) reimbursement system, which pays providers a predetermined rate for 470 diagnostic classifications.¹⁵ DRGs do not pay the provider an amount directly related to the actual cost of treating a particular patient; the provider is reimbursed a set amount based on the DRG which covers the patient's condition. If the provider keeps costs low, the portion of the reimbursement which is not actually expended on the patient represents pure profit. Thus, providers have an economic incentive to undertreat Medicare patients in order to make a windfall. This incentive becomes more powerful as the percentage of a hospital's completely unreimbursable care rises, making Medicare patients ever more likely to be undertreated or treated quickly and discharged early so that the provider

will cover what, and who is actually running the program. In 1965, for example, New York covered approximately half of its population with Medicaid. As a reaction to this generosity, Congress passed legislation which promptly prohibited such benevolence. On the other hand, over the years the states have been reducing or freezing eligibility limits while Congress has looked the other way. In the early 1980s, federal support waned and the states followed suit. However, in the mid-1980s, Congress began to expand eligibility while some states were reluctant to do so. These states found themselves giving in to federal pressure. By the late 1980s, stress on strapped state budgets from increased eligibility and skyrocketing costs forced the cutting of provider payments. This has threatened some providers' survival and has reduced physician participation. *Id.*

The costs of funding Medicaid have increased substantially since its inception. Some have proffered that "basing payment on 'reasonable costs' without some effort at cost control" would guarantee that the program would become prohibitively expensive. Such prophecies were quickly realized. *Id.* at 38, 42. Even so, Medicaid has ended up costing vastly more than anyone had predicted. In 1972, total payments were \$6.3 billion; by 1988, the total was \$48.7 billion. *Id.* at 46. Controlling its growth has proven difficult. Congress began passing legislation to control costs even before some states had implemented the program. Such reform has included mandatory quality oversight in the form of professional standards, review organizations, and peer review organizations; health planning through health systems agencies; reconfiguration of the hospital payment system; and recently the passage of legislation aimed at physicians' payment based on a resource-based relative value scale. *Id.* at 42. The continued rise in the program's costs will probably lead to additional legislation changing eligibility requirements, funding, and cost control.

14. 42 U.S.C. § 1395ww (1988).

15. For a good discussion of DRGs, see Marshall B. Kapp, *Legal and Ethical Implications of Health Care Reimbursement by Diagnosis Related Groups*, 12 LAW MED. & HEALTH CARE 245 (1984); see also John K. Iglehart, *Health Policy Report: The American Health Care System*, 326 NEW ENG. J. MED. 962, 966 (1992).

may keep costs below the DRG reimbursement amount.

In the early 1980s private health insurers began to devise methods for curtailing price increases. The proliferation of Health Maintenance Organizations (HMOs)¹⁶ and Preferred Provider Organizations (PPOs)¹⁷ were part of this effort. Like the proponents of DRGs, supporters of HMOs argued that fee-for-service payment schemes were largely responsible for the unrelenting inflation in health care costs. HMOs contract with providers on a prepaid basis and guarantee a variety of services to subscribers who generally make periodic, fixed payments for comprehensive health services.

PPOs enter into contractual arrangements with employers or insurance companies and health care providers. The PPOs operate on a fee-for-service basis, but providers prenegotiate rates with insurance companies or employers contracting for their services.

The combined effect of cost cutting and management in the 1980s on the part of Medicaid,¹⁸ Medicare, and private insurers has made it virtually impossible for hospitals to pass on the costs of indigent, unreimbursable care to other, paying patients. Not surprisingly then, the 1980s saw a huge increase in patient dumping as hospitals scrambled to avoid the most undesirable of all emergency patients: those with serious, expensive-to-treat emergency conditions with no prospect for payment.

This article examines the patient dumping phenomenon

16. For a short, nontechnical discussion of HMOs, see EMPLOYEE BENEFIT RESEARCH INST., *FUNDAMENTALS OF EMPLOYEE BENEFIT PROGRAMS* 209-15 (4th ed. 1990). According to the Employee Benefit Research Institute (EBRI), "[a]s of July 1, 1989, there were an estimated 590 HMOs covering 32.5 million people." *Id.* at 209.

17. EBRI describes PPOs as "contractual *arrangements*, generally between health care providers and an employer or insurance company to provide fee-for-service health care, usually at a discount." *Id.* at 217. The major distinction between HMOs and PPOs is that the former are organizations which provide service on a prepaid basis; PPOs are contractual relationships which arrange for coverage on a fee-for-service basis.

18. Several other very serious problems exist with respect to the Medicaid program. In particular there is ample evidence that the low reimbursement rates have discouraged many physicians from participating in the program, making access difficult even for those who remain covered. See Susan Garner, *Increasing Clients' Access to Medicaid Providers: New Developments*, 18 CLEARINGHOUSE REV. 1269, 1270 (1985); Robert Pear, *Low Medicaid Fees Seen as Depriving the Poor of Care*, N.Y. TIMES, Apr. 2, 1991, at A1 ("Medicaid pays doctors about 69 percent of what Medicare paid, and an even smaller proportion of what private insurers paid.").

and explains why the federal legislation that was supposed to end dumping of emergency patients has failed. Section II reviews the federal and state regulatory frameworks which ostensibly prohibit all emergency dumping. Section III describes the most important characteristics of the market for health insurance and explains the tremendous reluctance of hospital providers to deal with uninsured consumers. This section also focuses on a troubling question. Why is it that complaints about the present health care system consistently raise two seemingly contradictory issues: first, that we overspend on health care; and second, that the health needs of many are not being met? The answer, I conclude, is that in spite (and because) of well-intentioned but excessive regulation of the health insurance market, access is unnecessarily limited. I argue that the elimination of burdensome regulations would actually decrease the number of uninsured and ease the dumping problem.

Section IV examines several important dumping cases in light of the model presented in Section III. These narratives demonstrate that dumping is a serious problem that has proven fatal on many occasions. In addition, there is a review of the incentives that encourage hospitals to dump and a suggestion that the total elimination of dumping is not politically feasible and ought to be abandoned. Absent a scheme of universal health insurance¹⁹ (which would presumably

19. Several plans have been unfurled as proposed cures to the health care crisis. Among them is President Bush's plan which calls for a so-called voucher system. Under the plan, working families earning less than \$14,300 annually would receive vouchers worth as much as \$3750 to pay health insurance premiums. Middle-class families earning up to \$80,000 a year could deduct premiums of as much as \$3750 from their federal tax returns. David Ellis, *Rx Band-Aids to Patch Up Health Care*, TIME, Feb. 17, 1992, at 20. In addition, employers could not turn down employee applicants because of their preexisting health status. *Id.*

Several other plans have been proposed in Congress. The first, universal health care, calls for the government to set minimum care for all Americans while "[p]rivate companies would continue to offer coverage to workers under employer-paid plans and could devise policies to defray the costs of risky or experimental procedures." *Id.* at 21. A similar plan is the "single-payer" system in which private insurers would be replaced by the government, who would also regulate physician fees. *Id.* (This is the system currently in place in Canada.)

Another plan is "play or pay" which "would require businesses with 25 or more employees to provide worker coverage or pay a 7% payroll tax for the uninsured. To hold down spending on common medical procedures, a federal board would monitor fees and streamline the claim process." *Id.*

The final proposal is the "managed care" plan. "This approach is designed to maximize the clout of consumers by encouraging them to organize into groups to

eliminate the large pool of uninsured), an interim solution is needed. The most popular solution, which proposes to increase both the penalties and the likelihood of detection for violators of the federal antidumping statute, is unworkable and potentially very harmful. I propose first to reduce the pool of uninsured by encouraging private insurers to do business with the profitable segments of this market; those who remain in the pool should receive a subsidy from the state to pay for health insurance coverage, the contours of which would be politically determined.

Section V contains a summary of the arguments presented and a conclusion. This article does not purport to evaluate ways in which all-inclusive health care services could be provided to the working and nonworking poor. Nor is this a paper that proposes reform of the Medicaid program. The focus here is not on cost, but on access, and specifically access to emergency care. To the extent that the demand for emergency room services can be decreased via the provision of cost-effective preventive care,²⁰ the issues discussed here obviously affect the broader questions of comprehensive health care reform.

II. THE REGULATORY FRAMEWORK

[A]s a rule, regulation is acquired by the industry and is designed and operated primarily for its benefit.²¹

negotiate with health providers and insurers. Employers, providers of group insurance, and agencies representing the poor and unemployed would aggressively lobby for lower-cost coverage." *Id.* at 22.

20. This is indisputably true, for example, with respect to prenatal care. Study after study has concluded that the risk of expensive, emergency procedures is significantly decreased when a pregnant woman has access to early, regular prenatal care. For an excellent discussion of the link between poverty and low birth weight and infant mortality, and for a review of the data, see Orentlicher & Halkola, *supra* note 4, at 216-46. Moreover,

the Reagan administration's relentless crusade to cut the budget for domestic social policies without regard to the financial consequences has produced a situation in which America will spend more money than was "saved" by slashing federal health funding, at least in terms of prenatal care This sad fact becomes tragic when one considers that more money could be saved by correcting the causes for these burdens than by ignoring or aggravating them.

Id. at 237.

21. George J. Stigler, *The Theory of Economic Regulation*, 2 *BELL J. ECON. & MGMT. SCI.* 3, 3 (1971).

A. *Federal Initiatives*

In 1946, Congress enacted the Hospital Survey and Construction (Hill-Burton) Act.²² This legislation required hospitals which received federal funds for construction and capital improvements to furnish a "reasonable" amount of free or reduced-cost care to indigent patients for a period of twenty years, and to make their services available to all persons residing in the community. There is widespread agreement that this program has been a complete failure with respect to increasing the supply of indigent care.²³ This failure has been attributed to, among other things, ambiguity about what constitutes an "emergency," ineffective enforcement mechanisms, and the absence of sanctions for noncompliance.²⁴ As we shall see, the very same conditions have likewise doomed Congress's only other explicit attempt to secure emergency indigent care—the COBRA amendments of 1986.

The antidumping rules set forth in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)²⁵ became effective on August 1, 1986, and established a duty on the part of hospitals that have emergency rooms and participate in the Medicare program²⁶ to provide emergency indigent care in either of two situations: an "emergency medical condition" or "active labor."²⁷ It is important to note that the COBRA rules do *not* require a hospital to treat nonemergency cases or to continue treatment after the emergency condition has been

22. 42 U.S.C. §§ 291 to 291o-1 (1988). In 1979 Congress finally adopted regulations establishing specific dollar amounts of uncompensated care to be rendered annually. See 42 C.F.R. §§ 124.501-512, .601-.607 (1991).

23. See Andrew J. McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173, 198 n.107 (1989) ("Federal enforcement of Hill-Burton, left to the Department of Health and Human Services Office of Health Facilities, has been dismal. The significance of Hill-Burton diminishes each year as more and more hospitals complete their twenty-year obligation. By 1990, the number of hospitals required to provide uncompensated health care under Hill-Burton is expected to drop to 1,000, and, by 1995, to 400.") (citing Michael A. Dowell, *Hill-Burton: The Unfulfilled Promise*, 12 J. HEALTH POL. POL'Y & L. 153 (1987)); Treiger, *supra* note 5, at 1198.

24. See Phillip Green, Note, *COBRA: Another Patch on an Old Garment*, 33 ST. LOUIS U. L.J. 743, 768 (1989).

25. 42 U.S.C. § 1395dd (1988).

26. Currently, about 90% of all hospitals registered with the American Hospital Association participate in the Medicare program. AMERICAN HOSP. ASS'N, AHA HOSPITAL STATISTICS 202 Table 10A (1991).

27. See 42 U.S.C. § 1395dd(b)(1) (1988).

stabilized. In other words, it is completely lawful, under these federal regulations, to dump indigent patients who are not in active labor and who are in stable condition.

The statute contemplates that a covered hospital will do an "appropriate medical screening examination" to determine whether either of these two triggering conditions exist.²⁸ COBRA defines "active labor" as "labor at a time at which—(A) delivery is imminent, (i) there is inadequate time to effect safe transfer to another hospital prior to delivery, or (ii) a transfer may pose a threat of [sic] the health and safety of the patient or the unborn child."²⁹

An "emergency medical condition" is

a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

- (A) placing the patient's health in serious jeopardy,
- (B) serious impairment to bodily functions, or
- (C) serious dysfunction of any bodily organ or part.³⁰

A transfer of a patient who is in an unstable medical condition or who is in active labor may still be appropriate if qualified medical personnel certify that the benefits of the transfer outweigh its risks.³¹ If a transfer is to take place, the transferring hospital must send relevant medical records with the patient and provide appropriate equipment and personnel during the transfer. In addition, the receiving hospital must agree to take the patient and have the appropriate space and personnel for treatment.³²

Penalties for failure to comply with the statute include termination of the hospital's Medicare provider agreement³³ and fines of up to \$50,000 for each violation by a physician or

28. *Id.* § 1395dd(a).

29. *Id.* § 1395dd(e)(1)(B).

30. *Id.* § 1395dd(e)(1).

31. The responsible person must certify that

based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer and, in the case of labor, to the unborn child from effecting the transfer.

Id. § 1395dd(c)(1)(A)(ii).

32. *Id.* § 1395dd(c)(2)(A).

33. *Id.* § 1395dd(d)(1).

hospital.³⁴ Termination of a hospital's Medicare provider agreement is by far the more serious penalty for dumping. Medicare revenues account for about 40% of total participating hospitals' revenues.³⁵ The statute also creates a private cause of action for victims of dumping and affected institutions (i.e., receiving hospitals) who may recover damages and other appropriate equitable relief.³⁶ However, experience suggests that few dumping victims or receiving institutions ever complain about the practice of dumping. Judith Waxman, of the National Health Law Program, has testified before Congress that

[o]ne other inadequacy of the [antidumping] law has been brought to our attention by hospitals that are dumped on. [These] are the facilities that receive the inappropriate transfers regularly. While the Federal law allows them to bring a private right of action against the hospitals that dumped on them, they are very hesitant to do that. They are often in the same hospital association with the other hospitals in their area, and political pressures prevent them from suing their associates.³⁷

In 1989, Congress amended the antidumping statute. An "emergency medical condition" was expanded to include:

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or the unborn child) in serious jeopardy,
- (ii) serious impairment to bodily functions, or
- (iii) serious disfunction of any bodily organ or part; or

(B) with respect to a pregnant women [sic] who is having contractions—

- (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

34. *Id.* § 1395dd(d)(2)(A)(B).

35. *Bush Health Plan Attacked, Defended*, REUTERS, Feb. 18, 1992, available in LEXIS, Nexis Library, Reuter File.

36. 42 U.S.C. § 1395dd(d)(3)(B).

37. *Equal Access to Health Care: Patient Dumping: Hearing Before a Subcommittee of the Committee on Government Operations, House of Representatives*, 100th Cong., 1st Sess. 39 (1987) [hereinafter *Equal Access to Health Care*] (testimony of Judith Waxman, Managing Attorney, National Health Law Program).

(ii) the transfer may pose a threat to the health or safety of the woman or the unborn child.³⁸

The amendments also specify that a hospital may not delay a medical screening exam or stabilizing treatment in order to determine whether the patient is indigent,³⁹ and must provide treatment to stabilize the emergency conditions and labor;⁴⁰ a physician must also include a summary of the risks and benefits upon which the certification for transfer was made⁴¹ and both physicians and hospitals must satisfy significantly expanded record-keeping requirements.⁴² The amendments also contain a provision which protects a physician who refuses to transfer a patient (because she believes the patient has an emergency medical condition and has not been stabilized) from adverse action by the hospital.⁴³

B. *The Failure of Federal Regulation*

Not long after the 1986 COBRA Amendments went into effect, their many weaknesses became apparent. Because others have catalogued these problems elsewhere,⁴⁴ I describe them only briefly. Essentially, the 1986 antidumping statute suffered from four serious defects: first, a flawed scheme for reporting dumping incidents; second, the use of vague terms having no precise medical meaning; third, weak penalties for failure to comply; and fourth, a refusal on the part of its drafters to come to terms with the market forces that encourage dumping. The 1989 amendments to the statute attempt to address the first and second issues, but ignore the remaining two. Thus, if experience with past regulation is any guide, the new amendments are not likely to decrease the amount of dumping.

Under the statute, the Inspector General (IG) and the Health Care Financing Administration (HCFA) share responsibility for enforcement. HCFA is authorized to terminate hospitals from the Medicare program, and the IG may assess civil

38. 42 U.S.C. § 1395dd(e)(1) (Supp. I 1989).

39. *Id.* § 1395dd(h).

40. *Id.* § 1395dd(b).

41. *Id.* § 1395dd(c)(1)(A)(ii).

42. *Id.* § 1395cc(a)(1)(I).

43. *Id.* § 1395dd(i).

44. See, e.g., Treiger, *supra* note 5, at 1209-21 (detailing weak enforcement and vague statutory language).

finer for violations. The IG's office has commented that it has no way of knowing how much dumping occurs, because "it can only act on what is reported to it."⁴⁵ Perhaps the crucial reporting problem concerns the fact that hospitals need not report incidents of dumping, and many apparently do not. Public Citizen's Health Research Group (PCHRG) notes that there has been "a tragic failure of HHS' [Health and Human Services] responsibility to punish and deter violations of [COBRA] as Congress intended."⁴⁶ A spokesman for PCHRG estimates that about 250,000 incidents of patient dumping occur each year, in large part "because there is now no requirement for hospitals to report dumping cases."⁴⁷

The present distinctions between the departments' duties mainly concern the investigative process. HCFA is responsible for investigating patient dumping complaints. If the HCFA investigation determines that the hospital or physician has acted out of compliance, HCFA will refer it to the IG. The IG and HCFA may then act upon the violation by imposing their respective penalties or fines. Beyond this, the duties and responsibilities of the HCFA and the IG are not clearly defined. At this time, the HHS is attempting to promulgate rules clearly specifying HCFA and IG duties and responsibilities. Neither department is currently responsible for reporting cases of patient dumping beyond those brought before them in the form of complaints and completed investigations.⁴⁸

Additionally, the definitional problems with key words in the statute such as "serious impairment," "active labor," and "emergency medical condition" are well known.⁴⁹ The 1989 amendments include changes designed to clear up some of the confusion generated in 1986; however, Congress has yet to

45. *Health Care, Public Citizen Calls HHS' Enforcement of Patient Dumping Act "Tragic Failure"*, Daily Rep. for Executives (BNA) No. 79, at A14 (Apr. 24, 1991) (quoting Judy Holtz, IG spokeswoman).

46. *Id.* (quoting Public Citizen Director Sydney M. Wolfe).

47. *Id.*

48. Telephone Interview with Mike Blank, Complaint Investigator at HCFA (confirmed Jan. 11, 1993).

49. See, e.g., McClurg, *supra* note 23, at 197-204; "Patient Dumping" After Cobra, [Oct. 1988] Medicare & Medicaid Guide (CCH) ¶ 37,436, at 18,215 (following a study of emergency room and other hospital records in October 1987, the IG recommends that the HCFA "clarify the definition of what constitutes 'stabilization' and 'emergency condition.'"); Treiger, *supra* note 5, at 1209-16; Danielle L. Trostorff, *King Cobra Recoils: The Effect of the OBRA 1989 Technical Amendments on Health Care Providers and Regulators*, 37 FED. BAR NEWS & J. 442, 444 (1990).

adopt terminology which would presumably be most meaningful to emergency room personnel—the definitions of the American College of Emergency Physicians.⁵⁰

The 1989 amendments do not change COBRA's original scheme of penalties for failure to comply, although the penalties now apply to a somewhat expanded list of hospital and physician obligations, particularly with respect to record keeping.⁵¹ It is important to note that the maximum civil fine remains \$50,000 for knowing violations.

By far the more serious potential penalty is exclusion from the Medicare program. However, because enforcement has been notoriously poor, many hospitals do not appear to take this threat seriously. As of June 30, 1991, HHS's Office of Survey and Certification reported 756 complaint investigations had been authorized since August 1986. "Of these, 710 investigations have been completed, . . . 517 hospitals have been found in compliance, 180 out-of-compliance and 13 are under review. Of the 180 found out-of-compliance, 7 hospitals [listed] have been terminated from the Medicare program."⁵² Of these seven, the report states, three were recertified—two in 1988 and one in 1989.⁵³

One can only guess at the reasons for terminating (and then only for a short period of time) the Medicare provider agreements of only seven out of 180 hospitals found guilty of dumping. From the hospitals' perspective, this fact suggests that, even when dumping occurs, the chance that HHS will terminate the provider agreement is less than four percent.⁵⁴ Anecdotal evidence,⁵⁵ however, suggests that HHS is generally loathe to impose this harshest penalty, even for a short period of time. Whatever the motivation, though, of the regulators in declining to terminate provider agreements (even in the face of

50. American College of Emergency Physicians, *Definition of Emergency Medicine*, 10 ANNALS EMERGENCY MED. 385-88 (July 1981).

51. See Trostorff, *supra* note 49, at 447.

52. Memorandum from Anthony J. Tirone, Director, Office of Survey and Certification, to Associate Regional Administrator, Division of Health Standards and Quality, Regions I-X, *Dumping Log Investigation Status as of June 30, 1991* (on file with author).

53. *Id.*

54. This figure is arrived at by dividing the total number of known wrongdoers (180 hospitals that dump) into the number of hospitals that actually had their Medicare provider agreements terminated (albeit for a short time period): 7 divided by 180 = .03888, or about 4%.

55. See *infra* Section IV.

evidence that dumping has occurred), it seems clear that a consensus has yet to emerge at HHS about whether and how to use the termination sanction.

The government's hesitancy with respect to imposing the harshest sanction is no doubt intensified by the most serious defect in the statute—it attempts to force presumably rational economic actors to behave in a manner that is at odds with self-interest. Patient dumping occurs because hospitals cannot afford to give unlimited amounts of uncompensated care. Prohibiting patient dumping without addressing its underlying causes is thus doomed to failure.

C. State Initiatives

While this article focuses primarily on federal regulations, it is worth noting that more than half of the states have statutes which purport to regulate patient transfers.⁵⁶ Some, like the Texas statute, are well drafted⁵⁷ but, unfortunately, rarely

56. See *infra* Appendix: State Statutes Regulating Patient Transfers.

57. The Texas statute, for example, reads:

(a) The board shall adopt rules to implement the minimum standards governing the transfer of patients

(b) The rules must provide that patient transfers between hospitals should be accomplished . . . in a medically appropriate transfer[] from physician to physician and from hospital to hospital by providing:

(1) for notification to the receiving hospital before the patient is transferred and confirmation by the receiving hospital that the patient meets the receiving hospital's admissions criteria relating to appropriate bed, physician, and other services necessary to treat the patient;

(2) for the use of medically appropriate life support measures that a reasonable and prudent physician exercising ordinary care in the same or similar locality would use to stabilize the patient before the transfer and to sustain the patient during the transfer;

(3) for the provision of appropriate personnel and equipment that a reasonable and prudent physician exercising ordinary care in the same or a similar locality would use for the transfer;

(4) for the transfer of all necessary records for continuing the care for the patient; and

(5) that the transfer of a patient not be predicated on . . . economic status.

(c) The board may not adopt minimum standards that require the consent of the patient . . . before the patient is transferred.

TEX. HEALTH & SAFETY CODE ANN. § 241.027. (West 1992).

Enforcement for violations is provided in §§ 241.053-.056. (Note that the penalties include temporary restraining order, denial, suspension or revocation of a hospital's license, and/or injunctive relief. Also, injured persons may be entitled to civil damages.) Section 241.053(a) provides that "[t]he department may deny, sus-

used.⁵⁸ Other state statutes, like those in Nevada⁵⁹ and

pend, or revoke a hospital's license if the [state's health] department finds that the hospital: (1) failed substantially to comply with this chapter or a rule or standard adopted under this chapter; or (2) aided, abetted, or permitted the commission of an illegal act."

Section 241.054(b)-(c) provides:

(b) After . . . notice and opportunity to comply [has been issued to a hospital for a violation], the department may petition a district court . . . for assessment and recovery of the civil penalty provided by Section 241.055, for injunctive relief, or both.

(c) The department may petition a district court for a temporary restraining order to restrain a continuing violation if the department finds that the violation creates an immediate threat to the health and safety of the patients of a hospital.

Section 241.055 provides: "(a) A hospital shall: (1) timely adopt, implement, and enforce a patient transfer policy in accordance with Section 241.027 (b) A hospital that violates subsection (a) is liable for a civil penalty of not more than \$1000, for each day of violation and for each act of violation."

Section 241.056 provides: "(a) A person who is harmed by [failure of a hospital to timely adopt, implement, or enforce a patient transfer policy in accordance with § 241.027] . . . may petition a district court for appropriate injunctive relief (c) The person may also pursue remedies for civil damages under common law."

58. According to Mary White, administrative technician in the Hospital Licensing Program of the Texas Health Facility Licensure and Certification Division [Licensure Department], the Licensure Department had referred eight complaints (five between 1987 and 1989, and three in 1992) to the Texas Attorney General for prosecution under the state statute. According to Ms. White, no action was taken on the five referred between 1987 and 1989 and, similarly, no action has thus far been taken on the three referred in 1992.

59. For relevant portions of NEV. REV. STAT. § 439B.410 (1987), see *infra* Appendix: State Statutes Regulating Patient Transfers. In addition, Nevada provides for enforcement in NEV. REV. STAT. § 439B.410(3) (1987):

A physician, hospital or other health facility which treats a patient as a result of a violation . . . by a hospital or a physician working in the hospital is entitled to recover from that hospital an amount equal to three times the charges for the treatment provided that was billed by the physician, hospital or other health facility which provided the treatment, plus reasonable attorney's fees and costs.

Furthermore, § 439B.410(6) provides that

[i]f an allegation of a violation . . . is made against a hospital . . . , the health division of the department of human resources shall conduct an investigation of the alleged violation. Such a violation, in addition to any criminal penalties that may be imposed, constitutes grounds for the denial, suspension or revocation of [the hospital's license], or for the imposition of any sanction prescribed in NRS 449.163.

Section 449.163(1) provides that the health division may

- (a) Prohibit the facility from admitting any patient . . . ;
- (b) Limit the occupancy of the facility to the number of beds occupied when the violation occurred . . . ;
- (c) Impose an administrative penalty of not more than \$1000 per day for each violation, together with interest thereon at a rate not to exceed 10 percent per annum; and

California⁶⁰ have also been used infrequently.

(d) Appoint temporary management to oversee the operation of the facility and to ensure the health and safety of the patients of the facility.

Section 439B.410(7) provides that

[i]f an allegation of a violation . . . is made against a physician licensed to practice medicine . . . , the board of medical examiners shall conduct an investigation of the alleged violation. Such a violation, in addition to any criminal penalties that may be imposed, constitutes grounds for initiating disciplinary action or denying licensure.

Only one case has been brought pursuant to the Nevada statute. SHEPARD'S/MCGRAW-HILL, INC., SHEPARD'S NEVADA CITATIONS (1988 & Supp. Jan. 1993).

60. For relevant portions of CAL. HEALTH & SAFETY CODE §§ 1317, 1317.2 (Deering 1990), see *infra* Appendix: State Statutes Regulating Patient Transfers. In addition, § 1317.6 provides for enforcement:

(a) Hospitals found by the state department to have committed or to be responsible for a violation of this article . . . shall be subject to a civil penalty by the state department in an amount not to exceed twenty-five thousand dollars (\$25,000) for each hospital violation.

. . . .

(c) Physicians and surgeons found by the board to have committed, or to be responsible for, a violation of this article . . . shall be subject to a civil penalty by the board in an amount not to exceed five thousand dollars (\$5,000) for each violation. A civil penalty imposed under this subdivision shall not duplicate federal fines, and the board shall credit any federal fine against a civil penalty imposed under this subdivision.

(d) The board may impose fines when it finds any of the following:

(1) The violation was knowing or willful.

(2) The violation was reasonably likely to result in a medical hazard.

(3) There are repeated violations.

. . . .

(f) There shall be a cumulative maximum limit of thirty thousand dollars (\$30,000) in fines assessed against hospitals under this article and under Section 1395dd of Title 42 of the United States Code for the same circumstances.

(g) Any hospital found by the state department . . . to have committed a violation of this article . . . may have its emergency medical service permit revoked or suspended by the state department.

(h) Any administrative or medical personnel who knowingly and intentionally violates any provision of this article, may be charged by the local district attorney with a misdemeanor.

. . . .

(j) Any person who suffers personal harm and any medical facility which suffers a financial loss as a result of a violation of this article . . . may recover, in a civil action against the transferring or receiving hospital, damages, reasonable attorney's fees, and other appropriate relief. Transferring and receiving hospitals from which inappropriate transfers of persons are made or refused in violation of this article . . . shall be liable for the reasonable charges of the receiving or transferring hospital for providing the services and care which should have been provided. Any person potentially harmed by a violation of this article . . . or the local district

New York's infrequent enforcement efforts appear to be typical. Recently, New York initiated its second ever criminal prosecution under a 1983 statute that makes it illegal—punishable by up to one year in prison—for hospitals or health care personnel to refuse emergency treatment.⁶¹ The most recent incident involved a resident doctor at Harlem Hospital, a public facility, who allegedly refused to admit a woman in labor who then gave birth in the hospital's waiting room. This is apparently the first instance in which New York has charged a doctor under the statute—the only other prosecution involved a nurse—and the peculiarity of the entire affair seems lost on everyone except the doctors. The executive director of the union representing the residents and interns noted recently: "It is indeed ironic that the very law our members support-

attorney or the Attorney General, may bring a civil action against the responsible hospital or administrative or medical personnel to enjoin the violation, and if the injunction issues, the court shall award reasonable attorney's fees.

Only six cases have been brought pursuant to the California statute. SHEPARD'S/MCGRAW-HILL, INC., SHEPARD'S CALIFORNIA CITATIONS (1988 & Supps. Feb. 1992, Dec. 1992, Jan. 1993).

There is evidence which suggests that the dumping problem in California is severe and deteriorating. The *Los Angeles Times* reported in 1986 that a recent study of patient transfers to the San Bernardino County Medical Center showed that 91% of the transfers were for economic reasons, and that 31 of 423 patients transferred (or about 7%) were in unstable condition at the time of the transfer. Robert Steinbrook, *Hospital "Dumping" of Poor: Lawmakers Seek a Cure*, L.A. TIMES, Apr. 7, 1986, at 3, 15; see also *\$300,000 Won In Patient Case*, L.A. DAILY J., Feb. 4, 1991, at 3 (uninsured patient discharged from hospital despite symptoms of life-threatening illness collapses and dies 15 hours later).

61. For relevant excerpts of N.Y. PUB. HEALTH LAW § 2805-b (McKinney 1985 & Supp. 1992), which makes it illegal for hospitals and health care personnel to refuse emergency medical care to patients requesting such treatment, see *infra* Appendix: State Statutes Regulating Patient Transfers. Section 2805-b(2)(b) establishes a criminal penalty for such a violation:

Any licensed medical practitioner [in cities with a population of one million or more] who refuses to treat a person arriving at a general hospital to receive emergency medical treatment who is in need of such treatment; or any person who in any manner excludes, obstructs or interferes with the ingress of another person into a general hospital who appears there for the purpose of being examined or diagnosed or treated; or any person who obstructs or prevents such other person from being examined or diagnosed or treated by an attending physician thereat shall be guilty of a misdemeanor and subject to a term of imprisonment not to exceed one year and a fine not to exceed one thousand dollars.

In addition, § 2805-b(2)(a) provides that any hospital, in cities with a population of one million or more, which fails to provide "emergency medical care and treatment to all persons in need of such care or treatment who arrive at the . . . hospital,]" shall be guilty of a misdemeanor. *Id.*

ed to prevent medically indigent patients from being dumped from private hospitals is being used to persecute a doctor employed at a public hospital which takes care of everyone."⁶²

While any number of factors may have motivated the doctor in question to refuse care, including the fact that the hospital's emergency room was overcrowded, it is hard to believe that the patient's uninsured status played any role in the incident. The targets of the legislation were private facilities that cannot turn to the taxpayer to absorb the costs of uncompensated care, not public hospitals such as Harlem or their house staff.

In any event, the only other New York dumping prosecution involved a nursing supervisor who refused emergency room care to an 81-year-old who was subsequently stabilized at another hospital.⁶³ Again, it is hard to believe that the nurse was responding to anything other than hospital protocol when she refused the patient on the grounds that her physician was not affiliated with the institution. In other words, if this was a case of dumping it almost surely was not the fault of the nurse. The hospital had existing instructions on how to proceed, which she was merely obligated to respect.⁶⁴ Nonetheless, the nurse was fined \$500 and sentenced to 200 hours of community service.

Because some of the state statutes suffer from the same vagueness that plagues the federal law,⁶⁵ state prosecutorial

62. Lisa Belkin, *Harlem Hospital Doctor Faces "Dumping" Charges*, N.Y. TIMES, Jan. 15, 1992, at B3.

63. *A Nurse Is Sentenced for Denying Treatment*, N.Y. TIMES, Dec. 6, 1989, at B8.

64. According to George Ernis of the Bureau of Hospital Services, New York State Health Department, Parkway Hospital was never fined for the incident. The Health Department, after an investigation, issued deficiencies against the hospital, requiring that it submit a plan of correction. The plan was ultimately accepted by the health department and no subsequent fine was imposed. In addition, there was no explicit finding that the procedures followed by the nurse were standard hospital policy or procedure. Telephone Interview with George Ernis (confirmed Jan. 1, 1993).

65. E.g., NEV. REV. STAT. § 439B.410 (1987) (failing to define "appropriate admission," "medically necessary," "medically fit," "indigent patient," "stabilized," "additional risk," "inadequate time . . . to transfer . . . safely," "threat," "sufficient severity," "reasonably . . . expected," "serious jeopardy," "serious impairment," "serious dysfunction," "sufficiently stabilized," and "acceptable risk"); N.Y. PUB. HEALTH LAW § 2805-b (McKinney 1985 & Supp. 1992) (failing to define such terms as "need of immediate hospitalization," "all convenient speed," "emergency medical care," "stabilized sufficiently," "best interest," "proper equipment or personnel," "reasonable time," and "available and willing to admit"); WYO. STAT. § 35-2-115 (1988) (failing

initiatives have been remarkably few. In addition, one can only wonder about the quality of reporting procedures that lead to defendants like those in New York, in spite of persistent anecdotal evidence that the relatively more prosperous private institutions dump regularly on public facilities.

III. THE MARKET FOR HEALTH INSURANCE

A. *Pricing Premiums and Assessing Risk*

Physicians and nurses, medical ethicists and philosophers, economists and political scientists express opinions about what care society owes or does not owe ill persons. As an aging population combines with advancing medical technology, more people will need treatment, and more treatment will be available. The question is who will get what and who will pay.⁶⁶

The market for health insurance, as one might expect, is linked closely to the forces that affect the cost of health care. Over the past ten years health care expenditures in the United States have risen from approximately \$238.9 billion in 1980⁶⁷ to \$738 billion in 1991, or 13% of the Gross National Product (GNP).⁶⁸ By the year 2000 it is estimated that 15% of GNP will be spent on health care, if current rates of growth continue.⁶⁹ This cost increase for health care represents a dra-

to define "emergency service and care," "danger of loss of life," "serious injury or illness," "appropriate facilities," "qualified personnel," "ordinary medical care and skill," "permanent illness or injury," and "sufficient qualified personnel").

66. ARTHUR W. FRANK, *AT THE WILL OF THE BODY: REFLECTIONS ON ILLNESS* 115 (1991).

67. John K. Iglehart, *Health Policy Report: The American Health Care System*, 326 *NEW ENG. J. MED.* 1715, 1717 Table 2 (1992).

68. Estimates vary. See Walter A. Costelo, Jr., *President's Message*, *MASS. LAW. WKLY.*, June 8, 1992, at 37 (reporting \$738 billion spent on health care in 1991, representing 13% of GNP); Ruth SoRelle, *70 Percent of Texans Unhappy with Health-Care System; National Plan Backed by One-Third of Those Surveyed in Poll*, *HOUSTON CHRON.*, Feb. 17, 1992, at 11 (reporting \$756 billion spent on health care in 1991, accounting for 12.2% of GNP).

69. See Charles A. Bowsher, *Let's Extend Health Care to All Our People*, *NEWSDAY*, Apr. 29, 1991, at 33 ("If current trends continue during this decade, the United States will be spending 15 percent of its GNP on health care by the turn of the century. This growth will add \$300 billion per year to national health spending in the year 2000."); *Uniform Payment Rules, Caps Needed to Cut Costs*, *GAO Tells House*, 18 *Pension Rep. (BNA)* No. 16, at 733 (Apr. 22, 1991) ("[N]early 15% of the United States' gross national product will be spent on health care by the year 2000."). Some estimates are even higher. See *Statement by Senate Finance Committee Chairman Lloyd Bentsen (D-Texas) on Health Care Reform Bill He Plans*

matic increase to the consumer of the potential cost of an event requiring the care and attention of a medical professional. For a consumer who is willing to assume a moderate amount of risk, this increase in cost, other things being equal, should have led to a decrease in the demand for health insurance.

In fact, over the past twenty years, the number of individuals with private (non-Medicaid or Medicare) health insurance has increased to 158 million.⁷⁰ Originally, the private insurance market was dominated almost completely by Blue Cross and Blue Shield, a collection of not-for-profit plans.⁷¹ Two rather remarkable changes have taken place in the market for health insurance recently. The first involves the way in which premiums are calculated. When Blue Cross was created in

to Introduce, Daily Rep. for Executives (ENA) No. 202, at L1 (Oct. 18, 1991) (health care costs consume 12% of GNP, a percentage projected to increase to 17.3% by the end of the decade—a trend the President's budget director has described as "unsustainable"); cf. Spencer Rich, *Study Finds Rx for U.S. in Canada Health Plan: In Decade, Savings Calculated in the Trillions*, WASH. POST, Oct. 18, 1991, at A19 ("[I]f the current system were to continue in effect and health care costs rise to 17.5 percent of gross domestic product by the year 2000 . . .").

70. Employee Benefit Research Inst., *Sources of Health Insurance and Characteristics of the Uninsured, Analysis of the March 1991 Current Population Survey*, EBRI SPECIAL REP. & ISSUE BRIEF NO. 123, Feb. 1992, at 5 Table 1 [hereinafter *Sources of Health Insurance*].

71. The first Blue Cross plans were established during the Great Depression in cooperation with hospitals. Premiums were based on hospital costs rather than on an assessment of individual consumers' risks. Because of the strong tie to hospitals, Blue Cross was often able to negotiate substantial hospital discounts for subscribers. *The Blues Are Displaying New Hues*, NAT'L J., April 18, 1987, at 938.

In 1939, Blue Shield plans were established, offering similar types of coverage, but for doctors' services as opposed to Blue Cross hospital costs. *Id.* Both Blue Cross and Blue Shield plans featured broad coverage and no deductibles or copayments. The plans were open to all consumers, regardless of health risks. Both plans assessed costs based on "community rating" systems, which meant that everyone within a certain geographical area paid the same rate. Blue Cross and Blue Shield plans were set up according to special state legislation and were afforded tax-exempt status. *Id.*

The Blues began to face major competition in the 1940s with the advent of managed-care plans. Dena Bunis & Michael Unger, *Growing Pains: Cost Squeeze Spurs an Industry*, NEWSDAY, Dec. 2, 1991, at 32. The first managed-care plan to challenge the Blues was started in 1942 by California industrialist Henry Kaiser. Kaiser Permanente had affiliated hospitals and clinics all along the West Coast. Workers contributed five cents a day in exchange for free medical care at affiliates. Kaiser's East Coast counterpart, the Health Insurance Plan of Greater New York (HIP), was begun in 1947 by then New York Mayor Fiorello LaGuardia. HIP's first members were city workers and union members. Kaiser and HIP were the forerunners of today's HMOs. *Id.*

This competition had a marked effect on the Blues operation nationwide. After World War II, commercial pressure forced a shift away from community rating. *The Blues Are Displaying New Hues*, *supra*, at 938.

1933,⁷² premiums were assessed on the basis of a community rating.⁷³ That is, premiums were the same for all subscribers without regard to the actual experience of the group. However, when Blue Cross began to experience competition from the for-profit sector, it abandoned community rating in favor of experience rating—i.e., it began to charge premiums that reflected the risk of the insured group.

This change from community rating to experience rating is precisely what one would expect to see in an efficient market for health insurance because community rating, while attractive in some respects, is inefficient.⁷⁴ Any community consists of high-risk, high-use consumers and low-risk, low-use consumers. The effect of community rating by Blue Cross was to subsidize high-use consumers because the rate they paid did not accurately reflect the true cost of insuring them. The subsidy, of course, was provided by the low-risk subscribers who were paying more for insurance than their usage would indicate they should.

Community rating could be defended on equity grounds if one could determine that the subsidy toward high-use consumers was simultaneously a subsidy toward low-income consumers. In fact, though, a study of Michigan Blue Cross concluded that the groups enjoying the largest subsidies were *not* those with the lowest incomes. As Professor Paul Feldstein has noted, "What appears to have occurred in practice under community rating was that the subsidy-tax concept operated in reverse; higher income persons were subsidized by lower-income persons."⁷⁵

Besides its disproportionate equity effects, community rating also distorted the health insurance market in that it decreased the demand of the low-use/low-risk consumers for health insurance. An example may help to illustrate why.

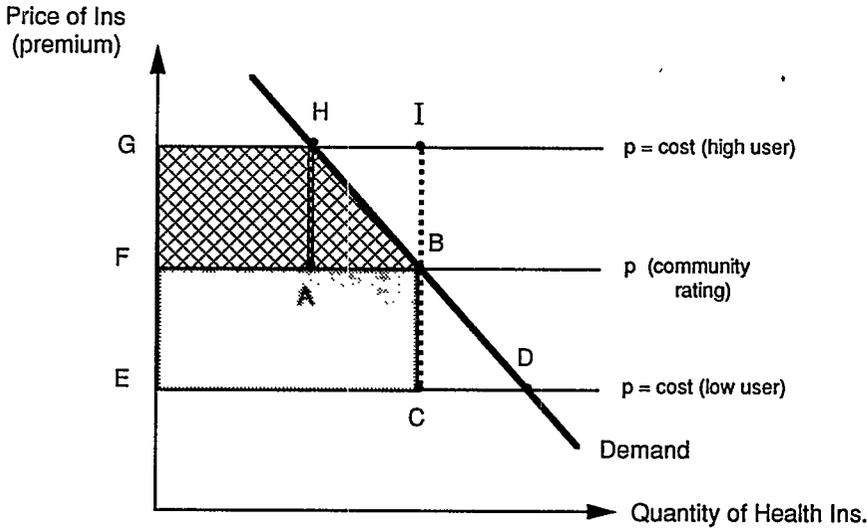
72. Annette Spence, *Healthy, Wealthy, and Wise*, BUS. DATELINE, Feb. 1992, at 16.

73. Recently, New York mandated a return to community rating for insurers who wish to sell small group or individual policies. See Peter Passell, *What Hidden Costs in Spreading the Insurance Risk?*, N.Y. TIMES, July 12, 1992, § 4, at 6.

74. See diagram, *infra*.

75. PAUL J. FELDSTEIN, *HEALTH CARE ECONOMICS* 159 (3d ed. 1988).

EFFECT OF COMMUNITY RATING ON DEMAND FOR HEALTH INSURANCE



A → B: increase in purchases of high users at community rating price.

D → C: decrease in purchases of low users at community rating price.

▨ : overall wealth gain for high cost users.

□ : overall wealth loss for low cost users.

△ B,C,D: wealth loss of low cost users that is not transferred to insurance company. This is pure deadweight loss.

□ E,F,C,B: wealth loss of low cost users transferred to insurers.

□ F,G,H,A: wealth gain of high cost users transferred to them by insurers.

△ A,B,H: wealth gain of high cost users transferred to them by insurers.

△ H,I,B: wealth loss of society that is not transferred to insurers. This is pure deadweight loss.

As the diagram illustrates, a low-risk user's demand for health insurance is artificially decreased by a community rating pricing scheme because the community rating, in effect, acts like a tax and discourages additional purchases. This is inefficient in the sense that dollars of coverage, which could be profitably insured, are not under a community rating plan. The opposite is also true. Dollars of coverage that cannot be profitably insured are covered under community rating.

When the market for traditional health insurance encountered competition from the relatively new for-profit sector, community rating disappeared quickly since Blue Cross could no longer hope to attract, maintain, and overcharge low-use consumers.

The second interesting development in the market for health insurance has been the recognition that the longstanding link between private coverage and employment, which has been described as "accidental,"⁷⁶ is not necessarily the most useful mechanism for ensuring maximum access. An examination of the link between employment and private health insurance is long overdue, especially in light of data which suggest that 19.9 million employed individuals are without any form of insurance.⁷⁷ It has never been the case that all employers offered some form of health coverage as a benefit to employees;⁷⁸ however, as the cost of coverage has increased, more employers, especially smaller ones, have decided to drop all coverage.⁷⁹ In other cases, employers have decreased their

76. ELI GINZBERG, *THE MEDICAL TRIANGLE: PHYSICIANS, POLITICIANS AND THE PUBLIC* 252 (1990).

77. EBRI reports that 55.7% of the 35.7 million Americans without health insurance are employed. *Sources of Health Insurance*, *supra* note 70, at 8.

78. In 1991, employee benefits represented 25.3% of workers' total compensation in firms with fewer than 100 workers. This included 5.5% spent on insurance benefits and 9.7% spent on legally required benefits such as unemployment insurance and Social Security. Employee Benefit Research Inst., *A Look at Compensation Costs from the Employer and Employee Perspective*, EMPLOYEE BENEFIT NOTES, Apr. 1992, at 1, 2. In firms with 500 or more workers, the benefits represented 30.7% of total compensation, including 7.6% spent on insurance benefits and 8.2% spent on legally required benefits. *Id.*

79. Small businesses offer disproportionately less health insurance coverage than their large counterparts. Gannett News Service reports that a 1986 study by the Small Business Administration found 44% of the nation's 3.7 million businesses did not have health coverage for employees. Businesses with large numbers of employees were most likely to offer some coverage. Judith Egerton, *Small Businesses Losing Grip on Soaring Insurance Costs*, Gannett News Service, Apr. 29, 1990, available in LEXIS, Nexis library, Gannett File. *Business Week* reports that "a number of small businesses are taking the ultimate step to solve the [health care cost] problem. They are simply jettisoning their health insurance plans, leaving their employees to fend for themselves." *Minor Surgery Won't Help Health Care*, BUS. WEEK, Nov. 26, 1990, at 202; see also Sara J. Harty & Adrienne C. Locke, *End to Cost Shifting May Spur Employers to Offer Health Plans*, BUS. INS., April 22, 1991, at 3, 14 (quoting Jill Foley, research assistant, EBRI: "As health costs continue to increase, we will probably see increased rates of non-coverage for people in small firms."); Robert Pear, *Insurers Plan to Fight Congress on Small-Business Health Coverage*, N.Y. TIMES, Sept. 24, 1991, at A26 ("Small employers with sick or disabled workers often find it difficult or impossible to get health insurance at prices they can afford."); Michael Tanner, *As Washington Dithers, States Reform*

premium contribution, pushing the added cost on to employees.⁸⁰ Either way, many employed individuals cannot obtain insurance coverage for themselves and their dependents at an affordable rate. It is not clear how the move from community rating to experience rating has affected the size of the working uninsured; one would expect, though, that as the cost of premiums rose for high-use employees to its true level (up from the subsidized, community rating level) employers with high-use workers would face even greater costs and concomitant incentives to substitute another lower-cost benefit.⁸¹

B. *The Demand for and Supply of Health Insurance*

Total demand for health insurance is determined by several factors, including the cost of the insurance, the probability of a covered event occurring, the income of the purchaser, the expected size of the loss, and the risk aversion of the purchaser.⁸² Like other products, health insurance may vary widely in

Health Care, HERITAGE FOUND. REP. (Nov. 27, 1991) (as a result of increased costs, many small businesses reluctantly choose to forego health insurance for their employees).

80. See Ron Pollack, *Business Expenses for Health Care Exceed After-Tax Profits*, Report Says, Daily Rep. for Executives (BNA) No. 238, at G7 (Dec. 11, 1991) ("The response by many employers [to increased insurance costs] has been to shift more of the burden onto their employees In fact, . . . employees are now paying a larger share of employer-sponsored health insurance, up from 18 percent in 1980 to 23 percent in 1991." By the end of this decade, health spending will absorb nearly twice as much family income as it did in 1980.).

81. Charles Klein of John Hancock Financial Services explains:

As far as recruiting people, a small company will never be able to [offer] the same types of benefits a larger organization [does]. It may be easier to implement, but the cost per employee is too high. Small employers need to do other things to attract people. They need to promote the work environment and non-qualified type plans An alternative to the fully insured plan is the self-funded plan, in which employers pay the cost of premiums into a reserve account, administered by a reinsuring company.

Tim Taylor, *The High Cost of Health*, ARK. BUS., Mar. 2, 1992, § 1, at 20. Brenda Weeks, owner of Employee Benefit Consultants, Inc. of Little Rock, Arkansas, helps small employers find policies that are affordable to them. Options to make policies more affordable include not offering maternity riders, opting for different coinsurance payment levels, and offering in-hospital benefits only. *Id.*

Many small employers opt for alternative health insurance plans. For example, B&B Industries (Boulder, Colo.) and Applied Technologies, Inc. (Boulder, Colo.) have plans which do not cover preventative care. Instead, each employee contributes to a company-devised and -run "self-insurance" pool which covers minor medical expenses such as office visits. Judy Floyd, *Health Insurance Reforms on Horizon?*, BOULDER COUNTY BUS. REP., Mar. 1991, § 1, at 1.

82. For a good discussion of the characteristics of the demand curve for health

terms of actual quality and reputation. Even when two policies purport to cover the same events under the same circumstances and paying the same amount, two companies may have widely varying reputations for service (e.g., rapidly processing claims; or, in the case of HMOs, quickly providing needed approvals). These factors might explain puzzling price differentials in otherwise identical policies.

Like other products, the price of health insurance is a major determinant of aggregate demand. Indeed, the distortions created by community rating are of concern because of their depressing effect on the demand for insurance by low-risk consumers. The flight from community rating, triggered by the entrance of for-profit competitors to Blue Cross, is ample proof of the central role that price plays in determining demand for health insurance. The other determinants depend on consumers' subjective assessments of the type of medical services, if any, they will require. The income of the consumer is important because as income rises, an employee's demand for fringe benefits (including health insurance) rises as well.⁸³

The supply side of the market appears to be characterized by relatively low barriers to entry for numerous firms—both nonprofit (the Blues) and for-profit.⁸⁴ There are currently more than 700 for-profit insurers⁸⁵ and 73 Blue Cross and Blue Shield plans.⁸⁶ Until 1986, Blue Cross enjoyed a market advantage over commercial for-profit insurers in the form of federal tax-exempt status. This status was revoked by Congress in 1986 because Blue Cross was operating much like a for-profit organization.⁸⁷ Many Blue Cross plans have negotiated sub-

insurance, see FELDSTEIN, *supra* note 75, at 76-97.

83. See, e.g., Mark V. Panly, *Taxation, Health Insurance, and Market Failure in the Medical Economy*, J. ECON. LITERATURE, June 24, 1986, at 644.

84. For some further general background on the health care market and discussions of proposals for reform, see AMERICAN ENTERPRISE INST. FOR PUB. POLICY RESEARCH, A NEW APPROACH TO THE ECONOMICS OF HEALTH CARE (Mancur Olson ed., 1981); Charles Bruner, SLICING THE HEALTH CARE PIE (1988); ISSUES IN HEALTH ECONOMICS (Roice D. Luke & Jeffrey C. Bauer eds., 1982).

85. BURTON T. BEAM, JR. & JOHN J. MCFADDEN, EMPLOYEE BENEFITS 165 (3d ed. 1992).

86. BLUE CROSS BLUE SHIELD ASS'N, QUESTIONS AND ANSWERS ABOUT THE BLUE CROSS & BLUE SHIELD ORGANIZATION 1 (1991).

87. Blue Cross Blue Shield's tax-exempt status was revoked by Congress in 1986. See *Comprehensive Tax Reform, Hearings Before the Committee on Ways & Means, House of Representatives*, 99th Cong., 1st Sess. 4510 (testimony of Rep. Stark, D-Calif.) ("[P]erhaps the time has come for Blue Cross Blue Shield, which is acting very competitive and very much like a profit making business, with tremen-

stantial hospital discounts with provider hospitals, and are able to pass along some of these savings through lower premiums to consumers.⁸⁸

However, many for-profit commercial insurers and the Blues have formed HMOs and PPOs in an attempt to attract consumers who are willing to forego complete freedom of provider choice in return for lower cost. By the end of 1991, there were 550 HMOs in the United States.⁸⁹ The growth of HMOs and PPOs has led many to question the wisdom of the fee-for-service method of reimbursement that many insurance companies (including Blue Cross) have used. The principal disadvantage of fee-for-service is that it does nothing to encourage providers to contain costs. On the contrary, it encourages providers to supply more tests and procedures than are medically necessary in order to maximize income. In the Medicare context, the move away from fee-for-service to DRGs by Congress (described in Section II) was an attempt to avoid this problem and contain costs. Unfortunately, providers have incentives to "upcode" cases into higher paying DRGs in order to resist attempts to limit their income.⁹⁰

C. Regulation and Other Market Distortions

Economists estimate that of the 35.7 million people thought to have no health insurance (public or private), 19.9 million are employed.⁹¹ The link between the absence of adequate insurance and dumping is well established.⁹² Congress's

dously aggressive marketing policies, and providing new products, doing all the things free enterprise does except helping to pay my salary.").

88. See BEAM, JR. & MCFADDEN, *supra* note 85, at 169.

89. GROUP HEALTH ASS'N OF AM., THE NATIONAL DIRECTORY OF HMOs 9 (1992).

90. See, e.g., Uwe E. Reinhardt, *Quality: The Achilles Heel of Market Strategy*, HOSPITALS, Oct. 5, 1988, at 24.

91. See *Sources of Health Insurance*, *supra* note 70, at 9 Chart 2.

92. Judith Waxman, of the National Health Law Program, testified before Congress that

[i]t is these uninsured people who are the least desirable to health care providers and who, as evidenced by the stories you have heard today, are at the highest risk of being dumped. A recent study by the Robert Wood Johnson Foundation found that 1 million Americans were denied health care because they couldn't pay for it and an additional 14 million did not seek care because they could not afford it.

Equal Access to Health Care, *supra* note 37, at 40.

Real-life examples abound. A 1988 congressional report cited the following examples from California:

stated goal has been to eliminate dumping of emergency patients, and it has tried to do this by making dumping illegal and threatening violators with serious penalties. Little or no attention has been paid to exploring why so many people cannot obtain insurance at any price.

The pool of uninsured can be divided into those who are employed (about 19.9 million) and those who are not. For the latter group, the traditional link between employment and health insurance no doubt serves as a barrier to finding an affordable policy, since the employment-based group normally provides the advantage of a larger pool over which the insurer can spread risk and charge a lower premium. In addition, the advantage of employment status is that many employers, in part because of tax advantages,⁹³ will pay a portion of the

In Contra Costa County, Eugene Barnes was a crime victim with a knife wound to the brain. No neurosurgeon would agree to come to any of the East Bay hospitals to treat him. After several hours he was transferred to the county hospital in San Francisco, where he died. Mr. Barnes had no health insurance.

About to deliver, Sharon Ford was turned away from two private hospitals, although a fetal monitor showed fetal distress. By the time she was admitted to the county hospital, it was too late and the baby died. Although Ms. Ford was a Medical patient enrolled in a health maintenance organization, a computer error did not show her on the list. The hospitals, by mistake, thought she was uninsured.

William Jenness bled to death 6 1/2 hours after a car accident in Stanislaus County. The private hospital where he was taken asked for a \$1,000 advance deposit. Because he couldn't pay, he was transferred to the county hospital where it took 4 hours before he reached the operating room. Mr. Jenness was uninsured.

In labor and uninsured, Anna Grant went to a private hospital. The hospital kept her in a wheelchair in their lobby for 2 hours and 15 minutes. She was checked only once, and no tests were done which would have shown that the fetus was in profound distress. She was told to "get herself" to the county hospital. The transferring hospital misrepresented her condition to the county hospital via phone. The baby was later still-born at the county hospital, where doctors spent 40 minutes in an attempted resuscitation.

H.R. REP. NO. 531, 100th Cong., 2d Sess. 6 (1988); *see also* *Burditt v. United States Dep't of Health & Human Serv.*, 934 F.2d 1362, 1366 (5th Cir. 1991) (Mrs. Rosa Rivera, in labor, was transferred to another hospital despite hypertensive complications. The baby was born en route to the transferee hospital.).

93. "Contributions by an employer to accident and health . . . benefits (through insurance or otherwise) for employees, or payments such as those for medical care or permanent injury in reasonable amounts, are deductible business expenses. They result in a business benefit in the form of improvement of employee morale." 1992-2 Stand. Fed. Tax Rep. (CCH) ¶ 8702.015, at 22,087 (CCH explanation, Temp. Treas. Reg. § 1.162-10T). Section 1.162-10 provides: "Amounts paid within the taxable year for dismissal wages, unemployment benefits, guaranteed annual wages,

group premium for each employee. Thus, when analyzing how to create incentives for insurers to deal with the uninsured, it is important to distinguish among the pool on the basis of employment status. The presence of an intermediate employer affects the insurer's ability to spread costs, and the quantity of health insurance demanded at any price may be higher for the employed consumer than for an individual who is unemployed.

Congress has focused, via COBRA and the Hill-Burton program, on the provision of medical services without examining why so many consumers cannot obtain the coverage that would eliminate provider reluctance to offer all covered services, emergency or otherwise. The failure to focus on the health insurance market as part of the dumping problem may stem from the fact that at least some of the uninsured remain uncovered precisely because of other well-intentioned, but ill-conceived, regulations not unlike COBRA itself. The point is that some of the regulations that health insurers confront as they attempt to do business in any of the state markets⁹⁴ discourage the provision of low-cost policies to the uninsured.

1. *Dictating the terms of the health insurance contract*

The insurance or hospital sections of many state codes detail regulations for private insurance contracts that are both surprising and disturbing. In Massachusetts, for example, health insurers of groups or individuals are required to cover,

vacations, or a sickness, accident, hospitalization, medical expense, recreational, welfare, or similar benefit plan, are deductible under section 162(a) if they are ordinary and necessary expenses of the trade or business." Treas. Reg. § 1.162-10 (1958).

94. For example, insurers in California face numerous regulations regarding required contract provisions. Policies issued to families must provide for the addition of new members and adopted minor children and provide extension coverage for termination. CAL. INS. CODE, § 11512.1 (West 1988). Insurers offering coverage for sterilization cannot limit coverage based on the reason for sterilization. *Id.* Contracts which offer mastectomy coverage must also include coverage for prosthetic devices or reconstructive surgery, and for mammography. *Id.* § 11512.10. Insurers must offer coverage for treatment of alcoholism. *Id.* § 11512.14. Insurers must also offer coverage for treatment in an extended care facility. *Id.* § 11512.16. Furthermore, coverage must be offered for orthotic and prosthetic devices. *Id.* § 11512.175. If long-term or home-based care coverage is offered, it cannot exclude persons having Alzheimer's or related dementing illnesses. *Id.* § 11512.177. In plans offering maternity coverage, coverage for prenatal diagnosis of genetic disorders must be offered. *Id.* § 11512.18. Additionally, coverage must be offered for diabetic daycare self-management education programs. *Id.* § 11512.23. Insurers must also offer coverage for mental or nervous disorders. *Id.* § 11512.5.

inter alia: adopted children, in-vitro and fertility procedures, mental illness, prenatal care, mammograms, handicapped children, and home health care.⁹⁵ In New York, group and individual policies must provide coverage for preadmission testing, second surgical opinions, and maternity care among other things.⁹⁶ In Texas, insurers of group and individual policies must provide coverage for in-vitro fertilization, in addition to the list of other items.⁹⁷ Moreover, some states now forbid insurers from inquiring about the HIV status of prospective consumers, on the grounds that this information encourages insurers to overcharge or avoid altogether persons suspected of carrying the HIV virus.⁹⁸

As one observer has noted, "There are now some 900 such mandates nationwide, the most frequent among them being those for alcoholism treatment (required in 42 states), mammography screening (41 states), mental health care (32 states), and drug abuse treatment (31 states)."⁹⁹

These kinds of regulations raise two issues: whether it is desirable to have the state dictate the terms of the insurance contract; and what the effect is of precluding insurers from gathering information about whether prospective consumers are likely to be high- or low-users of health care. With respect to the first issue, the obvious problem raised by requiring in-

95. MASS. GEN. LAWS ANN. ch. 175, § 110 (West 1987). In 1985 an insurance company challenged section 47B of Massachusetts's insurance code provision, which required insurers to include certain minimum mental health benefits in an individual's general health insurance policy or an employee health care plan that covered hospital and surgical expenses. The U.S. Supreme Court (reviewing a decision of the Massachusetts Supreme Judicial Court) determined that these mandated benefits were not preempted by either ERISA or the National Labor Relations Act. See *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985).

96. N.Y. INS. LAW § 3216 (McKinney 1985).

97. TEX. INS. CODE ANN. art. 3.51-6, § 3A (West Supp. 1992).

98. Various states regulate the use of HIV testing for insurance purposes. In Florida, for example, the Omnibus AIDS Act restricts the use of HIV-related tests by insurance companies, allowing testing only when based on the patient's current medical condition or history or when it is triggered by coverage amounts. Robert C. Waters, *Florida Omnibus AIDS Act of 1988*, 16 FLA. ST. U. L. REV. 441, 493 (1989).

Benjamin Schatz, of National Gay Rights Advocates in San Francisco, explains that the primary argument against HIV testing for insurance purposes is one of social policy. Therefore, the main focus of industry opponents is the perceived social cost of allowing insurance companies to use the test. Benjamin Schatz, *The AIDS Insurance Crisis: Underwriting or Overreaching*, 100 HARV. L. REV. 1782, 1793 (1987).

99. Iglehart, *supra* note 67, at 1719.

surers to provide, for example, maternity benefits, is that not all subscribers would expect to take advantage of such coverage. Single males would have little or no interest in pregnancy-related coverage. Likewise, couples without children are not likely to find mandated orthodontic coverage terribly helpful in most instances. And, of course, many people would not expect to make use of fertility treatments, and coverage for prosthetic devices, alcoholism, or drug addiction.¹⁰⁰

The point is that when the state insists on certain contractual provisions, the parties lose the ability to fashion a flexible contract that meets the needs of the particular individual or group in question. This is of particular concern in the health care arena, where access to coverage is clearly not optimal. Mandated coverage raises the insurer's cost of doing business (and therefore the cost of insurance), without any necessary corresponding increase in the satisfaction or security of the insured.

Take, for example, a single male who, in considering whether to purchase a policy, must purchase one that covers pregnancy-related expenses, orthodontia, breast reconstruction, and the costs of the drug AZT to combat HIV infection. Even if we assume this man is moderately risk averse, it is not hard to imagine many single men who would value these benefits at, or near, zero. The potential consumer, though, has no choice, since he is not free to bargain with the insurer over the terms for coverage. On the contrary, he is faced with accepting coverage more extensive (and therefore more expensive) than he desires, or foregoing coverage altogether.

Single men, of course, are not the only ones who may find themselves in this predicament. A married couple with children, too, may find some of the mandated coverage items virtually useless. The couple may believe that HIV infection and related expenses like AZT, for example, are not contingencies they wish to insure against. On the other hand, maternity

100. California requires insurers of group and individual policies to cover prosthetic devices. CAL. INS. CODE § 11512.175 (Deering Supp. 1993). In addition, both Texas and Michigan require coverage for chemical dependency. See TEX. INS. CODE ANN. art. 3.51-9, § 2A(a) (West Supp. 1993) ("Insurers . . . shall provide, directly or by contract with other entities . . . benefits for the necessary care and treatment of chemical dependency that are not less favorable than for physical illness generally . . ."); MICH. COMP. LAWS ANN. § 500.3425(1) (West 1983) ("Each insurer offering health policies in this state shall provide coverage for intermediate and outpatient care for substance abuse . . .").

coverage may be of great interest. The rigid requirements of the state that undertakes to draft the contract for health insurance interferes with the ability of people to negotiate for coverage that best suits their needs. At the same time, excess coverage for events that are unlikely to occur simply adds to the premium cost of the insurance without conferring any additional benefits in many cases. For this reason, mandated coverage provisions are inefficient.

The second, and more recent, way in which states interfere with the market for health insurance is by forbidding insurers from gathering certain kinds of information about the likely demand of various consumers for health care. Statutes prohibiting testing for and inquiring about HIV status are clear examples of this.¹⁰¹ The purpose of these rules is, ostensibly, to prohibit discrimination against those who are infected. The effect, however, of prohibiting testing and other procedures designed to determine whether a prospective consumer is infected, is to encourage insurers to use covert proxies to reach the same, albeit less accurate, result. There is now evidence of

101. Many insurers now require individuals and people insured through small group policies to take an HIV test for health or disability coverage. For example, Mutual of Omaha (the largest national underwriter of individual health insurance policies) requires an HIV test for both health and disability insurance. Northwestern Mutual Life requires full blood profiles for individuals applying for disability insurance. Travellers Insurance requires HIV tests, blood profiles, and urinalysis for applicants seeking small group health plans. Debra Beachy, *Screened Out of Health Insurance; Coverage Denied*, HOUSTON CHRON., May 3, 1992, at 1. Farmers Insurance in Seattle requires individuals seeking \$50,000 or more in life insurance coverage to have an HIV test. Shelby Gilje, *HIV and Insurance—Will Companies Require Applicants to Be Tested for the AIDS Virus?*, SEATTLE TIMES, Nov. 12, 1991, at C1. Prudential Insurance and Blue Cross/Blue Shield do not require HIV tests for health or disability policies. Blue Cross/Blue Shield, however, does require consumers to fill out a questionnaire about whether they have AIDS, the HIV virus, or any other illnesses. Beachy, *supra*.

A number of states have regulations regarding insurers' ability to test for HIV. A few examples: In Washington state, insurers are allowed to test for HIV as long as testing is done on a nondiscriminatory basis. Gilje, *supra*. Under current Missouri law, insurers are allowed to require HIV testing before considering policy applications. Arlene Zarembka, *HIV: Insurance, Employment and Mandatory Testing Issues*, 53 MO. L. REV. 679, 680 (1988). In the District of Columbia, insurers cannot deny, cancel, or refuse to renew policies based on positive HIV results; however, insurers can refuse coverage to applicants diagnosed with AIDS. Insurers cannot mandate testing for HIV. Suzanne J. Scrutton, Comment, *Left of Center and Right in Front of Us: AIDS Testing in Insurance Underwriting—The Social and Economic Implications of This Practice on Individuals and Society*, 17 CAP. U. L. REV. 273, 285-86 (1988). In New York, efforts to stop companies from testing for HIV have failed. Jeanne D. Cooper, *AIDS Insurance Screening: Practice Widespread, But Criticized by Activists*, NEWSDAY, Nov. 10, 1991, at 3.

widespread efforts by insurers to use proxies like zip codes, occupation, and marital status to avoid insuring gay men who are thought to be at high risk for HIV infection.¹⁰²

The essential problem is that whether an individual is likely to be a high- or low-use consumer of health care makes a tremendous difference to the insurer in a market that relies on experience rating to determine prices. When the state attempts to keep critical information from an insurer, one would expect to see efforts to gather that same information in more circuitous, expensive, and less accurate ways.

Both mandated terms of coverage and attempts to rid the market of discrimination have the effect of introducing a measure of irrationality and inefficiency into the market for health insurance. These regulatory efforts raise costs directly by forcing consumers to purchase contracts for coverage that are broader than the consumer deems desirable, and indirectly by forcing insurers to expend resources to gather prohibited information circuitously. The onerous nature of state regulatory efforts in this area is further evidenced by the recent trend toward self-insurance. As Professor Iglehart argues, self-insured companies "are exempt from providing the various medical benefits that must be included in private health insurance plans according to the mandate of state legislatures."¹⁰³

Given the general consensus that access to health care is at a suboptimal level, regulations which raise costs and de-

102. These measures are used by insurers to determine which applicants to test for HIV. Underwriters use factors such as race, residence, occupation, and marital status to determine who to test. Zarembka, *supra* note 101, at 686. In addition, some insurance companies have denied coverage to single men who live in certain zip codes or who work in professions thought to be dominated by gay men, such as hairdressing. Sarah Henry, *Health Insurance Caps: Redlining People With AIDS*, NATION, Nov. 11, 1991, at 582.

Benjamin Schatz, director of the AIDS Civil Rights Project of the National Gay Rights Advocates in San Francisco, launched a successful challenge to underwriting guidelines developed by Munich American Reinsurance Company of Atlanta. According to Schatz, the guidelines "were designed by the company to 'weed out' gay men and deny them coverage." John Heilman, *AIDS Discrimination*, L.A. LAW., June 1986, at 26, 30-31. The guidelines classified as high risk those men between the ages of 20 and 50 who lived in cities with large gay populations and who had "illicit lifestyles" or named as a beneficiary someone other than a spouse or child. *Id.* at 31. A similar action was filed against the Great Republic Life Insurance Co. of Santa Barbara, whose guidelines, according to Schatz, segregated applications from those in occupations not requiring physical exertion such as antique dealer, florist, interior designer, and restaurant, jewelry, and fashion industry employees. *Id.*

103. See Iglehart, *supra* note 67, at 1719.

crease access to insurance cry out for review.

2. *Other distortions*

Lest the reader be left with the false impression that all the forces which raise the cost of health insurance are external, several other anticompetitive practices that tend to raise the cost of medical care itself (and therefore the cost of insurance) deserve brief mention. These practices are licensure requirements, staff privileges, and peer review.

I consider licensure first because it raises the most fundamental questions about the desirability of competition in the market for health care. Professional licensure has been described as "edicts that individuals may not engage in particular economic activities except under conditions laid down by a constituted authority of the state."¹⁰⁴ In health care this means that only duly licensed physicians may practice in the various medical specialties, and that nurses' functions are limited to the terms of their license.¹⁰⁵ and other providers, and that licensure is the only mechanism by which quality can be guaranteed. To the extent that licensing requirements have little to do with technical competence, this argument obviously loses force.

As Professor Reinhardt has noted, health-care providers who claim to favor increased competition really only mean to

eliminat[e] . . . whatever government regulation . . . [they] find burdensome [T]he advocates of deregulation in medicine do not invariably favor a wholesale retreat of government regulators. Is one to assume, for example, that physicians and dentists who now celebrate the impending deregulation of medicine are implicitly advocating the abolition of

104. MILTON FRIEDMAN, *CAPITALISM AND FREEDOM* 138 (1962).

105. So many states license such a wide variety of professional activities that it is impossible to list them all. However, a sampling may be helpful.

In New York, one must have a license to work as a barber or beautician, N.Y. GEN. BUS. LAW § 432 (1984), a taxi driver, N.Y. TOWN LAW § 136(1) (1987), a nurse, N.Y. EDUC. LAW § 6906 (1985), a physician, *id.* § 6522, an accountant *id.* § 7402, a dentist, *id.* § 6602, a chiropractor *id.* § 6552, and a real estate broker, N.Y. REAL PROP. LAW § 440(a) (1989).

In California, accountants, CAL. BUS. & PROF. CODE § 5050 (West 1990), architects, *id.* § 5536, and veterinarians, *id.* § 4825, are licensed. Illinois requires licensing for the activities of veterinarians, ILL. ANN. STAT. ch. 111, § 6902 (Smith-Hurd 1978), kennel operators, *id.* ch. 8, § 303, and podiatrists, *id.* ch. 111, § 4901. In Texas, licenses are required for such professions as physical therapists, TEX. REV. CIV. STAT. ANN. art. 4512(e), § 7(a) (West 1976), funeral directors, *id.* art. 4582(b)(1)(A).

mandatory professional licensure? Would they actually favor letting pediatric nurse practitioners and dental hygienists practice independent entrepreneurship and compete head-on with physicians and dentists?¹⁰⁶

The abolition of licensure would undoubtedly enable some consumers to lower their health care costs by selecting an unlicensed caregiver. And, the increased competition would also force at least some of those currently protected by a license to compete for patients' business by lowering fees. Whether it would also lead to an increase in the amount of quackery and claims for negligence and fraud would depend upon the ability of consumers to gather and process relevant information about practitioners' quality. These concerns, though, probably would not outweigh the advantages to consumers generated by the abolition of medical licensure. A simple certification process would dramatically improve access, while still enabling consumers to figure out who has adequate medical training.

Concerns about quality notwithstanding, the economic interests of licensed medical practitioners are perhaps most evident in the areas of staff privileges and peer review where numerous antitrust cases demonstrate the tendency of physicians in particular to go to great lengths to eliminate competitors. The history of obstetricians and their quest to eliminate midwives from this segment of the medical profession is well known,¹⁰⁷ and does not require recitation here. Suffice it to say that Professor Enthoven's observation that the "medical profession has traditionally opposed economic competition in health care services"¹⁰⁸ and that physicians are "ambivalent"¹⁰⁹ about competition is probably understated.

As several antitrust cases demonstrate, physicians have attempted to deny or rescind the staff privileges of doctors whose competition for patients was resented,¹¹⁰ embark upon

106. Uwe E. Reinhardt, *Table Manners at the Health Care Feast*, in FINANCING HEALTH CARE: COMPETITION VS. REGULATION 13, 14 (Duncan Laggy & William G. Anlyan eds., 1982).

107. For an excellent discussion of the decline of midwifery, see DEBORAH A. SULLIVAN & ROSE WEITZ, *LABOR PAINS: MODERN MIDWIVES AND HOME BIRTH* (1988) (describing the largely successful efforts of the medical establishment to eliminate the profession of midwifery).

108. Alain C. Enthoven, *How Interested Groups Have Responded to a Proposal for Economic Competition in Health Services*, 70 J. AM. ECON. ASSOC. 142, 146 (1980).

109. *Id.*

110. *E.g.*, *Patrick v. Burget*, 300 F.2d 1498 (9th Cir. 1986), *rev'd*, 486 U.S. 94

campaigns designed effectively to boycott providers of certain kinds of medical services;¹¹¹ and, under the guise of concern over medical standards, encourage official harassment of clinics providing low-cost abortion services.¹¹² Especially in markets with few hospitals, physicians already on staff are sometimes tempted, in deciding whether to grant privileges, to focus on the economic threat posed by an additional competitor. And, as Professor Havighurst has explained, as hospitals assert their interests in controlling costs (which they must do as a result of increased competitiveness engendered by both public and private insurers) they find themselves increasingly at odds with staff physicians over admitting privileges. "Because a hospital can significantly influence physician behavior only by its perceived readiness to exercise its right to withhold or condition admitting privileges, an increase in the number of disputes over such privileges is likely to be a consequence."¹¹³

Peer review, which has been defined as the "oversight of the practices of an individual doctor by fellow professionals,"¹¹⁴ likewise presents opportunities for abuse premised on a desire to exclude competitors. At the same time, properly applied, peer review may enhance the services received by consumers of health care. Peer review is defended as a mechanism for maintaining practice standards and controlling costs.

(1988); *Maresse v. Interqual, Inc.*, 748 F.2d 373 (7th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985); *Tambone v. Memorial Hosp.*, 635 F. Supp. 508 (N.D. Ill. 1986), *aff'd*, 825 F.2d 1132 (7th Cir. 1987); *Straube v. Emanuel Lutheran Charity Bd.*, 600 P.2d 381 (Or. 1979), *cert. denied*, 445 U.S. 966 (1980).

111. See, e.g., *Wilk v. American Med. Ass'n*, 895 F.2d 352 (7th Cir. 1990), *cert. denied*, 496 U.S. 927 (1990) (holding that AMA had engaged in illegal restraint of trade when it enacted Medical Ethics Principle 3, which prohibited medical physicians from associating professionally with "unscientific practitioners"; deemed chiropractors "unscientific practitioners"; and advised members it was unethical to associate with chiropractors).

112. *Feminist Women's Health Ctr., Inc. v. Mohammad*, 586 F.2d 530 (5th Cir. 1978), *cert. denied*, 444 U.S. 924 (1979) (holding that medical review organizations are not public regulatory bodies for purposes of the *Noerr-Pennington* doctrine).

113. Clark C. Havighurst, *Doctors and Hospitals: An Anti-Trust Perspective on Traditional Relationships*, 1984 DUKE L.J. 1071, 1075-76 (footnote omitted); see also Philip C. Kissam et. al., *Antitrust and Hospital Privileges: Testing the Conventional Wisdom*, 70 CAL. L. REV. 595, 597 (1982) (arguing that a "set of relatively clear antitrust rules could be recognized that would guard against blatant anticompetitive abuses without disrupting the legitimate interests of hospitals and medical staffs in providing efficient and high quality medical care").

114. Clark C. Havighurst, *Professional Peer Review and the Antitrust Laws*, 36 CASE W. RES. L. REV. 1117, 1117 (1986). For a review of the history of peer review, see James F. Blumstein & Frank A. Sloan, *Antitrust and Hospital Peer Review*, LAW & CONTEMP. PROBS., Spring 1988, at 7, 10-14.

However, it clearly presents opportunities for anticompetitive behavior. In *Patrick v. Burget*, for example, a physician whose relationship with other doctors at a competing clinic had deteriorated argued that the peer review process was manipulated by his peers to terminate his hospital admitting privileges.¹¹⁵

The point is not that there is no legitimate role for licensure, controlling staff privileges, and peer review, but that each of these practices can be abused to reduce competitive pressure, thus raising health care costs and the cost of insurance.¹¹⁶ Insurance premiums may be higher than they ought to be because of external factors such as state-mandated contractual terms and because of the internal, anticompetitive practices of health care providers. Any serious attempt to make private health insurance more widely available will have to address the practices which tend to protect and enhance the income of providers while providing only dubious assurances of quality to consumers.

IV. DUMPING CANNOT BE REGULATED OUT OF EXISTENCE— IN DEFENSE OF A MARKET APPROACH

A. *The Dumping Narratives*

For ye have the poor always with you¹¹⁷

The ultimate value of illness is that it teaches us the value of being alive; this is why the ill are not just charity cases, but a presence to be valued.¹¹⁸

In recent years, the power of personal narratives has been amply demonstrated by the work of feminist legal scholars and others.¹¹⁹ It is well known that legal and economic argu-

115. *Patrick v. Burget*, 800 F.2d 1498, 1504 (9th Cir. 1986), *rev'd*, 486 U.S. 94 (1988).

116. For a thorough discussion of the pros and cons of competition in the health care market, see James F. Blumstein & Frank A. Sloan, *Redefining Government's Role in Health Care: Is a Dose of Competition What the Doctor Should Order?*, 34 VAND. L. REV. 849 (1981).

117. *Matthew* 26:11 (King James).

118. FRANK, *supra* note 66, at 120.

119. For example, Patricia Williams writes:

I remember with great clarity the moment I discovered that I was "colored." I was three. I already knew that I was a "negro"; my parents had told me to be proud of that. But "colored" was something else; it was the totemic evil I had heard my little white friends talking about for several

ments, however technical, coherent, or persuasive, tend to lose sight of the individuals affected.¹²⁰ Moreover, it is a very real

weeks before I realized that I was one of *them*. I still remember the crash of that devastating moment of union, the union of my joyful body and the terrible power-life of that devouring symbol of negritude. I have spent the rest of my life recovering from the degradation of being divided against myself, within myself; I am still trying to overcome the polarity of my own vulnerability. The tense poised trembling whirling joy of my mortality. The immortal unrelenting finality of my dangerous bottomless black fate.

Patricia Williams, *The Obliging Shell: An Informal Essay on Formal Equal Opportunity*, 87 MICH. L. REV. 2128, 2140 (1989).

Marie Ashe writes:

At 7:10 I felt a change. The grinding and tearing pain abated. The nurse shouted to someone, she's ten centimeters dilated. The doctor left the nursing area. I felt a sensation of incredible pressure, without pain, and a headiness. The nurse wheeled my labor room bed through a short hallway, through the double doors of the delivery room. She positioned it alongside a narrow table. Climb across, she said. I felt utter astonishment. She spoke matter-of-factly. Did it happen that other women were able, at this stage of their labors, to climb with agility from one table to another? I don't think I can do it alone, I told her. She helped me across.

Marie Ashe, *Zig-Zag Stitching and the Seamless Web: Thoughts on "Reproduction" and the Law*, 13 NOVA L. REV. 355, 359 (1989).

In her article *Rape*, Susan Estrich writes:

Eleven years ago, a man held an ice pick to my throat and said: "Push over, shut up, or I'll kill you." I did what he said, but I couldn't stop crying. A hundred years later, I jumped out of my car as he drove away. I ended up in the back seat of a police car. I told the two officers I had been raped by a man who came up to the car door as I was getting out in my own parking lot (and trying to balance the two bags of groceries and kick the car door open). He took the car, too.

Susan Estrich, *Rape*, 95 YALE L. J. 1087, 1087 (1986).

Martha Mahoney brings to life the words of a battered woman:

He beat me up on our wedding night. I wound up with a black eye, a very bad black eye, and a split lip. He was almost arrested that night I ran out of the house in my nightgown and flagged down a passing car and got them to take me to my father-in-law's house. When my father-in-law got back, the neighbors had called the police and the police were there. My father-in-law talked them out of taking him in.

Martha R. Mahoney, *Legal Images of Battered Women: Redefining the Issue of Separation*, 90 MICH. L. REV. 1, 20 (1991).

120. See, e.g., Duncan Kennedy, *Form and Substance in Private Law Adjudication*, 89 HARV. L. REV. 1685, 1777 (1976) ("Nonetheless, I believe that there is value as well as an element of real nobility in the judicial decision to throw out, every time the opportunity arises, consumer contracts designed to perpetuate the exploitation of the poorest class of buyers on credit. Real people are involved, even if there are not very many whose lives the decision can affect."); Alfred S. Konefsky & John H. Schlegel, *Mirror, Mirror on the Wall: Histories of American Law Schools*, 95 HARV. L. REV. 833, 841 (1982) ("In omitting any mention of the outer world impinging on their private island, law school historians are simply replicating what goes on in most law schools—the treating of law as an auto-

hazard for anyone writing about a problem like patient dumping. Indeed, law and economics as an approach to examining legal problems has received more than its fair share of criticism for focusing on allocative efficiency and not distributive justice, and for worrying more about competitive markets than about people.¹²¹ The final section of the article anticipates criticisms along these lines, and makes the case for the centrality of eco-

mous and apolitical ordering. Intellectual movements, large-scale political events, debates on social issues, theoretical musings, and ideology warrant no mention in a law school history for they apparently have no significant influence on the teaching of law at most schools."); Roberto M. Unger, *The Critical Legal Studies Movement*, 96 HARV. L. REV. 561, 655 (1983) ("The most obvious conclusion about ideological controversy to be drawn from the work of the critical legal studies movement . . . is our attack upon the validity of the tacit identification of abstract institutional endeavors, like democracy or the market, with the concrete institutional forms that these endeavors happen to take in the contemporary world. We have taught ourselves not to see the major governmental and economic systems that now compete for world mastery as the exhaustive options among which mankind must choose."); Elizabeth Mensch, *The History of Mainstream Legal Thought, in THE POLITICS OF LAW: A PROGRESSIVE CRITIQUE* 13, 21 (David Kairys ed., 1990) ("[T]he realists urged judges to eschew the rigid, abstract formalism of constitutionally protected property and contract rights Meanwhile, in private law, enlightened, progressive judges should be willing to sacrifice rigid adherence to the logic of doctrine for the sake of doing a more commonsense and overtly policy-oriented 'justice' within the particular context of each case.")

121. See, e.g., Unger, *supra* note 122, at 574-75 ("The chief instrument of the law and economics school is the equivocal use of the market concept. These analysts give free reign to the very mistake that the increasing formalization of microeconomics was largely meant to avoid: the identification of the abstract market idea or the abstract circumstance of maximizing choice with a particular social and institutional complex Such are the sophistries by which the law and economics school pretends to discover both the real basis for the overall evolution of the legal order and the relevant standard by which to criticize occasional departures of that order from its alleged vocation."); Jeremy Miller, *Economic Analysis of Legal Method and Law: The Danger in Valueless and Values*, 21 GONZ. L. REV. 425, 448 (1985) ("The problem with Posner's economic analysis is that it omits the subjective 'content' quality of law. Although, as stated and restated, he admits that benefits can include some other values, nevertheless, putting a dollar and cents cost on something like 'truth,' or 'fairness,' is science gone sour Human ethical-legal values must be present in any just society. They cannot be discarded simply because they might appear at that moment to be impractical (inefficient)."); Morton J. Horwitz, *Law and Economics: Science or Politics?*, 8 HOFSTRA L. REV. 905, 905-06 (1980) ("It was 'science' that gave the cloak of legitimacy to the Posnerian school's ability resolutely to ignore the question of Distribution for so long It was one thing to be agnostic about the initial Distribution of Wealth, as modern economic theorists purported to be. It was still another thing to propose or defend changes in common law rules without taking responsibility for the resulting distributional changes. In law, it was impossible to be indifferent about the distributional consequences of common law rules. It was only a matter of time before this systematic bias of Chicago law-and-economics favoring the status quo became obvious.").

conomic analysis in solving even intensely human problems like illness and inadequate access to health care.

First, a comment about the immense suffering and danger dumped patients experience. The most striking and highly publicized recent example of egregious dumping took place in 1986 at a private hospital in Victoria, Texas. The case is remarkable not only because of the extraordinarily high risk of harm to which the responsible physician exposed the patient and her unborn child, but also because it represents a rare instance in which responsible authorities decided to pursue a claim under COBRA. In December of that year, Mrs. Rosa Rivera arrived at the emergency room of DeTar Hospital in labor. She was examined by nurses who found her to have "dangerously high blood pressure."¹²² She had no prenatal care and was without any form of health insurance. Because she was an "unaligned" patient, the nurses contacted Dr. Burditt who was next on DeTar's list of rotating, on-call obstetricians. As soon as Burditt was told of Rivera's situation, he told the nurses he did not wish to care for her and ordered them to arrange for her transfer to a public hospital 170 miles distant. Dr. Burditt was then told by the nursing supervisor that under federal regulations he would at least have to examine Rivera before she could be transferred. Burditt did examine her and found her blood pressure to be "the highest he had ever seen."¹²³ High blood pressure can create complications during delivery that can kill either the mother or the baby or both. After examining Rivera, Burditt signed a "Physician's Certificate Authorizing Transfer" without listing any reasons and remarked that "until DeTar Hospital pays my malpractice insurance, I will pick and choose those patients that I want to treat."¹²⁴

About two hours later an ambulance finally arrived and Rivera left the hospital accompanied by an obstetrical nurse. Burditt never examined her again, nor did he order any medication or life support equipment for her during the transfer. About 40 miles into the trip Rivera gave birth to a healthy baby. The nurse called Dr. Burditt who ordered them to continue onto the public hospital, but Rivera wished to return to

122. *Burditt v. United States Dep't of Health & Human Serv.*, 934 F.2d 1362, 1366 (5th Cir. 1991).

123. *Id.*

124. *Id.* at 1367.

DeTar, so they did. Dr. Burditt refused to see Rivera when she returned to the hospital because she had disobeyed his order to transfer. Rivera was cared for by another physician and she and her baby left in good health three days later.

The opinion of the U.S. Court of Appeals for the Fifth Circuit describes Burditt's complete indifference to Rivera's (and her child's) well-being and his pro-forma "certification":

The ALJ properly disregarded Burditt's self-serving, after-the-fact justification for transferring Rivera—that DeTar lacked facilities to care for Rivera's underweight infant. The record shows that upon hearing of Rivera's condition over the telephone, Burditt made an immediate and unwavering decision to transfer her without weighing the medical risks and benefits of transfer. Because he signed her transfer certification as a mere formality, it lacks legal effect as a certification.

Every reasonable adult, let alone physician, understands that labor evolves to delivery, that high blood pressure is dangerous, and that the desirability of transferring a patient with these conditions could well change over a two-hour period. Burditt's indifference to Rivera's condition for the two hours after he conducted his single examination demonstrates not that he unreasonably weighed the medical risks and benefits of transfer, but that he never made such a judgment. DAB's [the Departmental Appeals Board within HHS] statement that Burditt certified "under circumstances where no reasonable [obstetrician] would have certified" means only that the facts of this case show certification to be so unacceptable that it is unlikely that Burditt actually made the required certification.¹²⁵

The truth is that *Burditt* is surprising in that no long-term physical harm resulted to either Rivera or her child. (The opinion and the motion papers, briefs, and other litigation materials are silent about Rivera's pain and suffering during the two hours in which she waited to be transferred.)¹²⁶ Many dumping victims are not so lucky.¹²⁷

125. *Id.* at 1371-72.

126. A complete set of briefs, including those of amici curiae, and papers filed during the proceedings before HHS, are on file with the author.

127. The most comprehensive statistical study of dumping that I have been able to find was made of 467 patients who were transferred from various hospitals to Cook County Hospital in Chicago. See Robert L. Schiff et al., *Transfers to a Public Hospital*, 314 *NEW ENG. J. MED.* 552 (1986). The study came to some very interesting conclusions: 89% of those transferred were black or Hispanic; 87% were

Although many dumping cases involve pregnant women,¹²⁸ many do not. Indeed, an increasing amount of dumping cases involve patients who have insurance, albeit inadequate coverage. Recent reports have documented the dumping of cancer patients in mid-treatment whose coverage has run out,¹²⁹ and the dumping of AIDS patients.¹³⁰ In addition, there are those whose inadequate insurance coverage makes access to care virtually impossible. The *New York Times* recently described the plight of a single working mother in New York who

live[s] so close to the financial edge that [she] cannot afford to go to the doctor, even though she has health insurance. Under the rules of her policy, she must have at least \$100 in charges to file a claim, but she cannot afford to pay the money out of pocket and wait to be reimbursed.¹³¹

Even health care workers—who surely know the perils of going without insurance—frequently do not have insurance. A recent study in the *Journal of the American Medical Association* concluded that “[s]ubstantial numbers of health care workers lack health insurance.”¹³² In particular, the low-wage seg-

transferred because of inadequate medical insurance; only 6% of patients gave consent for transfer; 9.4% of transferees died, as opposed to a 3.8% death rate for nontransferred patients. *Id.* at 553-54.

There are several other good sources for additional dumping examples. George J. Annas, *Your Money or Your Life: “Dumping” Uninsured Patients from Hospital Emergency Wards*, 76 AM. J. PUB. HEALTH 74 (1986); Howard S. Berliner, *Patient Dumping—No One Wins and We All Lose*, 78 AM. J. PUB. HEALTH 1279 (1988); Geraldine Dallek & Judith Waxman, *“Patient Dumping”: A Crisis in Emergency Medical Care for the Indigent*, 19 CLEARINGHOUSE REV. 1413 (1986); David U. Himmelstein et al., *Patient Transfers: Medical Practice as Social Triage*, 74 AM. J. PUB. HEALTH 494 (1984); William G. Reed et al., *Special Report: The Effect of a Public Hospital’s Transfer Policy on Patient Care*, 315 NEW ENG. J. MED. 1428 (1986).

128. See, e.g., *Smith v. Richmond Memorial Hosp.*, 416 S.E.2d 689 (Va. 1992) (baby born with cerebral palsy and brain damage after delivery following transfer), *cert. denied*, 113 S. Ct. 442 (1992); *Owens v. Nacogdoches County Hosp. Dist.*, 741 F. Supp. 1269 (E.D. Tex. 1990) (pregnant teen transferred to same public hospital in Texas as Rivera); *Thompson v. St. Anne’s Hosp.*, 716 F. Supp. 8 (N.D. Ill. 1989) (premature infant dies five hours after delivery following transfer).

129. See, e.g., Allan Parachini, *Health View: “Dumping” Patients in Critical Care*, L.A. TIMES, June 16, 1987, § 5, at 1.

130. See Joseph Reiner, Comment, *AIDS Discrimination by Medical Care Providers: Is Washington Law an Adequate Remedy?*, 63 WASH. L. REV. 701, 708 (1988).

131. Celia W. Dugger, *Their Wages Low, Single Mothers Get Little Help*, N.Y. TIMES, Mar. 31, 1992, at A1.

132. David U. Himmelstein, *Who Cares for the Care Givers? Lack of Health*

ments of the health care field, such as nursing home workers, are frequently uninsured. This "lack of coverage parallels the inferior compensation and low status accorded many in the field of long-term care."¹³³

Finally, even the access of those covered by Medicaid is problematic, as low fees discourage many doctors from participating in the program and increase the incentive of private hospitals to send these patients to a public facility in the event of an emergency.¹³⁴ This means that the figures which purport to assess the size of the uninsured pool probably understate its true size.

This short recitation of the stories of a few dumping victims is meant to illustrate the tragic aspects of this issue in a way that statistics and descriptions of regulations simply cannot. This does not mean, however, that market-based proposals have no place in the dumping debate. On the contrary, true concern for dumping victims demands that one look carefully at the underlying economic conditions that make dumping a very rational response on the part of private health care providers. An emotional attack on "market proposals" and the concept of efficiency¹³⁵ as incompatible with "moral feeling"¹³⁶ is nonsense and ought to be recognized for the distraction that it represents to anyone genuinely interested in the needs of the poor, the unemployed, or the seriously ill who cannot afford insurance.

Dumping will not simply disappear on its own and, for reasons I demonstrate below, no amount of (politically feasible) regulation will eliminate it. Indeed, some of the human misery

Insurance Among Health and Insurance Personnel, 266 JAMA 399, 401 (1991).

133. *Id.* There is also evidence that a fear of losing employer-subsidized health coverage is discouraging the movement of employees from one job to another. See *Health Benefits Found to Deter Switches in Jobs*, N.Y. TIMES, Sept. 26, 1991, at A1.

134. See, e.g., *Low Medicaid Fees Seen as Depriving the Poor of Care*, N.Y. TIMES, Apr. 2, 1991, at A1; Don Terry, *As Medicaid Fees Push Doctors Out, Chicago Patients Find Fewer Choices*, N.Y. TIMES, Apr. 12, 1991, at A10.

135. Rand E. Rosenblatt, *Health Care, Markets, and Democratic Values*, 34 VAND. L. REV. 1067, 1067-68 (1981) (arguing that market-based proposals for resolving health care issues are "flawed seriously" and reinforce the "hierarchical aspects" of health care). The phenomenon of dumping, of course, tends to suggest that, at least from the perspective of the providers, medicine is more of an economic transaction than anything else. Unfortunately, there is no effective mechanism for making doctors and hospitals see it any other way.

136. *Id.* at 1100 (quoting approvingly Laurence Tribe, *Policy Science: Analysis or Ideology?*, 2 PHIL. & PUB. AFF. 66, 97 (1972)).

engendered by dumping can be laid directly at the door of those who unwittingly tinkered with the market in order to produce "moral" results. This means that something is going on—economically and politically—which if we continue to ignore we do so at the expense of many lives.

B. Infeasibility of Eliminating Dumping Through Regulation

The failure of COBRA and the persistence of dumping are not hard to explain if one understands COBRA as a symbolic effort of Congress to appear concerned with uninsured patients—and nothing more. For economic and political reasons which I discuss below, Congress has failed to recognize dumping as a rational response on the part of providers under given circumstances. What is needed is not additional regulation, but a recognition that no amount of regulatory effort (accompanied by a low probability of detection) can materially affect behavior that is dictated to providers by the health care market.

1. Economic regulation and likelihood of detection

In his important article,¹³⁷ Professor Stigler describes the ways various economic groups may actively "solicit the coercive powers of the state"¹³⁸—i.e., regulation. I will not restate all the arguments for and against an economic theory of regulation. Put simply, however, Professor Stigler's theory is that in many cases economic regulation is sought by a particular industry because the regulation is, itself, beneficial to those being regulated.¹³⁹ The economic theory of regulation is inconsis-

137. George J. Stigler, *The Theory of Economic Regulation*, 2 BELL J. ECON. & MGMT. SCI. 3 (1971).

138. *Id.* at 4.

139. There is a whole literature which has developed about the economic theory of regulation, and several economists have attempted to test Professor Stigler's theory. See, e.g., FRANK H. STEPHEN, *THE ECONOMICS OF THE LAW* (1988); William A. Niskanen, *A Reply to George Stigler: Evaluating Government Policy*, BUS. ECON., Jan. 1989, at 20; Peter J. Boettke, *Comment on Joseph Farrell, "Information and the Coase Theorem"*, J. ECON. PERSP., Spring 1989, at 195; Frederick H. Harris, *Economic Negligence, Moral Hazard, and the Coase Theorem*, S. ECON. J., Jan. 1990, at 698; Glenn W. Harrison & Michael McKee, *Experimental Evaluation of the Coase Theorem*, 28 J.L. & ECON. 653 (1985); Herbert Hovenkamp, *Rationality in Law and Economics*, 60 GEO. WASH. L. REV. 293 (1992); Daniel Kahneman et al., *Experimental Tests of the Endowment Effect and the Coase Theorem*, J. POL. ECON., Dec. 1990, at 1325; James Lindgren, *"Ol" Man River . . . He Keeps On Rollin' Along: A Reply To Donohue's Diverting the Coasean River*, 78 GEO. L.J. 577 (1990); Frederick M. Rowe, *The Decline of Antitrust and the Delusions of Models: The*

tent, of course, with the far more popular notion that regulation is demanded and secured by reform-minded individuals to protect "consumers" from whatever abuses the regulation is supposed to prevent. (Professor Posner has referred to this view as the "public interest" theory¹⁴⁰ of regulation.)

As the discussion of licensure and staff privileges above suggests, the economic theory of regulation is especially attractive in this case because of persistent state and federal government failures to force physicians and private hospitals to provide unlimited amounts of uncompensated health care. At first glance, COBRA, with its fines and the specter of Medicare participation forfeiture, would seem to represent a classic example of "public interest" regulation. However, as Professor Hall has pointed out, COBRA is "an anemic response"¹⁴¹ to the problem of increasing the supply of health care for the uninsured. As for the penalties, Hall argues that

[i]t is curious to condition Medicare participation on the manner in which hospitals treat patients who are almost exclusively *not* covered by Medicare. It is more peculiar still to enforce such a condition of participation through methods that go beyond termination of participating status. All other instances of Medicare civil penalties relate to fraud and abuse in the provision of *Medicare* services If Congress had a genuine concern about the inability of state law to deter inappropriate patient transfers, it should have struck directly at the problem without using the contrivance of Medicare participation.¹⁴²

And, in fact, the federal government has, as yet, never resorted to stripping a hospital of its Medicare participation status *solely* for a COBRA violation.¹⁴³ As the legislative history of CO-

Faustian Pact of Law and Economics, 72 GEO. L.J. 1511 (1984); Warren J. Samuels, *The Coase Theorem and the Study of Law and Economics*, 114 NAT. RESOURCES J. 1 (1974); Mark Wohar, *Alternative Versions of the Coase Theorem and the Definition of Transaction Costs*, Q.J. BUS. & ECON., Winter 1988, at 3.

140. Richard A. Posner, *Theories of Economic Regulation*, 5 BELL J. ECON. & MGMT. SCI. 335 (1974).

141. Mark A. Hall, *The Unlikely Case in Favor of Patient Dumping*, 28 JURIMETRICS J., 389, 393 (1988).

142. *Id.* at 393-94 (footnote omitted).

143. Telephone Interview with Rachael Weinstein, HCFA (Jan. 12, 1993). Since August 1986, seven hospitals have been stripped of Medicare participation status, but it is important to note that all seven hospitals had other serious violations in addition to COBRA. In fact, according to Ms. Weinstein, it is "fairly easy" for a hospital to correct a COBRA violation in order to avoid losing Medicare participa-

BRA makes clear, Congress understood that dumping was accelerating in direct response to its own increased regulation of reimbursement rates, which was making hospitals' cross-subsidization from covered to uninsured patients increasingly difficult.¹⁴⁴ COBRA is merely an example of a regulatory deal struck by legislators and interest group producers (i.e., organized medicine). COBRA gives the *appearance* of concern for emergency indigent care without requiring any meaningful action by hospitals or physicians.

COBRA does not, then, represent the triumph of advocates for the poor and uninsured over the interests of greedy hospitals and doctors. On the contrary, COBRA provides the appearance of a solution to the dumping problem (and sends the concurrent signal that members of Congress are concerned about the plight of the uninsured), all the while allowing hospitals to continue to dump a "patient on public facilities once it has rendered stabilizing care."¹⁴⁵ COBRA can be viewed as a legislative triumph for the hospital facilities it purports to regulate and treat harshly in the event a patient is dumped. Congress could only have done less by doing nothing at all.

One other issue bears mention in connection with the regulation of dumping: the importance of sending credible signals to the regulated regarding the regulator's willingness to impose serious penalties (as loss of Medicare provider status surely is), and a sufficiently high threat of detection.¹⁴⁶ I have noted already that HHS has, thus far, demonstrated an unwillingness

tion status. *Id.*

144. Dr. Arnold Relman, of the *New England Journal of Medicine*, testified before Congress that the

[d]umping of indigent patients is becoming more common these days and there is a lot of evidence to that effect, because fewer patients have hospital insurance and because most insurers, Medicare and Medicaid included, are no longer willing to pay hospitals for the extra costs of cross-subsidizing the care of those who are uninsured and those who are unable to pay for themselves.

Equal Access to Health Care, *supra* note 37, at 98 (testimony of Dr. Arnold S. Relman, Editor, *New England Journal of Medicine*).

145. Hall, *supra* note 143, at 392.

146. Much has been written about the relationship between deterrence and punishment. A few examples: Steven Klepper & Daniel S. Nagin, *The Deterrent Effect of Perceived Certainty and Severity of Punishment Revisited*, 27 *CRIMINOLOGY* 721 (1989); Toni M. Massaro, *Shame, Culture, and American Criminal Law*, 89 *MICH. L. REV.* 1880 (1991); J. L. Miller & Andy B. Anderson, *Updating the Deterrence Doctrine*, 77 *J. CRIM. LAW AND CRIMINOLOGY* 418 (1986); R. J. Spjut, *Criminal Law, Punishment, and Penalties*, 5 *OXFORD J. LEGAL STUD.* 33 (1985).

to strip offending hospitals of their Medicare provider status.¹⁴⁷ Chronically low staffing and other problems at HHS¹⁴⁸ have meant that the likelihood of detection is also low.

2. *Absence of political consensus*

Market considerations aside, the other major explanation for Congress's failure to focus on meaningful access to health care (as opposed to stabilization only in emergency situations) for the uninsured is, unquestionably, political. There is a lack of political consensus about the nature of a citizen's "right" to health care. All other Western industrialized countries, except South Africa, have affirmed that, like certain political rights, everyone is entitled to a minimum level of health care, usually determined by the state.¹⁴⁹ In the United States this sort of discussion makes some people distinctly uncomfortable, particularly physicians who rightly suspect that this kind of approach could quickly lead to unlimited and uncompensated demands for their professional services. Physician opposition also stems from a feared loss of autonomy. Lawyers get nervous in much the same way when mandated pro bono comes up.¹⁵⁰

147. This, of course, is probably not a bad position for the agency to have taken. The lack of access to health care a great many elderly would face as a result of a hospital's exclusion from the Medicare program might easily outweigh the misery inflicted on a few individuals whom the hospital refused to stabilize before transferring.

148. H.R. REP. NO. 531, *supra* note 92, at 8 ("[T]he failure of Health and Human Services to issue regulations implementing the 1986 anti-dumping amendment has left thousands of patients at increased risk of illegal transfers.").

149. The Constitution of the Republic of Cuba, for example, provides:

Everybody has the right to have his or her health protected and cared for. The state guarantees this right:

—by providing free medical and hospital care by means of the installations of the rural medical service network, polyclinics, hospitals, prophylactic and specialized treatment centers;

—by providing free dental care;

—by promoting the health publicity campaigns, regular medical examinations, general vaccinations and other measures to prevent the outbreak of disease. All the population cooperates in these activities and plans by means of the social and mass organizations.

CUBA CONST. (1976) ch. VI, art. 49, *translated and reprinted in* CASTRO'S CUBA IN THE 1970S, at 167, 174 (Lester A. Sobel ed., 1978).

150. In New York, for example, the State Bar Association proposed increased voluntary pro bono efforts by attorneys to head off a proposal for mandatory pro bono work. The mandatory proposal was recommended by former Chief Judge Sol Wachtler's Committee to Improve the Availability of Legal Services, and called for

At the heart of this matter is ambivalence about whether health care is a commodity like any other, coupled with some reluctance to force physicians to work without compensation. (Dr. Burditt made this argument in the Rivera case and it was not sympathetically received.)¹⁵¹ In general, when physicians have tried, this line of argument has not been successful.¹⁵² Nonetheless, there is considerable disagreement in our society about whether rights-based analysis leads one to the notion of a "decent minimum" of health care. As one commentator has noted:

Even if, for instance, there is wide consensus on the considered judgment that the lower health prospects of inner-city Blacks are not only morally unacceptable but also an injustice, it does not follow that this injustice consists of the infringement of a universal right to a decent minimum of health care. Instead, the injustice might lie in the failure to rectify past injustices or in the failure to achieve public health arrangements that meet a reasonable standard of equal protection.¹⁵³

As for the nature of health care—i.e., whether it is unique and therefore resistant to the kind of analysis (economic or otherwise) one would impose on any other commodity—there is literature about the special role of illness which would seem to suggest that the answer is yes.¹⁵⁴ Arthur Frank, writing

all practicing attorneys to devote at least 20 hours of pro bono work per year. Gary Spencer, *Bar Panel Rejects Mandatory Pro Bono*, N.Y.L.J., Oct. 24, 1989, at 1; see also Ronald H. Silverman, *Conceiving A Lawyer's Legal Duty to the Poor*, 19 HOFSTRA L. REV. 885, 887 (1991) ("The intense debate over the [Wachtler Committee] proposal has all too often suffered from excessive moralizing, from a misguided and unlaywerly taste for obscuring generalizations, and from the relative absence of analytic instruments and useful concepts drawn from disciplines like economics and public finance.").

151. Brief of Appellant Michael L. Burditt at 33, *Burditt v. United States Dep't of Health & Human Serv.*, 934 F.2d 1362 (5th Cir. 1991) (No. 90-4611); Brief of Amicus Curiae, Texas Hospital Ass'n, in support of Petitioner at 12, *Burditt v. United States Dep't of Health & Human Serv.*, 934 F.2d 1362 (5th Cir. 1991) (No. 90-4611); see also *supra* notes 124-27 and accompanying text.

152. See *Whitney v. Heckler*, 780 F.2d 963, 972 (11th Cir. 1986), *cert. denied*, 479 U.S. 813 (1986); *Association of Health Care Facilities v. Minnesota Dep't of Pub. Welfare*, 742 F.2d 442, 446 (8th Cir. 1984), *cert. denied*, 469 U.S. 1215 (1985).

153. Allen Bachanan, *The Right to a Decent Minimum of Health Care*, in 2 PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE & BIOMEDICAL & BEHAVIORAL RESEARCH, SECURING ACCESS TO HEALTH CARE 211 (1983); see also ROBERT P. RHODES, *HEALTH CARE: POLITICS, POLICY, AND DISTRIBUTIVE JUSTICE* (1992).

154. See, e.g., MOLLY HASKELL, *LOVE AND OTHER INFECTIOUS DISEASES* (1990);

about his own experiences with serious illness—a heart attack followed by a diagnosis of testicular cancer—has argued that a Canadian-type public health insurance system (as opposed to our present patchwork of public and private) is optimal.

Of course, private insurance provides treatment without the ill person having to pay for it directly. But private insurance is just that, available to some but not to all. There is nothing private about having cancer; I have never shared so self-consciously in the common risk of being human. Cancer may have been all I had in common with many of those in treatment with me, but cancer defined each of our lives. Because we shared cancer, I wanted no less for them than I wanted for myself. I did not want my treatment to be a privilege based on my occupation or income. If cancer occurs without prejudice, its treatment should be available without prejudice as well.¹⁵⁵

The response to this, of course, is that many illnesses, including certain cancers, do occur "with prejudice." That is, one of the justifications for experience rating is that it enables people who wish to engage in risky behavior—e.g., smoking—to pay the price via higher premiums. In addition, nothing about private insurance prohibits the state from subsidizing those who could not otherwise afford it. The fact that private insurance is not available to everyone is *not* an argument against private insurance, with its attractive tendency to experience rate and to allocate the costs of health care to high users efficiently. Instead, the access problem is an argument in favor of assisting those who are unable to afford private premiums in a way that does not stigmatize them. Stigmatization here refers to the refusal of many physicians to treat Medicaid patients because of the low reimbursement rates.

It is impossible to say with precision how ambivalence about expropriating the labor of health care providers contributes to cosmetic approaches to dumping like COBRA. Congress was aware, though, of the tremendous financial pressures facing hospitals and the fact that collectively they provide \$12.1 billion in uncompensated care every year.¹⁵⁶ It does not re-

ARTHUR KLEINMAN, *THE ILLNESS NARRATIVES* (1988); SUSAN SONTAG, *ILLNESS AS METAPHOR* (1978).

155. FRANK, *supra* note 66, at 117-18.

156. In 1990, hospitals provided uncompensated care totalling \$12.1 billion. See David Burda, *Charity Care: Are Hospitals Giving Their Fair Share?*, MOD. HEALTH

quire a tremendous amount of legislative sophistication to recognize that hospitals cannot provide an unlimited supply of uncompensated care, especially with DRGs forming the basis for Medicare reimbursement and private plans scrutinizing treatments.

V. CONCLUSION

As stories like Mrs. Rivera's make clear, patient dumping is a very serious problem that endangers the lives of many (mostly poor) people on a regular basis. Uninsured women in labor (and their unborn children) and others with health problems that may cause unexpected emergency situations are at the most risk. However, providers have also been known to dump patients whose insurance has run out or is otherwise inadequate. A profile of the uninsured is not exclusively a picture of the unemployed because millions of uninsured individuals work full time or are supported by someone who does. Thus, the accidental nexus between employment and health insurance coverage does not entirely explain the crisis of noncoverage.

In spite of evidence to the contrary, Congress has treated the problem of patient dumping as one readily amenable to regulation via the political process. This is simply not true, especially given the powerful economic incentives to dump and the relatively low probability of detection that providers face. Congress made it much more difficult in the 1980s for hospitals to pass on the cost of indigent patient care to other patients, and the outcome was entirely predictable: hospitals began to provide less uncompensated care and to foist these patients onto public institutions whenever possible. Congress's weak and ineffective response to increased dumping suggests either unimaginable naivete or a desire to appear to be reacting to the crisis, all the while permitting the forces it set in motion to continue to crush the uninsured. The entire scenario reminds one of a parent who, with a wink and a nod, sternly orders a child not to take any cookies from the open jar the parent has placed just under the child's nose.

A straightforward assessment of the market for health insurance and initiatives that will enable as many people as possible to purchase coverage is required. One obvious tactic is

to discourage the fifty states from dictating the terms of private insurance contracts. This should enable insurers to offer products that meet the needs of the working poor, whose demand for exotic fertility treatments or prosthetic devices may be limited. As for those who would still remain in the pool of uninsured, a direct subsidy that would enable the members of the pool to obtain coverage is most attractive.

There is as yet in this country no consensus over the nature of health care *qua* consumer product, which consensus will be necessary before a move toward universal health insurance is possible. In the meantime, which may be a long time, the needs of the uninsured (for both emergency and routine care) cry out for attention. The answer is not to insist that already stressed providers give away an unlimited amount of uncompensated care; rather, the solution lies in focusing on ways in which the numbers of uninsured can be reduced and in subsidizing coverage for those who cannot obtain it at any price.

Appendix:
State Statutes Regulating Patient Transfers

Alaska. ALASKA STAT. § 18.08.086(b) (1991) provides that a physician who in good faith arranges for a transfer is not civilly liable if the physician: (1) reasonably determines that the treatment of the patient is beyond the capability of the transferring hospital; (2) confirms the receiving hospital is more capable of treating the patient; and (3) prior to the transfer, secures an agreement from the receiving hospital to accept and render the necessary treatment.

Arizona. The Arizona Supreme Court has held that licensed hospitals have a duty to accept and render emergency services to all persons who arrive at the facility seeking such care. *Thompson v. Sun City Community Hosp. Inc.*, 688 P.2d 605, 610 (Ariz. 1984).

California. CAL. HEALTH & SAFETY CODE § 1317(a)-(e) (Deering 1990) provides:

(a) Emergency services and care shall be provided to any person requesting the services or care . . . for any condition in which the person is in danger of loss of life, or serious injury or illness . . . when the health facility has appropriate facilities and qualified personnel available to provide the services or care.

(b) In no event shall the provision of emergency services and care be based upon, or affected by, the person's . . . insurance status, economic status, or ability to pay for medical services

(c) Neither the health facility, its employees, nor any physician and surgeon . . . shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, . . . that the facility does not have appropriate facilities or qualified personnel to render those services.

(d) Emergency services and care shall be rendered without first questioning the patient . . . as to his or her ability to pay therefor. However, the patient . . . shall execute an agreement to pay therefor or otherwise supply insurance or credit information promptly after the services are rendered.

(e) If a health facility . . . does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency exists and shall

direct the persons seeking emergency care to a nearby facility which can render the needed services, and shall assist the persons seeking emergency care in obtaining the services including transportation services, in every way reasonable under the circumstances.

A separate provision, CAL. HEALTH & SAFETY CODE § 1317.2 (Deering 1990), regulates patient dumping. It provides:

No person needing emergency services and care may be transferred from a hospital to another hospital for any nonmedical reason (such as the person's inability to pay for any emergency service or care) unless each of the following conditions are met:

(a) The person is examined and evaluated by a physician and surgeon, including, if necessary, consultation, prior to transfer.

(b) The person has been provided with emergency services and care so that it can be determined, within reasonable medical probability, that the transfer or delay caused by the transfer will not create a medical hazard to the person.

(c) A physician and surgeon at the transferring hospital has notified and has obtained the consent to the transfer by a physician and surgeon at the receiving hospital and confirmation by the receiving hospital that the person meets the hospital's admissions criteria relating to appropriate bed, personnel, and equipment necessary to treat the person.

(d) The transferring hospital provides for appropriate personnel and equipment which a reasonable and prudent physician and surgeon in the same or similar locality exercising ordinary care would use to effect the transfer.

(e) All the person's pertinent medical records and copies of all the appropriate diagnostic test results which are reasonably available are transferred with the person.

(f) The records transferred with the person include a "Transfer Summary" signed by the transferring physician and surgeon which contains relevant transfer information[,] . . . [including] the reason for the transfer; and the declaration of the signor that the signor is assured, within reasonable medical probability, that the transfer creates no medical hazard to the patient

Florida. FLA. STAT. ANN. § 395.1041 (West Supp. 1993) provides for the supplying of emergency care to every person in need of such care. Section 395.1041(3) provides that

(a) Every general hospital which has an emergency department shall provide emergency services and care for any emergency medical condition when:

1. Any person requests emergency services and care; or
2. Emergency services and care are requested on behalf of a person by:
 - a. An emergency medical services provider who is rendering care to or transporting the person; or
 - b. Another hospital, when such hospital is seeking a medically necessary transfer, except when otherwise provided in this section.

....

(c) A patient, whether stabilized or not, may be transferred to another hospital which has the requisite service capacity or is not at service capacity, if:

1. The patient, or a person who is legally responsible for the patient and acting on the patient's behalf, after being informed of the hospital's obligation under this section and of the risk of transfer, requests that the transfer be effected; or
2. A physician has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another hospital outweigh the increased risks to the individual's medical condition from effecting the transfer.

....

(f) In no event shall the provision of emergency services and care, the acceptance of a medically necessary transfer, or the return of a patient . . . be based upon, or affected by, the person's . . . insurance status, economic status, or ability to pay for medical services

(g) Neither the hospital nor its employees, nor any physician . . . shall be liable in any action arising out of a refusal to render emergency services or care if the refusal is based on the determination, exercising reasonable care, that the person is not suffering from an emergency medical condition or a determination, exercising reasonable care, that the hospital does not have the service capability or is at service capacity to render those services.

(h) Emergency services and care shall be rendered without first questioning the patient or any other person as to the patient's ability to pay for the emergency services and care.

No hospital to which another hospital is transferring a person in need of emergency services and care may require the transferring hospital or any person or entity to guarantee payment for the person as a condition of receiving the transfer However, the patient or the patient's legally responsible relative or guardian shall execute an agreement to pay for emergency services or care or otherwise supply insurance or credit information promptly after the services and care are rendered.

. . . .

(j) If a hospital subject to the provisions of this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency medical condition exists and shall direct the persons seeking emergency care to a nearby facility which can render the needed services and shall assist the persons seeking emergency care in obtaining the services, including transportation services, in every way reasonable under the circumstances.

(k) Emergency medical services providers may not condition the prehospital transport of any person in need of emergency services and care on the person's ability to pay. Nor may emergency medical services providers condition a transfer on the person's ability to pay when the transfer is made necessary because the patient is in immediate need of treatment for an emergency medical condition for which the hospital lacks service capability or when the hospital is at service capacity.

Georgia. GA. CODE ANN. § 31-8-42 (Michie 1991) provides that any hospital operating an emergency service shall be required to provide treatment to any pregnant woman in active labor who is a resident of the state if such services are usually provided in that facility. It permits transfers where a physician has determined that the facility is unable to provide appropriate treatment and the facility has: (1) provided emergency services as the circumstances require; (2) contacted a receiving hospital; (3) arranged transportation if necessary; and (4) sent to the receiving facility any available information on the patient.

Hawaii. HAW. REV. STAT. § 321-232(b) (1985) provides that "no . . . emergency medical services . . . shall be denied to any person on the basis of the ability of the person to pay therefor or because of the lack of prepaid health care coverage or proof

of such ability or coverage.”

Idaho. IDAHO CODE § 39-1391b (1985) provides that the emergency services of a facility cannot be denied to any person seeking such aid based upon the person's financial ability to pay.

Illinois. ILL. ANN. STAT. ch. 111 1/2, § 86 (Smith-Hurd Supp. 1992) provides that any hospital that offers emergency services must furnish such services to any person seeking the same when the person suffers from a condition “liable to cause death or severe injury or serious illness.”

Kentucky. KY. REV. STAT. ANN. § 216B.400(1) (Michie/Bobbs-Merrill 1991) provides that no person requiring emergency service “shall be denied admission by reason only of his inability to pay for services to be rendered by the hospital.”

Louisiana. LA. REV. STAT. ANN. § 40.2113.4(A) (West 1992) provides that any hospital that fulfills the provisions' requirements and provides emergency services to the public shall make such services available to all persons in its area regardless of the insurance or inability to pay of the person seeking treatment. These requirements also apply to all offices, employees, and members of the medical staff of the hospital. *Id.* § 2113.6(B).

Maryland. MD. HEALTH-GEN. CODE ANN. § 19-308.2 (1990) provides that the Department of Health and Mental Hygiene shall adopt guidelines regulating the transfer of patients. At a minimum, the transferor must: (1) notify the receiving hospital before the transfer and the receiving hospital must confirm that the patient meets its admissions criteria; (2) stabilize the patient before transfer and for its duration; (3) provide appropriate personnel and equipment for the transfer; and (4) transfer “all necessary records for continuing the care for the patient.”

Massachusetts. MASS. GEN. LAWS ANN. ch. 111, § 70E (West 1983 & Supp. 1991) provides a patient bill of rights. The enumerated rights include the right of a patient,

if refused treatment because of economic status or the lack of a source of payment, to prompt and safe transfer to a facility

which agrees to receive and treat such patient. Said facility refusing to treat such patient shall be responsible for: ascertaining that the patient may be safely transferred; contacting a facility willing to treat such patient; arranging the transportation; accompanying the patient with necessary and appropriate professional staff to assist in the safety and comfort of the transfer, assure that the receiving facility assumes the necessary care promptly, and provide pertinent medical information about the patient's condition; and maintaining records of the foregoing.

Id. § 70E(n).

Michigan. MICH. COMP. LAWS ANN. § 333.20921(e) (West Supp. 1991) provides that an ambulance operation shall "provide life support . . . to all emergency patients without prior inquiry into ability to pay or source of payment."

Missouri. MO. ANN. STAT. § 205.989(1) (Vernon 1983) provides that "[n]o person because of inability to pay shall be denied the services of a . . . public facility or not for profit corporation in which a county or participating counties have established services or provided funds"

Nevada. NEV. REV. STAT. § 439B.410(1) (1987) provides that "each hospital in this state has an obligation to provide emergency services and care . . . and to admit a patient where appropriate, regardless of the financial status of the patient." In addition, § 439B.410(2) provides that

it is unlawful for a hospital or a physician working in a hospital emergency room, to:

- (a) Refuse to accept or treat a patient in need of emergency services and care; or
- (b) Except when medically necessary in the judgment of the attending physician:

- (1) Transfer a patient to another hospital or health facility unless, as documented in the patients' records:

- (I) A determination has been made that the patient is medically fit for transfer;
- (II) Consent to the transfer has been given by the receiving physician, hospital or health facility;
- (III) The patient has been provided with an explanation of the need for the transfer; and
- (IV) Consent to the transfer has been given by the patient or his legal representative; or

- (2) Provide a patient with orders for testing at another hospital or health facility when the hospital from which the orders are issued is capable of providing that testing.

However, § 439B.410(4) provides that subsection (2)

does not prohibit the transfer of a patient from one hospital to another:

- (a) When the patient is covered by an insurance policy or other contractual arrangement which provides for payment at the receiving hospital;
- (b) After the county responsible for payment for the care of an indigent patient has exhausted the money which may be appropriated for that purpose . . . ; or
- (c) When the hospital cannot provide the services needed by the patient. No transfer may be made pursuant to this subsection until the patient's condition has been stabilized to a degree that allows the transfer without an additional risk to the patient.

New Hampshire. N.H. REV. STAT. ANN. § 151.21(XVI) (Supp. 1991) provides a patient bill of rights which includes the right that "[t]he patient shall not be denied appropriate care on the basis of . . . source of payment." Section 151.21(V) states that "[t]he patient shall be transferred or discharged after appropriate discharge planning only for medical reasons, for his welfare or that of other patients . . . or for nonpayment for the patient's stay, except as prohibited by the title XVIII or XIX of the Social Security Act."

New York. N.Y. PUB. HEALTH LAW § 2805-b(1) (McKinney 1985 & Supp. 1992) provides that

[e]very general hospital shall admit any person who is in need of immediate hospitalization with all convenient speed and shall not before admission question the patient . . . concerning insurance, credit or payment of charges, provided, however, that the patient . . . shall agree to supply such information promptly after the patient's admission No general hospital shall transfer any patient to another hospital or health care facility on the grounds that the patient is unable to pay or guarantee payment for services rendered. Every general hospital which maintains facilities for providing out-patient emergency medical care must provide such care to any person who, in the opinion of a physician, requires such care.

Section 2805-b(2) provides that, in cities populated by a million or more, "a general hospital shall provide emergency medical care and treatment to all persons in need of such care and treatment who arrive at the entrance to such hospital therefor." Section 2805-b(2)(b) provides that

[a]fter examination, diagnosis and treatment by an attending physician and where, in the opinion of such physician, the patient has been stabilized sufficiently to permit it, subsequent medical care may be provided or procured by the general hospital at a location other than the general hospital if, in the opinion of the attending physician, it is in the best interest of the patient because the general hospital does not have the proper equipment or personnel at hand to deal with the particular medical emergency or because all appropriate beds are filled and none are likely to become available within a reasonable time after the patient has been stabilized.

Section 2805-b(2)(c) provides that if a transfer of an appropriately stabilized patient is initiated, "the attending physician authorizing the transfer . . . shall determine that a receiving hospital is available and willing to receive such patient and that an attending physician thereat is available and willing to admit such patient." A completed form must be sent with the transferred patient containing specific information. Section 2805-b(4) provides that "no person actually in need of emergency treatment, as determined by the attending physician, shall be denied such treatment by a general hospital in cities with a population of one million or more for any reason whatsoever."

Oregon. OR. REV. STAT. § 441.094(1) (1991) provides that "[n]o officer or employee of a hospital . . . may deny to a person diagnosed by an admitting physician as being in need of emergency medical services . . . customarily provided at the hospital because the person is unable to establish the ability to pay for the services." However, § 441.094(3) provides that "[a] hospital that does not have physician services available at the time of the emergency shall not be in violation . . . if, after a reasonable good faith effort, a physician is unable to provide or delegate the provision of emergency medical services."

Pennsylvania. PA. STAT. ANN. tit. 35, § 449.8(a) (Supp. 1992) creates an Indigent Care Program on the policy that

every person . . . should receive timely and appropriate health care services from any provider . . . ; that . . . each provider should offer and provide medically necessary, lifesaving and emergency health care services to every person in [Pennsylvania], regardless of financial status or ability to pay; and that health care facilities may transfer patients only in instances where the facility lacks the staff or facilities to properly render definitive treatment.

Rhode Island. R.I. GEN. LAWS § 23-17-26(a) (1989) provides that

[e]very health care facility that has an emergency medical care unit shall provide to every person prompt life saving medical treatment in an emergency, and a sexual assault examination for victims of sexual assault without discrimination on account of economic status or source of payment, and without delaying treatment for the purpose of a prior discussion of the source of payment unless the delay can be imposed without material risk to the health of the person.

South Carolina. S.C. CODE ANN. § 44-7-260(E) (Law. Co-op. Supp. 1992) provides that “[n]o person, regardless of his ability to pay . . . may be denied emergency care if a member of the admitting hospital’s medical staff or, in the case of a transfer, a member of the accepting hospital’s medical staff determines that the person is in need of emergency care.”

South Dakota. S.D. CODIFIED LAWS ANN. § 36-4B-25 (1992) provides that

[n]o physician, who in good faith arranges for, requests, recommends or initiates the transfer of a patient to a critical medical care facility in another hospital, may be liable for civil damages as a result of such transfer where sound medical judgment indicates that the patient’s medical condition is beyond the care capability of the transferring hospital, or the medical community in which that hospital is located, and where the physician has confirmed that the transferee facility possesses a more appropriate level of capability for treating the patient’s medical needs, and where the physician has secured a prior agreement from the transferee facility to accept and give necessary treatment to the patient.

Tennessee. TENN. CODE ANN. § 68-140-301 (1992) provides that “every hospital” which provides emergency services “shall

furnish such hospital emergency services to any applicant who applies for the same in case of injury or acute medical condition where the same is liable to cause death or severe injury or illness." Section 68-140-511(12) prohibits "[d]iscriminating in rendering emergency care because of . . . ability to pay." In addition, section 68-11-701 states that "inpatients should not . . . be involuntarily transferred for purely economic reasons but should receive the needed medical care as required by [this act]."

Texas. TEX. HEALTH & SAFETY CODE ANN. § 241.027(a) (West 1992) provides that the state's health board shall promulgate rules that provide minimum standards governing the transfer of patients between hospitals. Under § 241.027(b),

[t]he rules must provide that patient transfers . . . be accomplished through hospital policies that result . . . in a medically appropriate transfer . . . by providing:

- (1) for notification to the receiving hospital before the patient is transferred and confirmation by the receiving hospital that the patient meets the receiving hospital's admissions criteria relating to appropriate bed, physician, and other services necessary to treat the patient;
- (2) for the use of medically appropriate life support measures that a reasonable and prudent physician exercising ordinary care in the same or similar locality would use to stabilize the patient before the transfer and to sustain the patient during transfer;
- (3) for the provision of appropriate personnel and equipment that a reasonable and prudent physician exercising ordinary care in the same or a similar locality would use for the transfer;
- (4) for the transfer of all necessary records for continuing the care for the patient; and
- (5) that the transfer of a patient not be predicated on . . . economic status.

Utah. UTAH CODE ANN. § 26-8-8(1) (1989) provides that "[e]mergency medical services shall be provided to all patients in need of such services to sustain life or prevent loss of life without . . . prior inquiry as to ability to pay."

Vermont. VT. STAT. ANN. tit. 18, § 1852(a)(8) (Supp. 1992) provides a patient's bill of rights that includes

the right to expect that within its capacity a hospital shall

respond reasonably to the request of a patient for services When medically permissible a patient may be transferred to another facility only after receiving complete information and explanation concerning the needs for and alternatives to such a transfer. The institution to which the patient is to be transferred must first have accepted the patient for transfer.

Wisconsin. WIS. STAT. ANN. § 146.301(2) (West 1989 & Supp. 1991) provides that “[n]o hospital providing emergency services may refuse treatment to any sick or injured person.” In addition, § 146.301(3) provides that “[n]o hospital providing emergency services may delay emergency treatment to a sick or injured person until credit checks, financial information forms or promissory notes have been initiated, completed or signed if . . . the delay is likely to cause increased medical complications, permanent disability or death.” However, § 146.301(3) provides that “[n]o hospital may be expected to provide emergency services beyond its capabilities as identified by the [department of health and social services].”

Wyoming. WYO. STAT. § 35-2-115(a) (1988) provides that [e]mergency service and care shall be provided . . . to any person requesting such services or care, or for whom such services or care is requested, for any condition in which the person is in danger of loss of life, or serious injury or illness, at any hospital . . . that maintains and operates emergency services to the public when such hospital has appropriate facilities and qualified personnel available to provide such services or care.

However, § 35-2-115(b) provides that liability shall not attach

in any action arising out of a refusal to render emergency services or care . . . if ordinary medical care and skill is exercised in determining the condition of the person, and a decision is made that such refusal shall not result in any permanent illness or injury to such person or a decision is made that sufficient qualified personnel are not available to treat said person, or a decision is made that facilities or equipment are not available to treat said person or in determining the appropriateness of the facilities, the qualifications and availability of personnel to render such services.