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COMMUNITY-BASED HEALTH CARE: A LEGAL AND POLICY ANALYSIS

Lewis D. Solomon and Tricia Asaro***

Introduction

As we approach the next millennium, the United States' health care system is in turmoil. A major federal effort to reform our health care system failed; only modest federal incremental reforms were enacted in 1996.

While Washington has been unable to lead the way in significant health care reform, the health care system has begun to transform itself in terms of curbing skyrocketing health care costs, dealing with the more than forty million Americans who lack health care coverage, and the problems plaguing the Medicare and Medicaid systems. Clearly, hospitals, physicians, health plans, and purchasers of health care have begun to search for a health care model that ensures quality care to a wide population in a cost-efficient manner.

This article explores how the U.S. health care system currently functions, examines several innovative models, and suggests ways in which a decentralized, community-based approach to health care reform can address our nation's health care crisis. Specifically, Part I examines the current system of health care financing. Part II discusses current efforts to provide community based care. Part III offers suggestions for a community-based approach to health care reform, including ways to stimulate provider volunteerism, financing mechanisms, and methods to overcome potential legal barriers to local reform efforts.

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I. Current Structure for Financing Health Care

Introduction

Health insurance in the United States is obtained through a combination of private initiatives and public programs. Medicare provides health insurance for approximately 32 million people aged sixty-five or older.[1] Medicaid provides health insurance for approximately 32.1 million poor U.S. residents.[2] There are several other government insurance programs that provide health care coverage to millions of Americans (e.g., Defense Department insurance for active-duty military personnel, Veterans Administration health insurance for veterans and military retirees, Indian Health Service for Native Americans living on Indian Reservations, and Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) for military dependents).[3] Most of the remaining U.S. population purchases health insurance on the private market. An estimated 40 million U.S. citizens and legal residents, however, do not have health insurance.[4]

Beginning in the 1980s, the number of Americans lacking adequate health insurance increased steadily as health care costs rose several times faster than inflation. In 1993, the United States spent 13.9% of its Gross Domestic Product (GDP) on health care.[5] Without major reforms of the health care system, health care is expected to consume 14.1% of GDP in 1995, and 18.0% by 2005.[6] This rapid increase in health care costs is a major factor in the growth of the number of uninsured, and if costs continue to escalate unchecked, the number of Americans without insurance will continue to grow.

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1. BOARD OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND, 1995 ANNUAL REPORT 1.

2. THE KAISER COMMISSION ON THE FUTURE OF MEDICAID, MEDICAID FACTS 1 (1995).

3. Interview with Steven A. Kroll, Director of Federal Relations Healthcare Association of New York State, in Washington, D.C. (July 1, 1995).

4. *The Employer Group Purchasing Reform Act, 1995: Hearings on S. 1062 Before the Senate Committee on Labor and Human Resources*, 104th Cong., 1st Sess. (1995) (prepared testimony of Mark V. Nadel, Assoc. Director, National and Public Health Issues, Health, Education, and Human Services Division, General Accounting Office).

5. Richard Price and Richard Rimkunas, Health Care Fact Sheet: 1993 National Health Spending 1 (Congressional Research Service Report for Congress No. 94-952, Dec. 1,1994).

6. CONGRESSIONAL BUDGET OFFICE, THE ECONOMIC AND BUDGET OUTLOOK: AN UPDATE 83 (1995).

Private Insurance

Before the 1930s, few health insurance plans existed. Most Americans paid for their medical expenses out-of-pocket, either with cash or bartered goods. Hospitals, which were originally similar to poorhouses, filled in the gaps by providing care to those who could not afford to pay for medical services.[7] During the Great Depression, Americans were increasingly unable to afford to pay for medical services out-of-pocket. At the same time, hospitals, which had relied on charitable funding to operate, faced insolvency as revenues dissipated.[8] In response, several hospitals developed health plans designed to provide a more predictable flow of revenue. Under these plans, patients who made a periodic pre-determined payment to the hospital received hospital services. Eventually, groups of hospitals banded together to form multiple hospital plans.[9]

Blue Cross

Building upon the experiences of multiple hospital plans, Blue Cross established its first plan in Dallas, Texas in 1929.[10] The plan negotiated payment rates with participating hospitals that agreed to provide selected services to subscribers. Blue Cross spread health care costs among subscribers by charging a single, community-wide premium based on expected costs for all policyholders ("community rating").[11] Low-cost individuals or groups (e.g., young, healthy individuals) helped to pay for participants requiring more extensive hospitalization services.

Blue Cross plans assumed responsibility for serving the entire community and for providing insurance to low-income and moderate-income persons. Under Blue Cross's open enrollment policy, any individual or group could purchase insurance regardless of their health status. In exchange for providing coverage to all segments of the population, Blue Cross plans were tax exempt and were relieved from meeting certain requirements established by state insurance commissions.[12]

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7. SYLVIA A. LAW ET AL., AMERICAN HEALTH LAW 10 (1995).
8. *Id.* at 12-13, 17.
9. CONGRESSIONAL RESEARCH SERVICE, HEALTH INSURANCE AND THE UNINSURED: BACKGROUND DATA AND ANALYSIS 15 (1988).
10. BLUE CROSS BLUE SHIELD ASSOCIATION, FACT BOOK: ALL ABOUT THE BLUE CROSS AND BLUE SHIELD ORGANIZATION 2 (1996).
11. LAW ET AL., *supra* note 7, at 20.
12. CONGRESSIONAL RESEARCH SERVICE, *supra* note 9, at 15-16.

Commercial Insurers

While Blue Cross plans expanded their coverage throughout the United States, commercial insurers began to offer health insurance. Commercial insurers first offered employers and other groups "indemnity coverage" against hospital expenses.[13] Under this type of coverage, the insurer paid the enrollee directly for hospital services used. The enrollee, in turn, paid the provider and assumed responsibility for any provider charges that exceeded the insurer's payment.

By the late 1930s, many commercial insurers expanded their policies to cover surgery and other physician services delivered in the hospital setting. This type of coverage was commonly called "comprehensive insurance." Enrollees usually bore responsibility for a portion of the costs of these services under a cost-sharing arrangement.[14] As health care delivery became more sophisticated, some insurers also offered "major medical" plans that covered other medical expenses such as prescription drugs, rehabilitation care, and physician office visits.[15]

Commercial insurers differed from Blue Cross in significant ways. Unlike Blue Cross, commercial insurers employed experience rating under which the premium rate for each employer group was based on historic costs for that specific group.[16] Commercial insurers also adopted underwriting practices comparable to those traditionally used in other lines of the insurance business. Applicants perceived to be high risk might be charged higher premiums, or be denied coverage for problems already diagnosed at the time the health policy took effect under an exclusion of pre-existing conditions. Applicants with costly chronic conditions generally would be denied coverage altogether or charged extremely high premiums.[17]

Blue Shield

As noted earlier, commercial insurers offered coverage not only for hospital services but also for surgery, physician office visits, and other health care services. To compete with these comprehensive health insurance plans, Blue Shield was established. A counterpart to Blue Cross, Blue Shield provided insurance coverage for physi-

13. *Id.* at 16.
14. *Id.*
15. *Id.*
16. MARK A. HALL, REFORMING PRIVATE HEALTH INSURANCE 15 (1994).
17. *Id.* at 16.

cian services. Blue Shield reimbursed physicians for the full cost of services, based on a negotiated schedule. Like Blue Cross, Blue Shield employed community rating.[18]

Group-Practice Associations

In addition to the Blue Cross/Blue Shield plans and commercial insurers, group-practice associations, the forerunners of today's managed-care plans, evolved.[19] A group-practice association consisted of several physicians who joined forces and contracted to furnish care to an enrolled population for a pre-arranged fee. Group-practice associations were often established to serve specific employers, especially large industrial corporations that built and administered communities for their employees and their families.

Health Insurance's Evolving Role

By the Second World War, Blue Cross/Blue Shield plans dominated the health insurance market.[20] However, the industry was still in its infancy and insurance covered only a small percentage of the population. New economic policies implemented during the war, however, facilitated the growth of employer-based health insurance programs. Wartime price stabilization resulted in capped wages. Barred from offering workers higher wages, employers competed for the best employees by offering packages of noncash benefits. Health insurance served as an attractive benefit because employer's contributions were not subject to federal income taxes.[21]

After World War II, when the pool of available workers increased with the downsizing of the U.S. military, health care benefits remained a valuable negotiating tool in the labor force. This was bolstered by the growth of the labor union movement.[22] Commercial insurers fared quite well during the post-war period. First, commercial insurers began to employ more sophisticated marketing techniques. Second, they generally offered health insurance plans at more competitive prices than the Blues. Premiums for commercial insurance plans were cheaper than Blue Cross/Blue Shield plans because commercial insurers used experience rating. Instead of computing one premium on the basis of the entire com-

18. *Id.* at 14.
19. CONGRESSIONAL RESEARCH SERVICE, *supra* note 9, at 16.
20. LAW ET AL., *supra* note 7, at 8-11
21. HALL, *supra* note 16, at 14.
22. LAW ET AL., *supra* note 7, at 11-12.

munity, commercial insurers offered low premiums to employers with relatively healthy, low risk groups of employees.[23] This practice is known as "cherry picking."

Over the years, competition and cost increases have transformed both commercial insurers and the Blues, with the for-profit commercial insurers adapting more quickly, and the not-for-profit Blues plans often lagging behind. During the transition, many different health insurance models have developed and superseded the previously dominant fee-for-service type of health insurance plans. Most prevalent has been the development of new models designed to deal with rising costs.

Current Health Insurance Models

Today there are three basic health insurance models: (1) fee-for-service (FFS); (2) preferred provider organizations (PPO); and (3)health maintenance organizations (HMO). In addition, the evolving insurance market has created many off-shoots and hybrids of each model.[24]

FFS or traditional indemnity plans are increasingly rare. In a traditional indemnity plan, a provider receives a fee for each service delivered. Under this model, providers do not share the financial risk for the cost of medical treatment and health care plans have little control over provider behavior. Therefore, providers do not have the financial incentives to deliver services in the most efficient and cost-effective manner.

To restrain providers and control costs, most indemnity insurers have adopted some management of care techniques to oversee enrollees' use of services.[25] The large majority of indemnity plans now have utilization review programs and patient management programs through which they limit or control access to certain services or providers.[26] In addition, some FFS plans have estab-

23. HALL, *supra* note 16, at 14.

24. It is important to note the difference between health plans that use management of care techniques and managed care organizations. In the former, the insurance mechanism is completely separate from the provision of care, while in the latter there is often a blurring of the line between the insurer and the provider. Managed care organizations include PPOs and HMOs.

25. Memorandum from Sandra Christensen to the Health Staff of the Congressional Budget Office regarding Managed Care and the Medicare Program 2-3 (Apr. 26, 1995) (on file with author).

26. These programs include: prior authorization for certain services (especially for non-emergency hospital admissions); use of gatekeepers (i.e., a primary care physician who assumes responsibility for, reviews, and approves all medical care the patient receives, including care from specialists); concurrent review of hospital use to ensure

lished networks of preferred providers. Often these providers accept some of the plan's medical oversight and cost containment measures, and patients who use these preferred providers enjoy reduced cost-sharing requirements.[27]

A PPO represents a risk-bearing managed care plan that integrates the health care financing function with the health care delivery system. In exchange for a premium payment, the plan agrees to provide enrollees with any covered medical service they may require during the period, but enrollees must choose from a limited list of providers over whom the PPO has considerable oversight. The insurer remains at risk for the costs of its enrollees' care. However, the PPO shares this risk with the providers who treat the enrollees.[28] The providers typically agree to accept some financial risk for the patient in the form of reduced or negotiated prices. Providers usually participate in many different PPOs simultaneously and remain independent businesses (i.e., independent medical practices or hospitals).

An HMO is a risk-bearing managed care plan which further integrates health care financing and health care delivery. HMOs often pay providers on a capitated, or other fixed payment basis, for the patients they treat.[29] Providers are not paid for each office visit. Instead they are paid for all the treatment an individual requires (whether used or not) during a defined time period. The providers then bear a substantial financial risk since the link between services provided and payment is severed. Providers who share this level of risk have a financial stake in controlling utilization, avoiding unnecessary services, keeping hospital stays short, and keeping patients healthy by providing preventive care services.[30]

There are several types of HMOs, from the least integrated and controlled model (an "independent practice association") to the most integrated and controlled model (a "staff model"). An in-

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the patient's discharge to a less-intensive setting as soon as medically and financially appropriate; mandatory second opinions; case management for catastrophic illnesses and injuries; use of medical practice parameters or critical pathways to assist physicians in determining the appropriate course of action; and use of physician practice profiles to identify those with the most appropriate and inappropriate treatment patterns. *Id.*

27. *Id.*

28. PETER R. KONGSTVEDT, ESSENTIALS OF MANAGED HEALTH CARE 26 (1995).

29. James R. Knickman and Kenneth E. Thorpe, *Financing for Health Care, in* JONAS'S HEALTH CARE DELIVERY IN THE UNITED STATES 267, 279 (Anthony R. Kovner ed., 5th ed. 1995).

30. *See* PETER R. KONGSTVEDT, THE MANAGED HEALTH CARE HANDBOOK (2d ed. 1993).

dependent practice association (IPA) contracts with a number of separate physician practices and hospitals to provide care for the HMO's patients. Each HMO enrollee must choose, or is assigned, a physician. The physicians remain in their independent practices and may treat other patients along with the IPA's enrollees. As part of their contract with the plan, the physicians are subject to the plan's oversight when treating IPA patients.[31] The group model HMO contracts with a group of physicians and other health care providers who serve only the HMO's enrollees. The HMO has complete oversight over these physicians' entire practice.[32] Finally, the staff model HMO fully integrates physicians and health care providers into the health care plan as salaried employees who practice medicine according to plan standards and protocols.[33] Staff model HMOs often provide health care facilities and it is not uncommon for staff model HMOs to have an exclusive arrangement or ownership interest in hospitals and other residential care facilities.

HMOs may be for-profit or not-for-profit. Although many of the original giants that still dominate the market are not-for-profit (e.g., Kaiser Permanente), for-profit HMOs currently represent the fastest growing segment in managed care.[34]

HMOs, PPOs and other managed care organizations employ a variety of techniques to control costs and to manage patient care. Most require extensive utilization review programs and patient management programs.[35] They often offer services in one location to reduce overhead costs. Integrated, electronic patient records are standard. Practitioner behavior is closely monitored and controlled. For example, in-plan providers may be required to attend continuing education programs and to comply with education and treatment protocols. Cash bonuses reward appropriate provider behavior, and fee reductions punish inappropriate behavior. While IPAs generally allow patients to self-refer to in-plan specialists, most group and staff HMOs restrict access to specialists by requiring a referral from a patient's primary care physician who serves as a gatekeeper.

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31. KONGSTVEDT, *supra* note 28, at 32.

32. *Id.* at 31.

33. *Id.* at 30.

34. Erik Eckholm, *While Congress Remains Silent, Health Care Transforms Itself*, N.Y. TIMES, Dec. 18, 1994, at A1, A34.

35. Christensen, *supra* note 25, at 2.

In recent years, some managed care plans have begun to offer an open-ended or point of service (POS) option to its enrollees. This alternative allows members to use out-of-plan providers for any patient encounter but subjects them to a substantial cost sharing. Because it does not completely restrict patient choice, POS is an attractive option and currently represents the fastest growing managed care option.[36]

As previously noted, health insurance choices range from the totally unrestricted FFS to the highly controlled staff model HMO. This range of choices corresponds to a range of costs for health care services. Generally speaking, the ability of an insurance plan to control costs is directly proportional to its ability to control provider and patient behavior. For equal benefit coverage, an FFS plan generally costs more than an HMO. An HMO has the ability to strictly control the use of resources, something not possible in the FFS environment. POS options generally increase costs because patients can go out of network to receive treatment.[37]

Many larger employers have forgone the various types of health plans now available and have chosen to self-insure.[38] These employers cover the costs of their employees' health care directly. Often, self-insured firms contract with an insurer to serve as a third-party administrator managing the program for a fee and paying claims from employer funds.

Federal Health Insurance Programs

As part of the Social Security Amendments of 1965, Congress established the Medicare and Medicaid programs. Medicare is a health insurance program for the elderly and the disabled. Medicaid is a medical assistance program for needy individuals. Together these programs help pay for health care for more than 65 million Americans.[39]

Medicare

Medicare is the federal entitlement program, created by Title XVIII—Health Insurance for the Aged and Disabled, a 1965 amendment to the Social Security Act,[40] providing health insur-

36. KONGSTVEDT, *supra* note 28, at 28.

37. *See* CONGRESSIONAL BUDGET OFFICE, MEMORANDUM: THE EFFECTS OF MANAGED CARE AND MANAGED COMPETITION 7 (1995).

38. HALL, *supra* note 16, at 25.

39. *See supra* notes 1-2 and accompanying text.

40. 42 U.S.C. §§ 1395-1395ddd (1994).

ance benefits to persons over the age of 65 and to others eligible for Social Security benefits. The program consists of two sub-programs, known as Part A and Part B.

Medicare Part A, the Hospital Insurance Program, automatically enrolls all persons at age sixty-five if they are entitled to benefits under the Old Age, Survivors, Disability and Health Insurance Program or the Federal Railroad Retirement Program.[41] In addition, Part A covers persons under 65 who have been eligible for disability for more than two years[42] and insured workers (and their dependents) requiring renal dialysis or kidney transplants.[43]

Medicare Part A provides coverage for in-patient hospital services, up to 100 days of post hospital skilled nursing facility (SNF) care, hospice care, and home health services.[44] Beneficiaries must pay certain cost-sharing charges. In 1996, the deductible for in-patient hospital care was $736 per benefit period.[45] A benefit period is defined as the period beginning when a patient enters a hospital and ending when she has not been in a hospital or SNF for sixty days.[46] Patients requiring SNF care are subject to daily coinsurance charges for the twenty-first through one hundredth day.[47] In 1996, that charge was $92.00.[48] Although there are limited charges for hospice care, no charges are imposed for "services furnished to such individual which constitute hospice care, regardless of the setting in which such services are furnished."[49]

The Hospital Insurance Trust Fund finances Medicare Part A.[50] All working Americans and their employers pay a payroll tax that is deducted directly from paychecks and deposited into this trust fund. Employers and employees each contribute 1.45% of annual taxable earnings; self-employed workers contribute 2.90% of their taxable earnings.[51]

Medicare Part B, the Supplementary Medical Insurance Program,[52] represents the voluntary portion of Medicare that provides

41. 42 U.S.C. § 1395c (1994).
42. *Id.*
43. 42 U.S.C. § 1395rr (1994).
44. 42 U.S.C. § 1395d(a) (1994).
45. 60 Fed. Reg. 53,625 (1995).
46. 42 U.S.C. § 1395x(a) (1994).
47. 42 U.S.C. § 1395e(a)(3) (1994).
48. 60 Fed. Reg. 53,625 (1995).
49. 42 U.S.C. § 1395(e) (1994).
50. 42 U.S.C. § 1395i(h) (1994).
51. BOARD OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND, *supra* note 1, at 1.
52. 42 U.S.C. §§ 1395j-1395w-4 (1994).

coverage for physician services, laboratory services, durable medical equipment, outpatient hospital services, and other medical services.[53] All persons entitled to Part A, the Hospital Insurance Program, are eligible for Part B. Upon enrollment, Part B beneficiaries receive supplementary medical insurance in exchange for monthly premiums.[54] General government revenues and premiums paid by beneficiaries finance Medicare Part B. In 1996, both aged and disabled beneficiaries pay a monthly premium of $42.50.[55] Medicaid pays the Part B premium for many low-income elderly. General tax revenues pay the remaining program costs.

Medicare's costs now top $150 billion per year. They are increasing at an approximate rate of 10.5% annually.[56] Within seven years, experts predict that Medicare will exhaust its trust fund for Part A payments.[57] As the number of elderly drawing benefits increases, and the average lifetime benefit per beneficiary rises, and the number of workers supporting the trust fund decreases, the trust fund's future seems increasingly threatened. According to the Congressional Budget Office (CBO), Medicare must realize savings of $165 billion over the next seven years to remain solvent.[58]

The impending crisis has sparked intense debate about how to provide quality care to the elderly at lower costs. Policy makers face the following options: (1) cutting payments to providers; (2) raising costs to beneficiaries; (3) enrolling beneficiaries into managed care plans, or (4) raising the Medicare tax or other taxes.[59] Cutting payments to providers, although politically viable, could jeopardize some essential and already vulnerable providers.[60] For

53. 42 U.S.C. § 1395k (1994).

54. 42 U.S.C. § 1395r (1994).

55. 60 Fed. Reg. 53,625 (1995).

56. George Anders and Laurie McGinley, *Managed Eldercare: HMOs Are Signing Up New Class of Member: The Group in Medicare*, WALL ST. J., Apr. 27, 1995, at A1.

57. BOARD OF TRUSTEES OF THE FEDERAL HOSPITAL INSURANCE TRUST FUND, *supra* note 1, at 3.

58. Milt Freudenheim, *Medicare, Jot This Down: Employers Offer Valuable Lessons On Saving Money With Managed Care*, N.Y. TIMES, May 31, 1995, at D1.

59. In addition, efforts to stamp out fraud and abuse and to increase program efficiencies will bolster the trust fund. The Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (HHS) has several offices charged with detecting fraud and abuse, developing innovative models for delivery of care to beneficiaries, evaluating medical technology, and developing medical practice guidelines. Medicare's administrative budget is approximately 2% of program costs, much less than the overhead of commercial insurers which often exceed 10%. Interview with Steven A. Kroll, Director of Federal Relations Healthcare Association of New York State, in Washington, D.C. (July 1, 1995).

60. *Id.*

example, many hospitals in inner-city and rural areas currently operate at a loss. Excessively burdensome cuts could force these providers to close.[61] Raising costs to beneficiaries is politically unpopular, as is increasing Medicare or other taxes.

Managed care is increasingly viewed as an important component of any effort to restore the Medicare Trust Fund and rein in the cost of this federal program.[62] Many lawmakers and some health policy experts view HMOs and other managed care plans as the most effective way to reduce the rate at which health care costs for those over 65 increases. Noting that the private sector has slowed health care costs in part by adopting managed care techniques, advocates argue that billions of dollars could be saved each year if senior citizens were encouraged to enroll in managed care programs.[63] However, the amount saved by managed care plans directly relates to the level of control exerted over the insured.[64] In the current political environment, it may be difficult for the federal government to limit the health care choices of the elderly. Moreover, managed care organizations owe much of their success to their efforts in keeping people healthy. But elderly persons are more likely to get sick and need medical care regardless of preventive efforts. Thus, it is unclear whether Medicare could achieve extensive savings by expanding managed care programs. In fact, studies by the Congressional Budget Office and General Accounting Office indicate that the cost savings from Medicare managed care could be illusory.[65]

Currently, Medicare enrolls approximately 9% of its beneficiaries in managed care plans.[66] Of these, 7% are in Medicare risk contracts that accept a fixed payment to treat beneficiaries and 2% are enrolled in HMOs that have opted to participate in Medicare but receive payment on a cost-of-treatment basis.[67]

The remaining 91% of Medicare enrollees are in Medicare's fee-for-service sector, which utilizes limited management-of-care tech-

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61. *Id.*

62. *Id.* For instance, the Balanced Budget Act of 1995, passed by Congress and vetoed by the President, would have expanded Medicare managed care significantly.

63. Melinda Beck et al., *The New Fine Print: What Will Congress Do About Your Medicare? A Primer on What's Coming—and Whether It Will Work*, NEWSWEEK, Sept. 18, 1995, at 43.

64. *See supra* note 37 and accompanying text.

65. Christensen, *supra* note 25. *See also* GOVERNMENT ACCOUNTING OFFICE, MANAGED HEALTH CARE: EFFECTS ON EMPLOYERS: COSTS DIFFICULT TO MEASURE (1993).

66. Christensen, *supra* note 25, at 4.

67. *Id.*

niques.[68] Medicare currently influences treatment of these fee-for-service beneficiaries in two ways. First, Medicare's Peer Review Organizations (PROs) monitor the necessity of hospital admissions and the appropriateness of care provided in hospitals.[69] Second, through its prospective payment system for hospitals and relative value scale payment system for physicians, Medicare gives providers strong financial incentives to manage effectively the resources used to treat each beneficiary.[70] Medicare currently pays substantially discounted prices for both hospital and physician services. The program pays approximately 90% of costs and less than the average amount paid by private insurers for a given set of hospital services.[71]

All Medicare-certified hospitals and physicians who accept Medicare assignments are bound by Medicare's payment rates.[72] These providers may collect nothing from patients beyond the program's cost sharing limits. For physicians who are nonparticipating and will not accept assignment, the amount they can charge patients is limited to no more than 115% of Medicare's payment rates.[73]

The future of the Medicare program is currently at the center of national policy debate. Given current revenue and spending projections, the Medicare Part A Trust will run out of money early in the twenty-first century.[74] Both Congress and the President have proposed reducing the rate of growth of Medicare expenditures as part of their seven-year plans to balance the federal budget. In 1995, the 104th Congress passed Medicare provisions that would reduce the rate of growth of Medicare spending by $221 billion between fiscal years 1997 and 2002.[75] However, this legislation was vetoed by President Clinton, who was willing to accept no more than $124 billion in Medicare reductions. Although a number of Medicare proposals have since been advanced, a resolution is un-

68. *Id.*

69. *Id.* at 5.

70. *Id.*

71. Celinda M. Franco, Medicare: Description of Hospital Reimbursement of Inpatient Hospital Care Under the Prospective Payment System 6 (Congressional Research Service Report to Congress No. 93-230, Feb. 17, 1993).

72. Jennifer O'Sullivan & Richard Price, Medicare 2 (Congressional Research Service Report for Congress No. 95-44, Dec. 23, 1994).

73. 42 U.S.C. § 1395w-4(g) (1994).

74. *See supra* notes 56-58 and accompanying text.

75. H.R. 2491, 104th Cong., 1st Sess. (1995).

likely in the near future.[76] However, the Medicare program's long term financial health will continue to take center stage in 1997 as costs continue to increase, the trust fund balance drops, and the nation's population continues to age.

Medicaid

Medicaid is a joint federal-state program, created by Title XIX—Medical Assistance, a 1965 amendment to the Social Security Act, providing health care benefits to indigent and medically indigent persons.[77] The program provides insurance for recipients of Aid to Families with Dependent Children (AFDC—the main federal welfare program), the disabled, and increasing numbers of children and pregnant women living in low-income households.[78] Medicaid also covers the cost of nursing home care for elderly Americans who have exhausted their resources.[79] In addition, Medicaid provides special payments to assist hospitals treating disproportionately large numbers of poor and uninsured people.[80]

In 1993, Medicaid paid for the health care of 3.7 million elderly persons, 4.9 million blind and disabled persons, 7.4 million adults in families (mostly the mothers of eligible children), and 16.1 million children.[81] The cost of providing coverage to these 32.1 million individuals totaled $124.9 billion.[82] With annual increases in the number of individuals who meet the program's eligibility requirements, Medicaid's expenditures are increasing at an average rate of 10.7% per year.[83] The federal-state tab for Medicaid is expected to reach $170 billion in fiscal year 1996 and to provide coverage for more than 37 million Americans.[84]

Medicaid covers a broad range of services with few or no cost-sharing requirements,[85] thus ensuring that the poorest, most vulnerable populations do not encounter financial barriers to health

76. *See, e.g.*, President Clinton's Fiscal Year 1997 Budget Request, Submitted to Congress Feb. 5, 1996.

77. 42 U.S.C. §§ 1396a-1396v (1994).

78. 42 U.S.C. §§ 1396a(10)(A)(i)(I)-1396a(10)(A)(i)(III) (1994).

79. 42 U.S.C. § 1396d(a)(xi)(4)(A) (1994).

80. 42 U.S.C. § 1396r-4 (1994).

81. *See* THE KAISER COMMISSION ON THE FUTURE OF MEDICAID, *supra* note 2, at 1.

82. *Id.*

83. GENERAL ACCOUNTING OFFICE, MEDICAID: SPENDING PRESSURES DRIVE STATES TOWARD PROGRAM REINVENTION 5 (Apr. 1995).

84. Colette Fraley, *States Guard Their Borders as Medicaid Talks Begin*, CONG. Q. WKLY. REP., June 10, 1995, at 1638.

85. 42 U.S.C. § 1396o (1994).

services. The federally-mandated benefits package includes in-patient and outpatient hospital care, physician, midwife, and certified nurse practitioner services, laboratory and X-ray services, family planning, nursing home and home health care, and early and periodic screening, diagnosis, and treatment for children under age 21.[86]

The states administer their Medicaid programs through agencies which are subject to federal statutes, regulations, and guidelines.[87] States have broad discretion in designing and administering their Medicaid programs. At their discretion, states may add extra benefits.[88] Each state must operate its Medicaid program under a state plan, submitted to and approved by the Health Care Financing Administration (HCFA), a unit of the U.S. Department of Health and Human Services.[89] The state plan must detail eligibility, benefits, payment rates, and other program features. A state must also submit any amendments to an existing Medicaid plan, and receive HCFA approval before implementing changes in its program.[90]

The federal government and the states jointly finance Medicaid services and the associated administrative costs. States often share their Medicaid financing burden with city and county governments. Each year Congress makes federal funds available to match those funds expended by each state. The federal government matches state expenditures for health care services covered under the plan of each state according to a formula that is based on the state's per capita income.[91]

States may apply to HCFA for waivers of federal statutory requirements in order to develop cost-effective alternative methods of service delivery under their Medicaid programs. States often seek a freedom-of-choice waiver, under which a state may waive a recipient's right to unlimited provider choice.[92] The freedom-of-choice waiver allows states to implement statewide, mandatory managed care demonstration programs that broaden coverage.[93]

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86. 42 U.S.C. § 1396d(a) (1994).

87. 42 U.S.C. § 1396a(a) (1994).

88. 42 U.S.C. § 1396d(a)(xi)(25) (1994).

89. 42 U.S.C. § 1396a(b) (1994).

90. *Id.*

91. 42 U.S.C. § 1396b (1994).

92. 42 C.F.R. § 430.25 (1994).

93. *Id.* See THE KAISER COMMISSION ON THE FUTURE OF MEDICAID, *supra* note 2, at 2. As of January, 1995, nine states had been granted waivers and several more had applied and were awaiting HCFA approval. *Id.*

At present, 23% of the Medicaid population, representing about 7.8 million Americans, receives medical coverage through HMOs and other managed care plans.[94] Medicaid managed care models range from HMOs using prepaid capitated care to loose networks contracting with selected providers for discounted services. HMOs view those eligible for Medicaid as a major source of future enrollment growth.[95] By providing Medicaid patients with their own primary care doctors, HMOs believe they can sharply curtail the use of high-cost emergency room care and rein in surging costs while simultaneously improving health care for the poor and improving the treatment of individuals with chronic diseases.

But the shift to managed Medicaid has come at a price. Florida, which has spent the past five years trying to move as many Medicaid patients as possible into managed care to help curb costs, has struggled to crack down on widespread abuses, including fraudulent marketing and lapses in care.[96] Many Medicaid recipients have reported mistreatment by HMOs or their sales representatives. Managed care plans are not always recipient-friendly. For example, a recipient may enroll in an HMO with facilities on the other side of the state, or a recipient may not fully understand the way in which the plan operates (e.g., restricted choice).

The implementation of Medicaid managed care plans is further complicated by states' attempts to balance two competing concerns: (1) trying to promote the growth of Medicaid HMOs in an effort to save money and provide coverage for more people, and (2) enforcing quality-of-care standards. For example, in 1993, Tennessee proposed a five-year managed care demonstration program requiring several waivers to the Medicaid program. The program, known as Tenn Care, provides health care benefits to Medicaid recipients, uninsured state residents, and those whose medical conditions make them uninsurable. All enrollees must receive medical care through capitated managed care plans—either HMOs or PPOs.[97] Tenn Care has experienced several problems. Experts believe it went too far too fast, creating access problems and severe

94. Ron Winslow, *Medical Upheaval: Welfare Recipients Are a Hot Commodity In Managed Care Now*, WALL ST. J., Apr. 12, 1995, at A1.

95. *Id.*

96. Robert Pear, *Florida Struggles to Lift Medicaid Burden*, N.Y. TIMES, Apr. 24, 1995, at A12.

97. Interview with Steven A. Kroll, Director of Federal Relations, Healthcare Association of New York State, in Washington, D.C. (July 1, 1995).

economic dislocation for health care providers. It stretched Medicaid dollars further by providing coverage to more people.[98]

Changes to the Medicaid program are an important factor in the historic balanced budget debate between the 104th Congress and the Clinton Administration. The federal fiscal year 1996 budget reconciliation bill approved by Congress and vetoed by President Clinton would have reduced the rate of federal Medicaid spending by $133 billion over seven years.[99]

Several months of on-and-off budget negotiations between President Clinton, Republican congressional leaders, the nation's governors, and groups of moderate senators and representatives have hinged, in part, on Medicaid reform. The Republican leadership advocates turning program control over to the states in the form of block grants.[100] Under this approach, each state would receive a limited annual lump sum from the federal government to administer its program in whatever manner it sees fit. States would determine eligibility, benefits, and payment rates with minimal federal oversight.[101] The President, governors, and moderate members of Congress prefer to reduce spending by instituting a per-capita ceiling that would limit the amount of federal spending per Medicaid recipient.[102] To date, the future of the Medicaid program remains uncertain.

The Uninsured and Underinsured

The problems of the uninsured and underinsured plague our nation's health care system. The uninsured and underinsured pay for only a fraction of the health care they receive. Through cost-shifting, a substantial amount of Medicare, Medicaid, and private insurance funds actually pay for the care of those unable to afford it. The best estimates indicate that the number of people without any health insurance rose from 31 million in 1987 to 39.7 million in 1993.[103] "During [the] same period, the proportion of the popula-

98. *Id.*

99. H.R. 2491, 104th Cong., 1st Sess. (1995); CONGRESSIONAL BUDGET OFFICE, MEDICAID AS REESTIMATED UNDER DECEMBER 1995 BASELINE (Dec. 18, 1995).

100. *Health Provisions of OMB Section-By-Section Analysis of Clinton Administration Budget, GOP Conference Report, Coalition Proposal Dated Dec. 9, 1995*, 3 Health Care Pol'y Rep. (BNA) No. 50, at D-42 (Dec. 18, 1995).

101. *Id.*

102. *Id.*

103. LAURA SUMMER & ISAAC SHAPIRO, CENTER ON BUDGET AND POLICY PRIORITIES, TRENDS IN HEALTH INSURANCE COVERAGE 1987 TO 1993 1 (Oct. 19, 1994).

tion without insurance increased from 12.9% to 15.3%."[104] In 1993, an estimated 9.5 million of the uninsured were children.[105] Over 83% of the uninsured belonged to families that included a working adult.[106] Self-employed, part-time workers, and full-time workers in low-wage industries were most likely to lack coverage for themselves or their families.[107]

A larger proportion of the poor than of the non-poor lack insurance.[108] In 1993, 29.3% of the poor had no health insurance, while 12.8% of the non-poor lacked insurance.[109] But the large majority of people without insurance fall above the federal poverty line. Of those without insurance in 1994, 71% had incomes above the poverty line.[110] The lack of health insurance significantly impedes access to health care services. Spending per person on those without insurance only amounts to slightly less than two-thirds of spending for people who have insurance, and the uninsured generally receive lower quality care than that received by insured individuals.[111]

More than 10 million Americans are estimated to be underinsured.[112] Although insured, their policies do not cover all of their anticipated medical needs. Americans who purchase only catastrophic coverage must pay for routine check-ups and preventive care services out-of-pocket. As a result, they often neglect these important health care services. Many Americans have health insurance policies that do not cover pre-existing conditions. Others are covered by insurance plans that impose spending caps. When someone covered by such a policy becomes sick, she may easily reach this cap and become financially devastated by her illness.

Several factors contribute to the rising number of underinsured and uninsured. For most privately insured Americans, health insurance coverage is tied to employment. When these Americans

104. *Id.*

105. THE WHITE HOUSE DOMESTIC POLICY COUNCIL, HEALTH SECURITY: THE PRESIDENT'S REPORT TO THE AMERICAN PEOPLE 2 (Oct. 1993).

106. Beth C. Fuchs & Mark Merlis, Health Care Fact Sheet: Health Care Reform in the 104th Congress 1 (Congressional Research Service Report for Congress No. 95-138, Jan. 13, 1995).

107. THE WHITE HOUSE DOMESTIC POLICY COUNCIL, *supra* note 105, at 3-4.

108. SUMMER & SHAPIRO, *supra* note 103, at 2.

109. *Id.*

110. FUCHS & MERLIS, *supra* note 106, at 1.

111. CONGRESSIONAL BUDGET OFFICE, MANAGED COMPETITION AND ITS POTENTIAL TO REDUCE HEALTH SPENDING 1 (1993).

112. Interview with Steven A. Kroll, Director of Federal Relations, Healthcare Association of New York State, in Washington, D.C. (July 1, 1995).

change or lose their jobs, no guarantee exists that they or their families will remain insured. Increasing health care costs encourage many employers to reduce benefits or to require larger employee contributions. Other employers limit insurance to employees and are unwilling to subsidize spousal and dependent coverage. Still others choose to drop health insurance altogether. Some employees opt for cash rather than health insurance coverage.[113] Medical underwriting (whereby applicants are rated according to age and health status), waiting periods, and lack of coverage for pre-existing conditions also make health insurance unattractive to those most likely to need it.[114]

Risk selection and experience rating often aggravate the problems of the under- and uninsured. As health care costs rise, younger, healthier individuals and those who must seek out health insurance on their own (e.g., the self-employed) often decline to or cannot afford to purchase health insurance. Furthermore, when it comes to health care expenses, the Internal Revenue Code, even as amended, discriminates between individuals and businesses. Self-employed individuals can deduct only 30% of their health care insurance expenses in 1996, increasing to 40% in 1997, 45% in 1997 through 2002, 50% in 2003, 60% in 2004, 70% in 2005, 80% in 2006 and thereafter.[115] Businesses can deduct 100% of their employees' health insurance expenses.[116] And because large employers who provide health insurance to their workers typically demand experience rating for their group, insurers cannot adequately spread risk. The result is high-priced insurance for individual and small group purchasers.[117]

The current restructuring of the health care system has not alleviated the plight of the underinsured and uninsured. The increasing presence of for-profit entities in the health care system has transferred funds to shareholders. For instance, for-profit HMOs negotiate rate reductions with hospitals. The HMOs reap substantial returns while hospitals struggle to recoup their losses, often in the form of reduced services.[118] In the case of public not-for-profit

113. *See, e.g.*, THE WHITE HOUSE DOMESTIC POLICY COUNCIL, *supra* note 105, at 4.

114. *Id.* at 3.

115. I.R.C. § 162(l)(1) (West Supp. 1997) (amended by the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, § 311(a), 110 Stat. 1936 (1996)).

116. I.R.C. § 162(a)(1) (West 1988 & Supp. 1997).

117. *Id.*

118. *See, e.g.*, Eckholm, *supra* note 34, at A1, A4.

hospitals that provide a disproportionately large amount of free care to the uninsured, these already financially vulnerable facilities can cut costs only by reducing services to the poor and the uninsured.[119]

When the uninsured and underinsured do obtain access to the health care system, they frequently cannot afford to pay the full cost of their care. As a result, both physicians and hospitals accept losses in the form of uncompensated care.[120] The burden of uncompensated care does not fall evenly on providers. Public and teaching hospitals provide a disproportionate share of uncompensated care compared to proprietary and voluntary nonteaching hospitals.

After a year-long struggle, the Health Insurance Portability and Accountability Act of 1996, popularly known as the Kassebaum-Kennedy Act (KKA), was signed into law on August 21, 1996.[121] At its core, the measure is designed to improve portability and continuity of health insurance coverage in the group and individual markets.[122] It also includes provisions to promote the use of medical savings accounts and improve access to long-term care.

Portability and Continuity Reforms

Guaranteed Issue

KKA regulates the availability of private health insurance coverage by requiring health insurance issuers to cover any group or individual who applies, without regard to health status or claims experience.[123] Insurers that offer general coverage in a given state's small group market are required to offer coverage to every small

119. Interview with Steven A. Kroll, Director of Federal Relations Healthcare Association of New York State, in Washington, D.C. (July 1, 1995).

120. AMERICAN HOSPITAL ASSOCIATION, UNSPONSORED HOSPITAL CARE AND MEDICAID SHORTFALLS, 1980-1991: A FACT SHEET UPDATE (Nov. 1992). Uncompensated care is the sum of bad debt and charity care absorbed by a provider in providing medical care for patients who are uninsured or are unable to pay. AMERICAN HOSPITAL ASSOCIATION RESOURCE CENTER, HOSPITAL ADMINISTRATION TERMINOLOGY 60 (1986). Bad debt is defined as the payments providers expect to be made that are not. AMERICAN HOSPITAL ASSOCIATION, *supra*, at 19. Charity care is defined as the costs of services for patients who are not expected to pay. *Id.*

121. Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936 (1996) [hereinafter Health Reform Act of 1996].

122. REPORT ON H.R. 3103, HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, H.R. CONF. REP. NO. 736, 104th Cong., 2d Sess. (1996), *reprinted in* 4 Health Care Pol'y Rep. (BNA) No. 32, at D-59 (Aug. 5, 1996).

123. I.R.C. § 9802(a)(1) (West Supp. 1997) (added by the Health Reform Act of 1996, § 401(a)).

employer (defined as two to fifty employees) that applies for such coverage.

All issuers in the individual market will be required to offer coverage to all eligible individuals moving from group to individual coverage. To be eligible, the individual (1) must have been covered under one or more health plans for the past eighteen months; (2) must not be eligible for group coverage, Medicare, or Medicaid; and (3) must have exhausted continuation of coverage under COBRA.[124] Insurers may offer (1) a choice among all their plans, (2) a choice between their two most popular plans, or (3) a choice between two new policies, one with a high deductible and one with a low deductible. KKA also provides for special enrollment periods under group coverage for employees who experience a change in family composition, employment status, or employment status of a family member.[125] During these periods, employees must be offered the opportunity to enroll in the plan if they previously declined coverage or to change the individual or family basis of coverage.

Guaranteed Renewal

The law requires insurers, with certain exceptions, to renew coverage in a group health plan, which is a multi-employer plan, without regard to health status or use of services.[126] An insurer may, however, discontinue coverage in cases of non-payment of premium, fraud, or similar reasons unrelated to health status.

Preexisting Condition Restrictions

KKA limits periods before preexisting conditions are covered in group market insurance. Specifically, the law limits to twelve months the period in which a group insurer could refuse or limit coverage for a health condition that was treated or diagnosed on the six-month period before enrollment.[127] The twelve-month period is reduced by the period of continuous coverage before enrollment. KKA does not limit the use of preexisting condition restrictions in the individual market, except for eligible people who move from group to individual coverage.

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124. I.R.C. § 9801(f)(1) (West Supp. 1997).

125. *Id.*

126. I.R.C. § 9803(a) (West Supp. 1997) (added by the Health Reform Act of 1996, § 401(a)). The term "multi-employer plan" is defined in I.R.C. § 414(f) (1994).

127. I.R.C. § 9801(a) (West Supp. 1997) (added by the Health Reform Act of 1996 § 401(a)). The term "preexisting condition exclusion" is defined in I.R.C. § 9801(b)(1)(A) (West Supp. 1997).

Tax-Related Health Provisions: Medical Savings Accounts

KKA includes a medical savings account demonstration project. From 1997 through 2000, 750,000 policyholders may open medical savings accounts.[128] The trial population includes employees of companies of fifty or fewer, self-employed individuals, and unemployed persons.[129] Individuals would purchase high deductible insurance plans (i.e., catastrophic coverage).[130] They would then open a medical savings account to which tax-deductible contributions could be made.[131]

In addition to earnings on the account being taxfree, individuals may draw money from the account to pay for qualified medical expenses, taxfree.[132] For individuals age sixty-five and under, withdrawals for other purposes are subject to an early withdrawal penalty of 15% and are taxable. Individuals over age 65 may withdraw for other purposes without incurring the 15% penalty.[133]

Long-Term Care Insurance and Services

Prior to the enactment of KKA, long-term care insurance premiums were generally not deductible for federal income tax purposes. Under the new law, the cost of long-term care insurance premiums, as well as the cost of qualified long-term care service, is included in the definition of deductible medical care, up to specified, annual dollar limits.[134] To the extent that the cost of long-term care premiums and services qualify as medical services, their cost is subject to various limitations on deductibility.

Accelerated Death Benefits

Chronically or terminally ill individuals may receive life insurance policy benefits before death without federal income tax con-

128. I.R.C. § 220 (West Supp. 1997) (added by the Health Reform Act of 1996 § 301(a)).

129. I.R.C. §§ 220(c)(1)(A), (c)(4) (West Supp. 1997).

130. I.R.C. § 220(c)(2) (West Supp. 1997).

131. I.R.C. § 220(b)(1) (West Supp. 1997). The amount allowable as a deduction to an individual for the tax year for a contribution to a medical savings account cannot exceed the sum of the specified monthly limitations for months during the tax year that the individual is an eligible individual.

132. I.R.C. § 220(f)(1) (West Supp. 1997) (added by the Health Reform Act of 1996, § 301(a)).

133. I.R.C. § 220(f)(4)(C) (West Supp. 1997).

134. I.R.C. § 213(d)(1) (West Supp. 1997).

sequences.[135] Thus, a chronically or terminally ill person can cash in or sell a life insurance policy without paying any tax, and use the proceeds to pay for the cost of health care.

Individual Retirement Accounts

KKA allows taxpayers who spend more than 7.5% of their adjusted gross income on medical expenses to withdraw money from tax-deferred individual retirement accounts without incurring the 10% tax penalty on early withdrawals.[136] In addition, the 10% tax penalty does not apply to certain unemployed individuals who withdraw to pay for medical insurance.[137]

II. Current Status of Community Based Care

Introduction

This section first discusses, in general terms, the delivery of ambulatory health care in the United States. It next focuses on the delivery of four specific types of community-based health care: (1) free clinics, (2) community health clinics, (3) hospital clinics, and (4) for-profit clinics.

Ambulatorv Health care Delivery

Diversity characterizes the U.S. health care delivery system. Apart from community-based health care clinics discussed later in this section, three major types of ambulatory health care delivery exist: private practice, managed health care organizations, and hospitals.

Private Practice

Private medical practices in the United States have typically been run on a fee-for-service basis.[138] A physician in private practice delivers care to a patient in return for monetary compensa-

135. I.R.C. § 101(g) (West Supp. 1997), *amended by* the Health Reform Act of 1996 § 331(a). The terms "terminally ill" and "chronically ill" individuals are defined in I.R.C. § 101(g) (C) and (D) (West Supp. 1997).

136. IRC § 72(t)(3)(A) (West Supp. 1997) (as amended by the Health Reform Act of 1996, § 361(a)).

137. IRC § 72(t)(2)(D) (West Supp. 1997) (as amended by the Health Reform Act of 1996, § 361(b)).

138. Andrew P. Mezey & Robert S. Lawrence, *Ambulatory Care, in* JONAS'S HEALTH CARE DELIVERY IN THE UNITED STATES 122, 124 (Anthony R. Kovner ed., 5th ed. 1995).

tion.[139] Private practice has functioned as the dominant means by which physicians deliver health care in the United States.[140]

Managed Health care Organizations

Managed health care organizations attempt to deliver health care in an economically efficient manner by managing patient care. Typically, managed health care organizations use primary care[141] providers, usually physicians, to act as gatekeepers.[142] The primary care provider sees the organization's members for both regular check-ups and medical problems. When a member reports a medical problem, the primary care provider evaluates whether the member should be sent to a specialist for treatment.[143] Controlling member access to other health care providers enables a managed care organization to control costs better.[144]

Hospitals

Hospitals[145] typically offer traditional in-patient and outpatient (same day) treatment, and emergency services.[146] Although revenues from in-patient services remain the main source of income for

139. *Id.*

140. *Id.*

141. Primary care represents basic or general health care, the patient's usual entry point into the medical system, as opposed to specialist or subspecialist care. A more specific definition remains problematic because some health services (*e.g.* , pap smears, controlling hypertension) are considered primary care by some and preventive care by others. *See, e.g.*, Mary T. Koska, *Primary Care: Hospitals Begin to Target Community Needs*, HOSP. & HEALTH NETWORKS, Apr. 5, 1990, at 24 (defining primary care as ongoing care of the patient based on a continuous relationship with a provider).

142. Mezey & Lawrence, *supra* note 138, at 127.

143. *Id.*

144. *Id.* at 126.

145. Although a variety of terms can be used to describe hospitals, they can be classified into four basic categories: teaching hospitals, multihospital systems, public hospitals, and rural hospitals. These categories are not mutually exclusive. Teaching hospitals are committed to education, research, and patient care. They represent 6% of all hospitals in the United States. As the name suggests, multihospital systems are systems that oversee the direction of two or more hospitals. Multihospital systems represent 43% of all U.S. hospitals. Public hospitals are facilities owned by federal, state, or local governments. Typically, they are required to provide services to indigent individuals for free or at a discount. Approximately 21% of all U.S. hospitals are public hospitals. Rural hospitals are facilities outside a metropolitan area as defined by the U.S. Census Bureau. About 43% of all hospitals are classified as rural. Anthony R. Kovner, *Hospitals, in* JONAS'S HEALTH CARE DELIVERY IN THE UNITED STATES 162, 169-70 (Anthony R. Kovner ed., 5th ed. 1995).

146. *Id.* at 168.

most hospitals,[147] outpatient, or ambulatory, services are becoming increasingly important. In recent years, third party payers have become increasingly reluctant to pay for in-patient treatments, forcing hospitals to look for alternative means to meet their expenses and keep their doors open.[148]

Hospital emergency departments are designed to treat individuals who need immediate medical attention.[149] But emergency departments in many hospitals, especially public hospitals, are crowded with individuals who otherwise lack access to the health care system.[150] As one hospital administrator noted, "[t]he use of emergency rooms for primary care has become so routine that some patients, particularly indigent ones, name their ER physicians when asked about their primary care-giver."[151] Because many emergency room patients are indigent or are Medicaid recipients, they end up not only crowding out those truly in need of emergency care, but also costing hospitals money because their care is not fully compensated.[152] Furthermore, because the care received by the patients is primarily episodic, it does not have the long-term benefits more continuous care provides.[153]

To address the problems of shrinking in-patient populations and emergency department overcrowding, hospitals have expanded their ambulatory care programs.[154] Underlying such initiatives is the realization by hospitals that primary care is the access point of patients into the health care delivery system.[155] In addition to focusing on acute, short-term care, hospitals are now focusing on preventive, coordinated care.[156]

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147. Mezey & Lawrence, *supra* note 138, at 128.

148. *'Virtual' Integration, Community Focus, Called New Vision for California Reform*, Health Care Pol'y Rep. (BNA) No. 44, at D-30 (Nov. 7, 1994).

149. Kovner, *supra* note 145, at 168.

150. *Id.*

151. Peggy McNamara et al., *Patchwork Access: Primary Care in EDs on the Rise*, HOSP & HEALTH NETWORKS, May 20, 1993, at 44. McNamara notes that in 1990, 43% of all emergency department visits were for non-urgent conditions. *Id.*

152. *Id.* at 46.

153. *Id.*

154. Anne M. Murphy & Tecla A. Murphy, *Using the Emergence of Primary Health Care in Hospital Strategy and Community Reform*, 25 J. HEALTH & HOSP. L. 321 (1992).

155. Koska, *supra* note 141, at 25.

156. Howard J. Anderson, *Hospitals Seek New Ways to Integrate Health Care*, HOSP. & HEALTH NETWORKS, Feb. 5, 1992, at 26. This expanded form of hospital care is known as "vertical integration." Because hospitals are still developing vertically integrated delivery systems, a universal model does not exist. According to some experts, however, such systems will probably have in common the following: (1) the development of a continuum of health care, with a primary care network as the focal

Community-Based Health care Clinics

Community-based health care clinics have delivered primary care for years. This article next examines the current delivery of primary health care through four types of community-based health care facilities: free clinics, community health centers, hospital clinics, and for-profit clinics.

Free Clinics

In an attempt to deal with the large number of uninsured Americans, hundreds of free clinics have been established in the United States.[157] Because the initiatives for these clinics are extremely local in nature, the clinics have varying organizational structures, services, and patients, and provide different treatments.

Most free clinics are run by predominantly volunteer staffs.[158] There is usually a paid executive director and possibly one or two other paid support personnel. The remainder of a free clinic's health care staff typically includes a varying mixture of physician assistants, nurse practitioners, doctors, dentists, dental assistants, psychiatrists, medical students, nurses, social workers, pharmacists, and lay people who volunteer their time by working at the clinic site[159] and/or accepting uncompensated referrals.[160]

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point; (2) the integration of health care services, allowing patients to move efficiently through the system; and (3) the collection of data concerning community impact so that hospitals may be held accountable for meeting their missions. *Id.* at 30. Vertically integrated systems encompass various components, including health clinics and clinic networks, long-term care facilities, urgi- and emergi-care centers, surgi-care centers, and drug treatment programs. Mezey & Lawrence, *supra* note 138, at 140.

157. Kevin C. Kelleher, *Free Clinics: A Solution That Can Work . . . Now!*, 266 JAMA 838 (1991).

158. *See* Susan Smith, *A Healthy Dose of Caring With the Help of Many Dedicated Volunteers: Chesapeake's Free Clinic Serves Needy Patients*, VIRGINIA PILOT AND LEDGER-STAR, Jan. 13, 1995, at 12; Anne Carothers-Kay, *Free Clinics Making Impact*, DES MOINES REGISTER, Apr. 9, 1995, at 1; Health Lines, *Lorain County Free Clinic Is Helping All of Us Stay Healthy*, THE PLAIN DEALER, Sept. 28, 1993, at Supp. 2; Jim Nesbitt, *A Local Prescription for a National Ailment: Free Clinic Serves the Uninsured Working Poor in Roanoke, VA*, THE PLAIN DEALER, Jan. 10, 1993, at 10A.

159. Paul DeMarco & Mohan Nadkarni, *The Charlottesville Free Clinic*, 269 JAMA 2496 (1993); Kevin C. Kelleher, *Free Clinic: Health Care that Remembers to Care*, ROANOKE TIMES & WORLD NEWS, Oct. 20, 1994, at A17; *Health Lines*, *Lorain County Free Clinic Is Helping All of Us Stay Healthy*, THE PLAIN DEALER, Sept. 28, 1993, at Supp. 2; Wendi C. Thomas, *Health Reform on the Front Lines: Volunteers Take a Crisis Into Their Own Hands and Make a Difference at a Free Health Clinic*, THE INDIANAPOLIS STAR, Oct. 1, 1994, at C1.

160. Kevin C. Kelleher, *Care for the Poor? We Found a Solution*, MED. ECON., Mar. 8, 1993, at 136, 138.

Because most clinics receive only a minority of their funding from their local governments,[161] a free clinic's ability to serve its patients' needs depends on the generosity of its community. Free clinics obtain much of their funding through grants and through individual and corporate donations.[162] For example, in 1993 the Bradley Free Clinic in Roanoke, Virginia received 27% of its budget from the United Way, 40% from foundation grants, 17% from county and government grants, and the remaining 16% from individual and corporate donations.[163] The Los Angeles Free Clinic receives one-third of its budget from state, county, and city governments and the remainder through private donations.[164] In addition to monetary donations, many corporations support free clinics by donating their health care products.[165] For example, donations in kind by physicians and hospitals enable clinics to distribute drugs they could not otherwise afford.[166] Illustrative is the Bradley Free Clinic, which has an annual operating budget of $300,000,[167] but supplied its patients with $315,000 worth of donated drugs in 1993.[168]

Free clinics provide general ambulatory care and are neither equipped nor intended to treat complex, acute cases requiring hospitalization.[169] The specific services each clinic offers varies greatly. Some clinics offer only the most basic services such as blood pressure checks and school physicals.[170] Others offer a broad range of services, such as dermatological, ob-gyn, and dental

161. Nesbitt, *supra* note 158, at 10A.

162. *See* DeMarco & Nadkarni, *supra* note 159, at 2496; Grant Dillman, *Free Medical Clinic Realizes Doctor's Dream*, THE PLAIN DEALER Dec. 20, 1994, at 8E; Health Lines, *supra* note 158; *Morning Edition: Free Clinics Provide Quick Relief to Health Care Crisis* (National Public Radio Broadcast, Transcript No. 1211-6, Nov. 8, 1993) (available on Lexis, News library, Script file) [hereinafter *Free Clinics*]; Nesbitt, *supra* note 158, at 10A; Thomas, *supra* note 159; Ryan Ver Berkmoes, *An Upscale Clinic for the Down-and-Out: Los Angeles Free Clinic*, AM. MED. NEWS, Mar. 9, 1990, at 7.

163. Nesbitt, *supra* note 158, at 10A.

164. Ver Berkmoes, *supra* note 162, at 7.

165. See *Free Clinics*, *supra* note 162; Thomas, *supra* note 159; Kelleher, *supra* note 160, at 137.

166. *See Twenty Years of Free Medicine*, ROANOKE TIMES & WORLD NEWS, Nov. 7, 1994, at A6.

167. *National Directory of Free Clinics*, Free Clinic Foundation Of America.

168. *Id.*

169. Nesbitt, *supra* note 158, at 10A; Dawn Gibeau, *Free Clinics Deliver Basic Care With a Vision*, NAT'L CATHOLIC REP., June 30, 1993, at 6.

170. Gibeau, *supra* note 169, at 6; Phil McCombs, *Where Healing Comes Without a Price Tag: For 25 Years, Free Clinic Has Helped D.C.'s Poor*, WASH. POST, Oct. 28, 1993, at D1.

services.[171] Still others offer substance abuse and psychological counseling.[172]

The medical services offered by clinics are generally dictated by their communities' needs. Because they are so local in nature, clinics have the ability to see trends in their communities and to adapt to them.[173] For example, in Cuyahoga County, Ohio, where there are an estimated 7,000 to 8,000 intravenous drug users and a resurgence of heroin use has occurred, the Free Clinic of Greater Cleveland operates a free needle exchange service.[174] Similarly, the Kansas City Free Clinic, located in Kansas City, Missouri, plans to open a clinic run by Native American doctors, nurses, and case managers to treat the four federally recognized Indian tribes that reside within 100 miles.[175]

Although clinics are responsive to their communities' needs, they are mindful of not duplicating readily available services. For example, the free clinic chain that operates in central Iowa does not offer obstetrical examinations, X-rays, or major lab work because those services are provided by other facilities or by specialists who accepts the clinic's referrals without compensation.[176]

Through ease of location and expanded hours of operation, clinics alleviate access and transportation problems, both of which plague the communities they serve.[177] Clinics are generally located in areas in which most of their clients reside, thereby reducing transportation problems.[178] Most clinics remain open in the evening, enabling their working clients to take advantage of clinic services without missing work.[179]

Free clinics tend to deliver two types of care: episodic and continuous. Episodic care addresses an individual's problems as they arise. Patients who receive episodic care turn to the clinic because they are experiencing an acute medical crisis. These patients will

171. Kelleher, *supra* note 159, at A17.

172. Clay Evans, *Free Clinic—New Setting, Same Mission*, L.A. TIMES, Feb. 12, 1990, at B1.

173. Kelleher, *supra* note 157, at 838.

174. Joe Dirck, *Free Clinic Braves Controversy Again*, THE PLAIN DEALER, Dec. 18, 1994, at IB.

175. Laura R. Hockaday, *An Insurance Policy For Those Who Have None: Free Health Clinic Provides Care for Those 'Lost Between the Cracks'*, THE KANSAS CITY STAR, Feb. 5, 1995, at H8.

176. Carothers-Kay, *supra* note 158.

177. Kelleher, *supra* note 157, at 838.

178. *Id.*

179. Malcolm Gladwell, *Doctors Without Bills: Saving the World a Patient at a Time*, REASON, Mar. 1992, at 40, 42.

probably not return to the clinic once treated for their ailment.[180] For instance, the Los Angeles Free Clinic sees many of its patients only once.[181] Although episodic care addresses the immediate needs of the patients, it fails to establish a more permanent relationship between patients and care-givers. Nonetheless, episodic care provided by clinics offers indigent patients primary care. In turn, this primary care alternative relieves emergency departments that would otherwise bear the burden of providing primary care to these patients.[182]

Although episodic treatment focuses on addressing the immediate needs of the patient, it can also detect potentially serious health risks. As one free clinic volunteer recounted, "[W]e saw a patient here who came in with a cold, but when we checked her out, she had tremendous high blood pressure, and didn't know it, hadn't been treated for it. If she had gone another six months without any treatment, there's a fair likelihood she'd have had a stroke.[183] Although episodic treatment does not serve as a substitute for comprehensive preventive care, it does offer a degree of medical care to people who would probably not otherwise receive any treatment.[184]

In addition to episodic care, some clinics offer care which is more continuous in nature. The Heartland Community Health Clinic, for example, has an active caseload of 1,000 patients who go to the clinic regularly for their medical needs.[185] Although this care is continuous, it does not provide patients true continuity of care.[186] When an individual receives care at a private practice or at an HMO facility, he or she establishes an ongoing relationship with one care-giver who follows his or her medical progress. By contrast, a patient who visits a free clinic will probably not see the same care-giver on two successive visits.[187] Instead, a patient will be seen by the care-giver who happens to be volunteering at the time of the appointment.[188] Without continuous care provided by

180. Ver Berkmoes, *supra* note 162, at 7.

181. *Id.* at 9.

182. *See, e.g.*, Nesbitt, *supra* note 158, at 10A.

183. *Free Clinics*, *supra* note 162.

184. *See* Kelleher, *supra* note 157, at 839.

185. Interview with Alison H. Watkins, Executive Director of the Heartland Community Health Clinic, in Peoria, IL (June 21, 1995).

186. DeMarco & Nadkarni, *supra* note 159, at 2496; WASH. REV. CODE ANN. § 4.24.300 (West 1995).

187. DeMarco & Nadkarni, *supra* note 159, at 2496.

188. *Id.*

one care-giver, a patient cannot receive comprehensive health care.[189]

Each free clinic establishes criteria for the individuals it will treat. Some free clinics will not turn an individual away even if he or she can afford to pay for treatment.[190] Other free clinics screen patients to assure that they fall within the clinic's financial guidelines for treatment eligibility.[191] Although a typical free clinic serves many groups, including homeless persons, HIV/AIDS patients, runaways, and prostitutes,[192] the working poor compose a fast-growing component of the clinic's clientele.[193] The working poor are individuals who work but cannot afford insurance of any kind. They are "too affluent for Medicaid but too far down the income ladder to afford health insurance on their own, too young for Medicare and too underemployed to be covered by an employer's policy."[194] Without free clinics, the working poor would fall between the cracks.[195]

United States Bureau of Primary Health care Programs

The U.S. Bureau of Primary Health Care administers nine major federal grant programs designed to support primary health services for medically underserved, disadvantaged, high-risk, and hard-to-reach populations.[196] These nine programs include the Community Health Center Program, the Migrant Health Program, School-Based Clinics, the Health Care for the Homeless Program, the Federally Qualified Health Center Look-Alike Program, and the Rural Health Clinics Program.[197]

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189. *See id.*

190. Ver Berkmoes, *supra* note 162, at 7.

191. Kelleher, *supra* note 157, at 838.

192. Evans, *supra* note 172, at B1.

193. *Id.*; Jean McCann, *Free Clinic Make a Comeback*, 31 MED. WORLD NEWS 49 (1990); Nesbitt, *supra* note 158, at 10A; Joan Stanus, *Free Clinic Offers TLC: Treating People With Dignity and Respect Is as Important as Quality Health Care at This Facility*, THE VIRGINIAN-PILOT & THE LEDGER-STAR, Oct. 6, 1994, at 10; DeMarco & Nadkarni, *supra* note 159, at 2496.

194. Nesbitt, *supra* note 158, at 10A.

195. Hockaday, *supra* note 175, at H8.

196. U.S. DEP'T OF HEALTH AND HUMAN SERVS., BUREAU OF PRIMARY HEALTH CARE: PRIMARY CARE PROGRAM DIRECTORY I (1994).

197. *Id.* The other programs are: the Alzheimer's Demonstration Grant Program, the Black Lung Clinics Program, the HIV Early Intervention Services Program, the Public Housing Primary Care Program, and the Integrated Primary Care and Substance Abuse Treatment Program. *Id.*

Community Health Clinics and Migrant Health Clinics

Community Health Clinics (CHCs), formerly Neighborhood Health Clinics, are private, not-for-profit health clinics owned and operated by local communities.[198] Originally designed to provide comprehensive health care and social services for the poor, these clinics now strive to bring cost-efficient, affordable health care to the medically underserved in urban and rural areas. Currently, over 500 CHCs serve approximately 6,000,000 people annually.[199]

Like CHCs, migrant health clinics (MHCs) try to bring cost-effective, affordable health care to migrant populations.[200] To address the special needs of migrants, MHCs also incorporate efforts to emphasize environmental health services and patient mobility.[201] Initially, the vast majority of the CHC/MHC client population fell below the poverty level.[202] Today, however, CHCs/MHCs serve a mixture of patients at, below, and above the poverty level.[203] This change resulted from two factors. First, clinics have expanded into rural areas with more affluent populations. Second, clinics have actively sought patients who can afford to pay for services to make up for federal funding shortfalls.[204]

Nevertheless, the vast majority of CHC/MHC patients are uninsured or receive publicly provided health insurance. Specifically, 49% are uninsured, and 39% receive publicly provided health insurance.[205] A majority of those with public health insurance are Medicaid recipients.[206] Only 12% of CHC/MHC patients have private insurance.[207] The Shawnee Health Service Development Corporation, a not-for-profit corporation that operates five CHC/MHC sites in southern Illinois, has a typical patient population,

198. NATIONAL ASS'N OF COMMUNITY HEALTH CENTERS, INC., AMERICA'S HEALTH CENTERS: ACCESSIBLE, EFFICIENT PROVIDERS OF QUALITY HEALTH CARE FOR UNDERSERVED PEOPLE AND COMMUNITIES 2 (1995).

199. John T. Hammarlund, *Community Health Centers and Rising Malpractice Premiums: An Overview of the Community Health Center Program and Proposed Solutions to the Malpractice Insurance Rate Crisis*, 1 CORNELL J.L. & PUB. POL'Y 135, 137 (1992).

200. 42 U.S.C. § 254b (1994).

201. Alan W. Strange, *Financing of Outpatient Care: The Case of Community Health Centers*, 13(4) J. AMBULATORY CARE MGMT. 46, 47 (1990).

202. *Id.*

203. *Id.*

204. *Id.*

205. Hammarlund, *supra* note 199, at 139.

206. *Id.*

207. *Id.*

80% of whom are uninsured or receive Medicaid.[208] CHC/MHCs require all patients to pay for services received.[209] Payment is calculated using the national poverty index.[210] Patients at or below the federal poverty level pay a nominal fee.[211] Patients above the poverty level by less than 200% pay on a sliding-scale basis.[212] All other patients pay in full for services rendered.[213]

Although CHC/MHCs are private entities, each represents a public-private partnership between a clinic and the federal government. Under the Public Health Service Act,[214] CHC/MHCs receive approximately 50% of their funding from the federal government.[215] This funding alleviates revenue shortfalls and helps keep the clinics financially sound.[216] To receive federal funding, CHC/MHCs must meet certain federal requirements.[217] The clinics must offer accessible comprehensive care, including physician services, diagnostic and radiological services, preventive care, emergency care, transportation services,[218] and health services information.[219] Clinics must also provide patient case management[220] and must offer appropriate supplemental care and referrals.[221] In addition, clinics must meet federal staffing, productivity, and quality assurance standards.[222]

Federal rules also require control of CHC/MHCs to remain in the hands of their local communities. These rules stem from the premise that a community responds more favorably to ideas generated by its members and will, therefore, more readily accept a clinic with community representation.[223] Community control of a CHC/MHC is established through a governing board, a majority of

208. PAUL H. CAMPBELL ET AL., U.S. DEP'T OF HEALTH AND HUMAN SERVS., PHYSICIAN COMPENSATION: A GUIDEBOOK FOR COMMUNITY AND MIGRANT HEALTH CENTERS 91 (1990).
209. Strange, *supra* note 201, at 47.
210. *Id.* at 46.
211. *Id.*
212. *Id.*
213. *Id.*
214. 42 U.S.C.A. § 254b-c (West 1991 & Supp. 1996).
215. Ann Zuvekas, *Community and Migrant Health Centers: An Overview*, 13(4) J. AMBULATORY CARE MGMT. 1, 2 (1990).
216. Hammarlund, *supra* note 199, at 142.
217. Murphy & Murphy, *supra* note 154.
218. 42 U.S.C. § 254c(b) (1994).
219. 42 U.S.C. § 254c(a)(5) (1994).
220. 42 U.S.C. § 254c(a)(6) (1994).
221. 42 U.S.C. §§ 254c(a)(2)-(3), (b)(2) (1994).
222. *See* U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, PROGRAM EXPECTATIONS FOR COMMUNITY AND MIGRANT HEALTH CENTERS 22 (1991).
223. *See* Zuvekas, *supra* note 215, at 3.

whom are clinic patients.[224] The board oversees major decisions, including budgetary considerations, and controls clinic operations.[225] Through the governing board, which has developed the trust of the community and the power to implement changes, CHC/MHCs effectively respond to the needs of their communities.[226]

In addition to federal funding and patient payments, CHC/MHCs receive funding from local governments, hospitals, private foundations, and public insurers, including Medicare and Medicaid.[227] Under the Federally Qualified Health Center Program, Medicaid reimburses CHC/MHCs 100% of reasonable costs, and Medicare reimburses up to 80% of reasonable costs.[228]

School-Based Clinics

Established in the late 1960s,[229] the number of school-based clinics (SBCs) skyrocketed in the 1990s[230] and now number over two hundred nationwide.[231] SBCs attempt to improve the health of school children through the provision of comprehensive health care.[232] SBC services typically include primary care, health education programs, and reproductive health services.[233] Some SBCs offer dental screenings, mental health services, and substance abuse services.[234] According to a six-cite study conducted by the U.S. Department of Health and Human Services, such SBC services have successfully improved access to care, resulting in reduced school dismissals, absenteeism, and dropouts.[235]

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224. 42 U.S.C. § 253c(e)(3)(G) (1994).

225. Zuvekas, *supra* note 215, at 4.

226. The U.S. Department of Health and Human Services advances community involvement by requiring centers to engage in community-based program planning. These planning sessions have led some clinics to develop special programs to address problems in their communities such as teen pregnancy, substance abuse, infant mortality, and AIDS. Hammarlund, *supra* note 199, at 138 n.20.

227. Zuvekas, *supra* note 215, at 2.

228. 42 U.S.C. § 1396(u) (1994); 42 U.S.C. § 1395w-4 (1994).

229. U.S. DEP'T OF HEALTH AND HUMAN SERVICES, SCHOOL BASED CLINICS THAT WORK 2.

230. *Id.* at 3.

231. *Id.* at v.

232. *Id.*

233. *See id.* at 17. This information is based on a six-site study conducted by the U.S. Department of Health and Human Services.

234. *Id.*

235. U.S. DEP'T OF HEALTH & HUMAN SERVICES, *supra* note 229, at 11-15.

Generally, CHCs manage SBCs,[236] which receive a large portion of their funding through federal grants.[237] Additional SBC funding includes private grants, Medicaid payments, and patient fees.[238]

Health Care for the Homeless Program

Under the Health Care for the Homeless Program, HCHs are required to provide homeless persons with comprehensive primary health care services and substance abuse services.[239] In addition, HCHs must have appropriate referral and outreach mechanisms.[240]

Federally Qualified Health Centers and Look-Alikes

Federally Qualified Health Centers (FQHCs) and FQHC Look-Alikes serve the primary and preventive health needs of Medicaid, Medicare, and medically indigent patients living in designated medically underserved areas.[241] FQHCs are public or private non-profit community health centers funded under the migrant health center, community health center, health care for the homeless, or Medicare Part B programs, and certain Native American tribal programs.[242]

FQHC Look-Alikes are health centers that meet the eligibility requirements for the CHC Program, the MHC Program, or the HCH Program, but do not actually receive funding from these programs.[243] To receive Look-Alike status, a clinic must satisfy four basic conditions. The clinic must: (1) demonstrate community need; (2) deliver a range of primary health care and ancillary services, including preventative care; (3) adhere to specific management and finance criteria; and (4) follow community-based governance requirements.[244] All FQHCs and FQHC Look-Alikes receive partial or total reimbursement of reasonable costs for services to Medicaid[245] and Medicare patients.[246] In addition, the

236. *Id.* at 6.
237. *Id.* at 10.
238. *Id.*
239. 42 U.S.C. § 256 (1994).
240. *Id.*
241. The George Washington University National Health Policy Forum, Issue Brief No. 613, Access to Primary Care in Underserved Areas: Expanding Medicaid, Medicare, and Public Health Services Through the FQHC Program (Jan. 1993).
242. *Id.*
243. 42 U.S.C. § 1395aa(4) (1994).
244. PUBLIC HEALTH SERVICE, APPLICATION FOR DESIGNATION AS A FEDERALLY QUALIFIED HEALTH CENTER.
245. 42 U.S.C. § 1396u (1994).
246. 42 U.S.C. § 1395w-4 (1994).

FQHC programs provide public health grants to give expanded primary care services to low-income uninsured persons.[247]

Rural Health Clinics Program

The Rural Health Clinics Program (RHC), the rural counterpart to the FQHC program,[248] promotes primary care to medically underserved individuals.[249] Like FQHCs, RHCs receive reasonable cost-based Medicaid and Medicare reimbursement.[250] However, they receive reimbursement for only 80% of reasonable costs.[251] RHCs must provide certain primary care and diagnostic services, meet a theshhold level of physician supervision, and make hospital referral arrangements for the admission of individuals needing inpatient care.[252] As with FQHCs, federal regulations require RHCs to locate in medically underserved areas.[253] Unlike FQHCs, RHCs are not bound by strict community-based governance standards.[254]

Hospital Clinics

Hospital Clinics represent one means by which hospitals increase the amount of primary health care they provide. Hospital clinics, which have existed since the nineteenth century in voluntary hospitals,[255] originally served a charitable function.[256] Today, some hospitals continue to own and operate free clinics. For example, U.S. Health Corporation, a Columbus, Ohio-based multihopsital system, operates eleven free neighborhood clinics.[257] In underserved areas in the Salt Lake City area, Intermountain Health Care operates seven free clinics.[258] The majority of hospital clinics, however, require patients not covered by a third-party payer to pay for the medical care they receive in accordance with their means.[259]

247. The George Washington University National Health Policy Forum, *supra* note 241.
248. *Id.*
249. *Id.*
250. Murphy & Murphy, *supra* note 154.
251. 42 C.F.R. § 405.2425 (1991).
252. 42 U.S.C. § 1395x(aa)(2) (1994).
253. *Id.*
254. Murphy & Murphy, *supra* note 154.
255. Such hospitals were created and financed by community leaders. Kovner, *supra* note 145, at 163.
256. Mezey & Lawrence, *supra* note 138, at 129.
257. Jay Green, *Systems' Charity Care Tells Only Part of Story*, MOD. HEALTHCARE, Jan. 11, 1993, at 27.
258. *Id.*
259. Mezey & Lawrence, *supra* note 138, at 129.

Clinic structures vary among hospitals. Clinics can be either physically attached to a hospital or freestanding. Some hospitals own and operate clinics. Others form partnerships with physician groups or community health clinics.[260] Hospitals may also acquire or form multiple partnerships, resulting in the creation of a primary care network.[261] Finally, hospitals wishing to expand primary care services without starting or acquiring clinics may sponsor the conversion of an existing clinic to a Federally Qualified Health Clinic or Rural Health Clinic.[262] Clinics originally received primary sponsorship from teaching hospitals and medical schools, but these institutions proved less successful in sponsoring community health clinics than community-controlled corporations. By the mid 1970s, community corporations became the sole sponsors of community health clinics.[263]

Although community health centers and hospitals turned away from each other as they began competing for patients, they are now attempting to collaborate.[264] For example, the Plainfield Neighborhood Health Services Corporation, which operates the Plainfield Health Center, and the Muhlenberg Regional Medical Center, an acute-care regional teaching hospital, combined their ambulatory services to eliminate wasteful duplication of medical services and to give medical residents improved outpatient training.[265] Hospitals administrators are also interested in developing relationships with CHC/MHCs because they help relieve emergency room overcrowding and provide primary care access points for the hospitals, thereby serving to enlarge their patient bases.[266] CHC/MHCs are interested in collaborating with hospitals because hospitals generally possess better resources. Additionally, a hospital's close ties with physicians and other health care professionals can aid in increasing the continuity of care provided to patients.[267]

260. Julane W. Miller & Susan Walmsley-Ault, *The Hospital-Health Center Collaborative: A Model for Ambulatory Care*, J. AMBULATORY CARE MGMT., Oct. 1990, at 22.

261. Murphy & Murphy, *supra* note 154.

262. *Id.*

263. Zuvekas, *supra* note 215, at 1-3.

264. *Id.* at 8.

265. Miller & Walmsley-Ault, *supra* note 260, at 22.

266. Zuvekas, *supra* note 215, at 8-9.

267. *Id.* at 9.

Some hospitals, generally public hospitals,[268] are pioneers in the creation of clinical networks. The Parkland Hospital in Dallas, Texas operates a nationally recognized example of such a network. In the late 1980s, Parkland, a public teaching hospital, faced the same emergency room problems as other hospitals across the country. In an effort to curb emergency room use and give its patient population more comprehensive primary care, Parkland introduced a Community Oriented Primary Care (COPC) program in 1989.[269] The COPC program, which includes nine clinics,[270] offers primary care and comprehensive support services, including laboratory, pharmacy, dental, and radiology services.[271] The COPC program attempts to meet the needs of its community by delivering primary care at the neighborhood level.[272]

According to one expert, Parkland's philosophy centers on building a health care system that assumes responsibility for a defined population, focusing on patients in terms of primary and preventive care and public health.[273] Parkland's COPC program remains committed to targeting its services to the community's needs through a formal needs assessment program.[274] This program examines city, county, and state health data to determine the community's greatest health risks.[275] The community-oriented programs implemented by Parkland include a sudden infant death center, which provides counseling for parents; "Project First Step," which follows low-weight babies for five years; and the "Lifespan" program, which teaches teenage mothers about prenatal and maternal care, parenting, and the importance of education.[276]

Observers have concluded that Parkland's COPC program represents a successful model. Before the program started, three-fourths of its patients had never been involved in any form of primary health care.[277] Emergency room visits have dropped 60,000 a

268. *See* John Burns, *Caring for the Community: Hospital Programs Provide a Lifeline for the Inner Cities, But Only a Few Are To Be Found*, MOD. HEALTHCARE, Nov. 8, 1993, at 30.

269. Ellen Sweets, *Community-Based Health Programs: Dallas: Series: The We Decade: Rebirth of Community*, DALLAS MORNING NEWS, Mar. 8, 1995, at 1C.

270. Murphy & Murphy, *supra* note 154.

271. Koska, *supra* note 141, at 26.

272. Anderson, *supra* note 156, at 34.

273. Renee Blankenau, *Caring for the Poor—and More; Public Hospitals Prepare for a Changed Delivery System*, HOSP. & HEALTH NETWORKS, Feb. 20, 1993, at 42.

274. Koska, *supra* note 141, at 25.

275. *Id.*

276. Renee Blankenau, *Foster G. McGaw Awards: Defining and Solving Community Problems*, HOSP. & HEALTH NETWORKS, July 5, 1994, at 92.

277. *Id.*

year from a decade ago.[278] In addition, asthma, diabetes, and hypertension hospital visits have decreased.[279] Although the hospital invested significant funds to start the COPC program, administrators have concluded that this investment will save them money in the future.[280] Parkland is not the dominant model of hospital care, but it serves as a successful model and has attracted national attention.[281] The Parkland model will likely be one example of the future structure of hospitals and the care they will provide.

Although successful community health care programs improve public health, reduce the need for expensive services, extend inpatient services, and alleviate emergency room overcrowding, few private hospitals operate such programs, leaving the task to public hospitals.[282] According to one public hospital administrator, "[a]lthough organizations such as the American Hospital Association constantly discuss the development of community care networks, very few not-for-profit hospital systems are developing them."[283]

For-Profit Clinics

The term "for-profit clinic" refers to two types of clinics: ambulatory care centers and ambulatory surgical care centers. Ambulatory care centers (ACCs) began as emergency centers for patients with non-life threatening conditions.[284] These include two types of facilities. The first type, an urgi-center or walk-in clinic, is usually

278. *Id.*
279. *Id.*
280. *Id.*
281. *See id.*
282. Burns, *supra* note 268, at 30.
283. *Id.* In an effort to increase their patient bases, hospitals are also investing in ambulatory care centers, including urgi-care, emergi-care, and surgi-care centers. Physician ownership of these centers is decreasing, and hospital ownership is increasing. Joyce Riffer, *Hospitals Becoming Driving Force in ACC Market*, 60 HOSP. & HEALTH NETWORKS 67 (1986). The increase in hospital ownership results from the desire of hospitals to integrate their services vertically, thereby increasing their patient bases through a feeder system. *Id.*

To control the flow of patients in emergency departments, hospitals have adopted triaging programs. Murphy & Murphy, *supra* note 154. Through triage, the condition of each patient is evaluated and classified as emergent or non-emergent. *Id.* If the patient is non-emergent, he or she is redirected to outpatient services, another hospital, or a freestanding clinic. *Id.* The patient obtains appropriate care while leaving the emergency room free for emergent patients. Despite this advantage, triage only redirects patients. Unlike clinic networks, triage fails to establish a continuum of care, providing only episodic care. *Id.*

284. Anthony Birritteri, *Ambulatory Care Centers: Expeditious Medical Service*, 39 N.J. BUS., Feb. 1993, at 16.

open seven days a week, twelve hours a day. The second type, an emergi-center, receives patients twenty-four hours a day, 365 days a year.[285]

The number of ACCs in the United States' health care delivery system is growing rapidly. In 1993, there were an estimated 5,492 ACCs in the United States, a 32% increase from the previous year.[286] ACCs are attractive to patients because they are open long hours, generally do not require appointments, and usually do not have long waiting periods.[287] ACCs emphasize service, making patient satisfaction a high priority.[288] In addition, ACCs, which usually operate as for-profit institutions, have lower costs than hospital emergency rooms, due in part to the fact that they do not inflate paying patients' prices to compensate for the care the hospital provides indigent patients.[289] In 1993, the average cost for a visit to an ambulatory care center was $60.[290] Although ACCs began as an option for injured individuals not in need of a hospital emergency department, they have since expanded into other areas such as primary care, pediatrics, orthopedics, employee health, cancer treatment, diagnostic imaging, physical therapy, and other medical specialties.[291] Some centers deal exclusively in specialty treatment such as dialysis and cancer treatment.[292]

ACCs generally require payment or proof of worker's compensation eligibility at the time services are rendered.[293] However, pa-

285. Suzanne B. Cashman et al., *Investor-Owned Ambulatory Care Walk-in Centers: How Have Primary Care Physicians Responded?*, 11 J. HEALTH CARE MARKETING 61 (1991).

286. John Burns, *Outpatient Care Growing Both in Numbers, Scope*, MOD. HEALTHCARE, May 23, 1994, at 81.

287. Barbara Bigelow, *Ambulatory Care Centers: Are They a Competitive Advantage?*, 36 HOSP. & HEALTH SERVICES ADMIN. 351 (1991).

288. Cashman et al., *supra* note 285, at 61.

289. Birritteri, *supra* note 284, at 16.

290. *Id.* Costs ranged between $38 and $100. *Id.*

291. John Baronowski, *Labs in Ambulatory Care Centers: Medicine's Growth Sector*, 17 MED. LABORATORY OBSERVER 26 (1985); Burns, *supra* note 286, at 81; COMMITTEE ON IMPLICATIONS OF FOR-PROFIT ENTERPRISE IN HEALTH CARE, FOR-PROFIT ENTERPRISE IN HEALTH CARE 37 (Bradford H. Gray ed., 1986) [hereinafter COMMITTEE].

292. *See* COMMITTEE, *supra* note 291, at 38; Arnold S. Relman, *The Health Care Industry: Where Is It Taking Us?*, 325 NEW ENG. J. MED. 854, 855 (1991); Michael A. Romansky & Diane S. Millman, *Legal, Regulatory, and Reimbursement Issues Affecting Ambulatory Health Care Providers: Surgicenters, Diagnostic Centers, Radiation Therapy Centers, and Clinical Labs*, *in* HEALTH LAW HANDBOOK, 171, 175 (Alice G. Gosfield ed., 1989).

293. COMMITTEE, *supra* note 291, at 106.

tients can receive reimbursement from third-party payers, depending on the individual's health care policy.[294]

Originally only physicians owned ACCs.[295] Now, ownership of ACCs is divided among physicians, hospitals or hospital systems, and for-profit corporations.[296] Hospital-owned centers comprise the fastest growing segment of the ACC industry.[297] Although not-for-profit hospitals operate them, most centers are run as for-profit enterprises.[298] Hospitals open ACCs to retain patients and increase revenues, although some studies indicate there is no proof that ACCs accomplish either of these goals.[299]

Ambulatory Surgical Centers (ASCs) perform surgical procedures that do not require an overnight stay.[300] Ambulatory surgery grew rapidly in the 1980s because of three developments: new technologies made more outpatient surgery possible; third-party payers encouraged use of them; and patients found ASCs more convenient.[301] As of 1993, there were an estimated 1,862 ambulatory surgery centers in the United States. Seventy-seven percent were independent, seventeen percent were corporate-owned, and six percent were hospital-owned.[302] Like ACCs, almost all ASCs are run as for-profit enterprises.[303] Corporate chains with multiple facilities represent the fastest growing section of ambulatory surgical centers.[304]

Although freestanding ambulatory facilities provide many benefits, they present two significant problems. The first problem is quality assurance. Public regulation of freestanding centers, which are generally not subject to the same standards as hospitals, varies greatly from state to state and is extremely limited in some cases.[305] The second problem is fragmentation of care. Because freestand-

294. Brenda L. Becker, *Ambulatory Care Centers: Off and Running*, 15 MED. LABORATORY OBSERVER 39, 40 (1983).

295. COMMITTEE, *supra* note 291, at 36-37.

296. *Id.* at 37.

297. Bigelow, *supra* note 287, at 353.

298. COMMITTEE, *supra* note 291, at 38.

299. *See* Bigelow, *supra* note 287, at 352.

300. COMMITTEE, *supra* note 291, at 35.

301. Irene Fraser, *Healthcare Policy: Ambulatory Care and Healthcare Reform*, 2 ANNALS OF HEALTHLAW 215, 219 (1993).

302. Harris Meyer, *Hospitals Respond By Expanding Outside Care: Ambulatory Care and Home Health Centers*, AM. MED. NEWS, Jan. 9, 1995, at 38.

303. COMMITTEE, *supra* note 292, at 37.

304. Meyer, *supra* note 302, at 34.

305. Fraser, *supra* note 301, at 222.

ing centers specialize in certain types of care, the treatment of patients can become fragmented and lack continuity.[306]

III. Strengthening Community-Based Health Care

This part begins by developing the rationale for a decentralized, "bottom-up" community-based approach to health care. It then discusses two specific implementation strategies: encouraging volunteerism and community-based models for reforming health care.

Rationale for Community-Based Health Care

Alienation and loneliness characterize late twentieth century America. Making our institutions smaller and more comprehensible may not only facilitate their revitalization but also provide affordable preventive and primary health care, especially for the uninsured and underinsured. In the future, people may want to assume a greater degree of control over their lives, rather than leaving key decisions and their implementation to far removed, nameless, faceless legislators and bureaucrats. Citizenship and public involvement, through participation and empowerment, matter. Participation connotes more people taking control over their lives, taking charge and organizing for themselves. Participation is based on the premise that no one has the right to make decisions affecting an individual without that person taking part in the decision-making process. Involvement in decision-making also serves to promote human developments. Focusing on community-based health care will enable each person to see the need for an active role in society where each person's actions have meaning and impact. Smaller political units, which characterize a decentralized approach to health care, are less complex and therefore more comprehensible.

Beyond recognizing that citizenship matters and encouraging a higher degree of participation in local institutions, the implementation of community-based health care serves another, more pragmatic, goal. Decentralization would encourage localities to experiment with various techniques designed to meet the nation's health care crisis. We next consider two community-based health care strategies: (1) encouraging volunteerism and (2) reforming health care at the local level.

306. *Id.*

Encouraging Volunteerism

Introduction

With spiraling medical costs, limited access to health care, and millions of uninsured Americans, we need to devise solutions. Although many people argue that radical change of our health care system is necessary, almost everyone agrees that the quality of our health care system is among the best in the world. Most agree that we need to devise programs that will allow everyone in our society access to quality medical care without causing our government to go bankrupt or the quality of our medical care to deteriorate. One solution that some doctors propose is to implement a mandatory national health service program whereby doctors are required to give time serving the poor in order to obtain a license in any jurisdiction. Another solution is to encourage non-mandatory volunteerism as a means of staffing free clinics.

Mandatory Volunteerism

One controversial solution to help alleviate the national health care problem focuses on requiring physicians to give their services to the poor or indigent population as a condition for licensing. Several different proposals have been suggested.

American Medical Association's Position

The proposal put forth to the American Medical Association was premised on the notion that physicians have historically devoted much of their practices to uncompensated care.[307] Actually, as far back as 1846, the American Medical Association's original Code of Ethics stated that "to individuals in indigent circumstances, professional services should be cheerfully and freely accorded."[308] In fact, according to an AMA survey conducted in 1994 to determine the extent of charity care by physicians, 67.7% of U.S. doctors provide some amount of care to patients without charge or at reduced fees.[309] In contrast, a survey conducted in 1988 showed that only 62% of physicians were providing charity care at that time.[310] At least in part, this increase in charity care is thought to be the result

307. *See* AMA's Council on Ethical and Judicial Affairs, *Caring for the Poor*, 269 JAMA 2533 (1993).

308. George D. Lundberg & Laurence Bodine, *50 Hours for the Poor*, 73 A.B.A. J. 55 (1987).

309. MARTIN L. GONZALEZ, AMERICAN MEDICAL ASSOCIATION, SOCIOECONOMIC CHARACTERISTICS OF MEDICAL PRACTICE 1995 at 11 (1995).

310. *Id.* at 12.

of an increase in the number of uninsured.[311] The survey also found that physicians are giving more time each week to charity care. In 1994, they gave 7.2 hours a week, or 12.4% of working hours, to charity care, compared to 6.5 hours, or 10.6% of their total practice time in 1990.[312] The dollar value of the charity care donated by physicians in 1994 amounted to a staggering $11.3 billion.[313]

Although these numbers are impressive, the survey does not address why one-third of physicians do not provide any charity care despite widespread public attention to the need for such services.[314] The AMA president, Robert McAffee, M.D., said, "For many patients charity care is their only means of obtaining necessary medical care. And, until significant reform is achieved, it remains a critical part of health care delivery."[315] The AMA president went on to describe his own charity care as a surgeon as "a routine part of my ethical responsibility to the community."[316] This statement leads to the question of how can we get all (or at least more) physicians to feel that it is their ethical responsibility to provide charity care?

One proposal to the AMA in 1992 attempted to answer the question by requiring physicians to devote 10% of their income or fifty hours a year to care for the indigent.[317] This proposal was rejected. However, in 1990, the AMA's Council on Ethical and Judicial Affairs included the following statement in its Fundamental Elements of the Patient-Physician Relationship: "Physicians should continue their traditional assumption of a part of the responsibility for the medical care for those who cannot afford essential health care."[318] Many people believe that all doctors should, "as a matter of ethics and good faith, . . . contribute a significant percentage of their total professional efforts without expectation of financial renumeration."[319] However, there remains reluctance to require charity care as a matter of AMA policy. Although the proposal to the AMA was probably rejected because of the common

311. J. Duncan Moore, Jr., *Physicians Providing More Charity Care, Although 32% Do None, AMA Survey Finds*, MOD. HEALTH CARE, June 5, 1995, at 26.
312. Gonzalez, *supra* note 309, at 12.
313. *Id.* at 13.
314. Moore, *supra* note 311.
315. *Id.*
316. *Id.*
317. *Id.*
318. *Id.*
319. Lundberg & Bodine, *supra* note 308, at 55.

belief that charity care should be given out of concern and kindness rather than forced upon physicians, another even more controversial proposal has been suggested.

Mandatory Service as a Requirement for Graduating Medical School

In a proposal contained in the Journal of the American Medical Association, the author writes that the solution to the national health care problem lies in incorporating national health service into graduate medical education.[320] Two major problems with our nation's health care system form the basis of this solution, namely, the need for more generalists and the geographic concentration of physicians.

First, there are far too many specialists in comparison to general physicians.[321] Currently, only about 2% of medical students choose further education in areas of general practice, such as internal medicine, family practice, or pediatrics.[322] The Council on Graduate Medical Education and the Association of American Medical Colleges have recommended that 50% of medical students should receive further training as generalists.[323] Possible solutions for training more generalists include revising medical education, restricting the number of postgraduate training residencies offered in non-primary care specialties, and providing economic incentives to induce more physicians-in-training to choose primary care as their field of practice.[324]

Second, physicians often do not locate in the areas of greatest need. Most affluent metropolitan areas have too many specialists, while other areas lack even a single generalist. This second problem, of course, is far more difficult to solve. Even if we achieve a better mix of physicians, it remains difficult to attract and keep doctors in rural, inner-city, and other underserved areas.[325] Physicians want access to facilities, laboratories, and colleagues not often found in these environments. Additionally, 80% of medical students graduate with loans exceeding $55,000.[326] This high debt

320. Michael M.E. Johns, *Mandatory National Health Service: An Idea Whose Time Has Come*, 269 JAMA 3156 (1996).
321. *Id.*
322. *Id.*
323. *Id.*
324. *Id.*
325. *Id.*
326. Johns, *supra* note 320.

causes young physicians to train for high-paying specialties and stay in affluent areas.[327]

327. What is the best way to solve the problems of physician mix and distribution and achieve the goal of universal access to health care? According to Dr. Michael Johns, "the best way to get physicians into underserved areas is to expand the National Health Service Corps and to incorporate national health service into graduate medical education." He suggests the following structure:

After four years of medical school, followed by the normal one year internship, the path of the physicians would divide into: (1) those pursuing generalist training, and (2) those pursuing specialist training. For those pursuing generalist training, after completion of their internship year they would spend two years of advanced generalist residency training. After completing this residency training, these physicians would serve two years in the National Health Service at their earned, advanced level of rank and pay. Upon completion of their service, they would receive a stipend equivalent to the cost of three years of the cost of medical school.

For the group pursuing specialist training, after the internship year, their advanced training would be delayed. They would go directly into national service for two years, earning a salary comparable to a public health service officer. After completion of their service, the members of this group would be able to apply for and pursue advanced specialist training. This group would receive a stipend at the end of their service equivalent to only two years of the cost of medical school. For both groups, however, debt repayment and interest accrual would be deferred during the period of national health service.

The opportunity to pursue immediately advanced training and to receive a stipend equal to the cost of medical school for only two years of service will provide an economic incentive for medical student to pursue generalist training.

Dr. Johns argues that financing for this system exists. He figures that the cost of paying 16,000 physicians per year in an expanded national health service would amount to only about 0.1% of the estimated $1 trillion a year cost of health care in two to three years (assuming an annual salary of $40,000). The nation would realize a cost savings by discouraging unnecessary and costly specialized training, combined with the health care dollars saved through proper distribution of preventive and primary care. According to Dr. Johns, this cost savings will more than offset the costs of this revised system of graduate medical education.

Many physicians do not approve of Dr. Johns' proposal. The underlying concern is that requiring medical students to perform national services restricts the student's freedom of choice. Although it is true that the requirement of national service will restrict young physicians for a brief time, the government imposes all types of requirements to help better serve the public welfare. In addition to the potential benefit society will reap from a mandatory national service program, physicians will also benefit. The physicians will not only receive paid on the job training, but will have their loans virtually paid off by the time they are finished with their service. They will then have more freedom in their career because they will not have the tremendous burden of $50,000 indebtedness.

Another criticism of the program is that it will not provide quality care because young, inexperienced physicians will be the care givers. However, care can be given in teams with more experienced physicians working as captains. This system will provide top-quality care while simultaneously enhancing the training of the less experienced physicians.

Although this type of solution has tremendous potential to solve the access problems of our nation's health care system, it will unlikely be implemented without the widespread support of the medical community. Because physicians, along with the members of any profession, will most likely be unwilling to accept proposals that

Non-Mandatory Volunteerism

Although requiring physicians to serve the poor as a matter of policy has great potential to solve the access problems of our nation's uninsured, it is necessary to consider alternatives that physicians will more likely accept. One such solution is to encourage non-mandatory volunteerism as a technique to staff free clinics thereby enhancing community- based health care. But the question remains how we can effectively accomplish this goal as a means of resolving the national health care crisis.

The AMA's Position

Perhaps the best resource our country can utilize is the large population of retired and senior physicians. This group of doctors, estimated at 55,000,[328] has the experience, financial security, and most importantly the willingness to contribute their time and serve to their local communities. The AMA "supports and encourages the utilization of retired and senior physicians who have maintained a required level of competence for the purpose of satisfying the need for physicians in inner-city and rural areas."[329] The AMA also supports the use of retired physicians to provide voluntary medical care to indigent populations and employed individuals who do not have medical coverage.[330] Currently, expensive liability insurance serves as the major stumbling block to utilizing retired physicians who seek to volunteer. After conducting an investigation, the AMA formulated the following recommendations to help encourage volunteerism by retired physicians:

> (1) That the American Medical Association request that the federal government encourage volunteerism among physicians as well as other professionals in law, education, etc., and that in doing so it would provide for the necessary liability waivers and projections that would make it more attractive for volunteers to serve.

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will require members of their profession to perform services they might choose not to do, it is necessary to consider more viable solutions. One solution may be to simply make Dr. Johns' proposal voluntary instead of mandatory. The program would still offer tremendous economic incentive for those wishing to participate, but will be more likely to gain widespread approval. *See* Johns,*supra* note 320; Gary L. Brown et al, *Mandatory National Health Service*, 270 JAMA 2805 (1993).

328. Fred Wurlitzer & Robert McCool, *Liability Immunity for Physician Volunteers*, 272 JAMA 31 (1994).

329. AMERICAN MEDICAL ASS'N, HOUSE OF DELEGATES ACTION 95 (June 1995).

330. *Id.*

> (2) That the AMA request that the appropriate agency in the federal government study and consider the feasibility of developing a National Retired Professionals Volunteer Public Service Corps with professionals from many disciplines.
> (3) That the AMA, should the federal government establish a National Retired Professional Volunteer Public Corps, lend its support to medical associations and speciality societies in the formulation of a Retired Professional Volunteer Public Service Corps with professionals from many disciplines.
> (4) That the AMA continue to encourage physicians to serve as volunteers in their communities, and further that it continue efforts to lobby for better protection for physicians against malpractice suits and immunity form professional liability for senior, part-time and other physicians who volunteer their services ... . .
> (5) That the AMA reaffirm [the policy], which encourages establishment of programs that will have appropriate levels of government pay professional liability premiums or indemnify physicians who deliver free services in free clinics or otherwise provide free care to the indigent.[331]

The AMA's recommendations contain the recurring theme of organized volunteer programs with protection from liability for the participants. Although the need for the protection from liability appears evident, some groups consistently lobby against such measures for fear that the poor will be injured from inappropriate medical care without remedy.

Fortunately, states already use various forms of "Good Samaritan" laws and other mechanisms to protect volunteer physicians.[332] By providing immunity from liability and negligence, Good Samaritan statutes encourage doctors to provide treatment voluntarily. For instance, Massachusetts requires that licensed physicians render medical services to a person experiencing a medical emergency, whether or not the person is able to pay.[333] The majority of states, however, provide inadequate protection for volunteer physicians.

The solution may lie in government-paid insurance premiums. The doctors would be protected from personal liability without paying for their own coverage while their patients would be able to seek remedies in the event of malpractice. However, taxpayer dol-

331. *Id.* at 97.
332. *Id.*
333. *See* George Annas, *Beyond the Good Samaritan: Should Doctors Be Required to Provide Essential Services?*, HASTINGS CENTER REP., Apr. 1977, at 16.

lars will be needed to pay for the insurance premiums in a time of consistent budget cutbacks. Overall, though, the cost savings from providing preventive and primary care for only the cost of malpractice insurance offers a tremendous benefit. Thus far, several states have launched cost-saving programs through the passage of appropriate legislation, while other states struggle to do the same.

Protecting Volunteer Physicians From Liability Claims

More and more physicians today are retiring at younger ages.[334] The most common explanation is the ever-increasing difficulty of practicing medicine in the U.S. in the face of a rapidly changing health care environment and rising professional liability claims.[335] Of course, with more physicians retiring early, an underused resource has started to swell. Many of these physicians would like to volunteer but are frustrated by the failure of their state legislatures to pass legislation dealing with potential malpractice liability.

For instance, in Massachusetts a strong demand for more volunteer opportunities for physicians led the Massachusetts Medical Society to invite all 1,200 known retired physicians in the state to join an organized community service campaign.[336] The physicians responded with overwhelming concern; over half of them accepted the invitation.[337] Because many of the physicians no longer carried malpractice insurance, the state needed to pass legislation to protect them from liability claims. Most thought this would not be a difficult challenge as shielding these doctors from liability seemed like a small price to pay for the service they sought to provide. The Massachusetts Medical Society introduced legislation that would have granted immunity from a professional liability action for ordinary negligence to physicians who volunteer in underserved areas.[338] The immunity would have been limited to their volunteer activities. Although expectation for passage was high, opposition "by the Massachusetts Association of Trial Attorneys and the Massachusetts Bar Association prevented the legislation from emerging out of committee."[339]

334. Barry Manuel, *No Good Deed Goes Unpunished*, WALL ST. J., Oct. 21, 1994, at A14.

335. *Id.*

336. *Id.*

337. *Id.*

338. *Id.*

339. Manuel, *supra* note 334, at A14.

State Initiatives

State legislation allowing physicians to volunteer without personal liability constraints have achieved a number of great successes. Several successful programs have begun in Florida. One program, run by the Senior Friendship Centers, Inc., operates in four Florida counties. The center runs nonprofit volunteer clinics which serve patients age 55 and older.[340] Although many of the patients are indigent or uninsured, none are ever turned away. The clinics serve more than 10,000 patients a year with the help of over 100 volunteer physicians, mostly comprised of retirees.[341]

Florida law is a key factor in the center's success. Physicians who retire in the state can obtain a special medical license to work in nonprofit settings.[342] More importantly, physicians and other volunteers have strong personal liability protection when they provide care for the needy. Florida covers liability judgments through a risk management trust fund.[343] Another successful Florida program, called We Care, operates in twelve Florida counties. Under the We Care program, volunteer doctors and hospitals give free medical and surgical care on a rotating basis to patients referred to them. The care includes office visits, laboratory tests, and surgery.[344] Potential patients are screened; if they qualify they will receive medical care free of charge.

In Marion County alone doctors and hospitals provided more than $2 million of volunteer medical care in one year.[345] Designed to cut down on expensive and unnecessary trips to the emergency room, the program provides access to primary and preventive care for the uninsured and the indigent.[346] The cost to the county constituted only a fraction of the value of the service provided. Florida offers just one example of the benefits a state realizes by encouraging volunteerism.

Washington and Kentucky have adopted similar measures that set up state subsidies for professional liability premiums for volunteer physicians.[347] Virginia set precedent when it enacted a statute

340. *Retired, But Not From Medicine*, 38 AM. MED. NEWS 19 (Aug. 21, 1995).
341. *Id.*
342. *Id.*
343. *Id.*
344. Lesley Clark, *We Care Program Offers Free Medical Help to Those in Need*, ORLANDO SENTINEL, Mar. 28, 1995, at Lake Sentinel 5.
345. Richard T. Bosshardt, *We Care Improves Medical Care Without Needless Laws*, ORLANDO SENTINEL, June 22, 1994, at Lake Sentinel 4.
346. Clark, *supra* note 344.
347. Manuel, *supra* note 334.

in 1983 holding volunteers at free clinic throughout the state free from malpractice liability unless they are grossly negligent.[348] In Missouri, a statutorily required legal expense fund protects health care providers who volunteer at free clinics.[349] Although more and more states are following the trend to encourage volunteerism, much work remains to be done at the state level.

Federal Initiatives

At the federal level, Senator Daniel Coats (R-Indiana) has introduced legislation that would encourage the provision of medical services in medically underserved communities by extending federal liability coverage to medical volunteers.[350] Specifically, the bill would require that a medical professional who provides health care service to a medically underserved person without receiving compensation be covered by the federal tort claims provisions for purposes of any medical malpractice claim arising in connection with the service.[351] To qualify for this protection, the health care professional would be required to furnish the service without charge to any person and to notify the recipient of care of the limited liability. The legislation explicitly preempts inconsistent state laws. However, it would not hamper state laws providing greater incentives or protections.

In an effort to expand access to health care services to low-income individuals, Kassebaum-Kennedy also includes a provision designed to shield certain health care volunteers from malpractice liability. Specifically, the law extends Federal Torts Claims Act coverage to medical volunteers in free clinics by deeming such individuals to be employees of the U.S. Public Health Service.[352]

Health professionals must meet certain conditions to fall within the protection of this provision. They must be licensed or certified in accordance with applicable law, and they must be volunteers. They may not receive compensation for the services in the form of salary, fees, or third-party payments.[353] Eligible health professionals must provide qualifying services at a free clinic or through free

348. VA. CODE ch. 1 § 54.1-106, § 32.1-127.3 (Michie 1983).

349. *Health Care Measure, Other Laws Take Effect*, KANSAS CITY STAR, Aug. 28, 1993, at C1.

350. S. 1217, 104th Cong., 1st Sess. (1995).

351. *Id.*

352. 42 U.S.C. § 233(o) (added by of the Health Reform Act of 1996, § 194).

353. *Id.* Health professionals are not, however, barred from receiving reimbursement from a clinic for reasonable expenses (e.g., transportation and supplies). The free clinic may also receive a voluntary donation from a patient. *Id.*

clinic programs or events. Health care professionals must provide written notice of limited liability to patients. Free clinics must apply to the U.S. Department of Health and Human Services to have each health care professional deemed a "free clinic health professional" covered by the new legislation. Finally, the legislative history indicates that the new provisions do not preempt state laws that provide greater incentives or protections to health care professionals.[354]

In addition to encouraging volunteerism, community-based health care models exist. We turn next to consider these models and the financial and legal issues they raise.

Models for Reforming Health Care at the State and Local Levels

Health care providers throughout the country have begun to develop integrated delivery systems to gain a competitive edge in an era in which all payers demand increased value for their health care dollars. These new delivery systems are bringing together many of the players in the health care system—private hospitals, physician practices, outpatient providers—in an effort to market a simpler, price competitive health care product. Although these efforts ensure increased access and lower costs, they fail to address the long term health care needs of the communities whom they serve.

Alternatively, a community-based model for health care reform shifts the emphasis from treating individuals at a lower cost to treating communities and subpopulations. This is achieved, in part, by examining and responding to population-based indicators of health, such as mortality, and emphasizing both education and prevention. Moreover, a community-based model emphasizes full coordination of a community's health care resources, ongoing community needs assessment, and heightened accountability standards. After analyzing an academic community health model, this section considers a foundation-sponsored comprehensive community health program and the San Diego County Medical Program.

Community Health Model

The key goals of a community-based health care model are: (1) planning, which includes needs assessment, goal setting, evaluation,

354. Text of Conference Report, Joint Explanatory Statement of H.R. 3103, Health Insurance Portability and Accountability Act of 1996, 4 Health Care Policy Rep. (BNA) S-73 (Aug. 5, 1996).

and accountability; (2) intensive participation by the population served; (3) full integration of multiple public and private funding resources; and (4) integration of services and active coordination with other community resources. Although federal funding of rural and community health centers achieves integration of funding resources,[355] it fails to meet the other key goals of a community-based health care model.

Several theorists have offered proposals designed to meet the goals of a community-based health care model, and some communities have achieved success with such programs. These proposals provide important insight into the potential strengths and weaknesses of a community based approach to health care reform.

Professor Steven Shortell, of Northwestern University's J.L. Kellogg Graduate School of Management, has proposed the creation of health promotion and accountability regions (HPARs).[356] According to Shortell, the HPARs would serve as a public-private partnership providing much needed incentives, focus, and organization to health care reform efforts.[357] Under Shortell's proposal, state legislatures would create HPARs, which would serve as the focus of development and implementation of health care policy. The state department of health would appoint representatives of hospitals, physicians, insurers, employers, labor, government, and consumers to a governing board.[358] An executive director assisted by a technical staff trained in clinical epidemiology, statistics, planning and evaluation, and relevant social science disciplines would report to the governing board.[359]

HPARs would assume responsibility for assessing community needs, establishing health care goals, determining premiums, allocating resources, and setting budgets necessary to meet those goals, contracting with health care plans to deliver services, and holding health plans accountable according to predetermined performance criteria. In meeting these responsibilities, HPARs would assess community needs and establish a corresponding benefit package.[360] Provided they operated within their HPAR's policies, health plans

355. *See supra* notes 248-307 and accompanying text.

356. Stephen M. Shortell, *A Model for State Health Care Reform*, 11 HEALTH AFFAIRS 108 (1992).

357. *Id.* at 124.

358. *Id.* at 109.

359. *Id.*

360. *Id.* at 110.

would be free to develop innovative approaches to providing cost-effective, high-quality care to its enrollees.[361]

Shortell foresees various funding sources for the benefit package an HPAR would offer. However, these funding sources would be anchored to traditional employment-based health insurance.[362] Copayments and deductibles would continue to be used.[363] Individuals not covered by employment-based health insurance would be covered through a state health plan financed with revenues deriving from targeted user taxes (e.g ., alcohol and tobacco) and general taxes.[364] The benefit package available to HPAR participants would be the same, regardless of the source of funding. All insurers doing business within the state would be required to offer the benefit package at or below established premiums.[365] Because the HPAR would risk-rate premiums in advance, insurers would have no need to avoid risk by excluding less healthy person.

Based on the region's health needs and available resources, the HPAR would establish a health care budget for each year. This budget would represent a locally determined expenditure cap reflecting the region's mission and health care objectives.[366] Although the financing mechanism for the HPAR budget would follow the play-or-pay model,[367] it differs by focusing on both local determination of needs, benefits and premiums, and its emphasis on community health objectives (as opposed to purely economic objectives). Shortell suggests that large states would have several HPARs, while small states may have only one.[368] However, the HPAR model can be adapted to serve even smaller populations. Moreover, the HPAR model could be modified to allow for further integration of federal, state, and local sources of funding.

Kellogg Initiative

The Comprehensive Community Health Models (CCHM) initiative represents a partnership between the W.K. Kellogg Founda-

361. *Id.*

362. Shortell, *supra* note 356, at 111.

363. *Id.*

364. *Id.*

365. *Id.* at 112.

366. *Id.*

367. Under the play-or-pay model, employers would be required to provide health insurance coverage to their employees or contribute to a public plan. *Id.* at 111.

368. Shortell, *supra* note 356, at 109.

tion and three Michigan counties.[369] The Kellogg Foundation contributes financial and technological resources to help communities bring payers, providers, and consumers together to assess and reform local health systems.[370] The program is designed to assist communities in building a more efficient and effective health care system by strengthening local control and restructuring how services are delivered. Specifically, the program helps communities: (1) assess and prioritize community health needs; (2) redefine health local visioning process; (3) develop a community-driven, comprehensive plan to provide basic care to all residents; and (4) provide community governance for implementation and management.[371]

The CCHM initiative is based on the Kellogg Foundation's experience with over 100 community-based health care projects.[372] The experience indicated that a community's health care delivery system must: (1) be managed by the community so that it reflects the community's needs and priorities; (2) maintain and improve the health status of people by reducing their morbidity and increasing their length of life through health promotion, primary prevention, and primary care; and (3) minimize the impact and costs of an injury, acute illness, or chronic illness through early diagnosis and treatment.[373]

According to program officials, when a community manages its health care resources with an understanding of the nature of its health care problems, the way its providers perform, and the financial limitations of its payers, it can establish priorities and develop programs that expand access, control costs, improve quality, and maximize program satisfaction.[374] To help communities achieve these goals, the CCHM initiative envisions: (1) establishing a community governing board; (2) creating an integrated administrative structure; (3) expanding community-wide coverage; (4) developing a comprehensive integrated delivery system; and (5) designing a health information system.[375]

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369. Pamela A. Paul-Shaheen, *Health Care Reform—A Community-based Alternative: The Comprehensive Community Health Models Initiative*, MICH. MED. 57 (Oct. 1994).

370. *Id.*

371. *Id.*

372. *Id.*

373. COMPREHENSIVE COMMUNITY HEALTH MODELS OF MICHIGAN, AN IN-DEPTH LOOK AT CCHM 2-3 (1994).

374. *Id.* at 3.

375. Paul-Sheehan, *supra* note 369, at 58.

San Diego as a Model for Change

The San Diego County Medical (CMS) Program is an innovative public/private partnership providing health care services to medically indigent adults. Through a coordinated system involving San Diego County, a private sector manager, and private sector providers, the CMS Program provides emergency services, in-patient services, speciality and primary care, and related ancillary services to more than 25,000 individuals.[376]

History of the San Diego Indigent Care Program

Prior to 1983, medically indigent persons in the State of California received health care services through Medi-Cal, the California Medicaid program.[377] When California passed the Medi-Cal Reform Act of 1982, however, the responsibility of providing health care to these persons shifted from the state to the counties.[378] Because San Diego County did not have any public hospitals, it decided to contract with other organizations to provide care to the medically indigent.[379] Initially, the county contracted with four organizations, each responsible for patient care in a certain geographical area.[380] Medicus Systems was hired to administer and to oversee the entire program.[381] Medicus Systems continues to administer the CMS Program.[382] Its responsibilities have included instituting a quality assurance program throughout the county, retrieving, analyzing and reporting program utilization and financial information, and establishing program policies and procedures.[383]

Problems With the Original Program

Four problems plagued the original CMS Program: barriers to access, cost-shifting, varying payment practices, and inconsistent management policies. Access constituted the most serious prob-

376. MEDICUS SYSTEMS CORPORATION, COUNTY MEDICAL SERVICES ANNUAL REPORT 2 (1995).

377. Letter from Robert K. Ross, M.D., Director, County of San Diego Department of Health Services, to Leonard E. Klein, Research Librarian, The George Washington University Law School 2 (Jan. 22, 1996) (on file with author).

378. Ron Threatt, *The San Diego County Medical Services Program*, 38 HENRY FORD HOSP. MED. J. 114 (1990).

379. *Id.*

380. *Id.*

381. *Id.* at 115.

382. MEDICUS SYSTEMS CORPORATION, *supra* note 376, at 5.

383. Threatt, *supra* note 378, at 115.

lem.[384] Under the original program, the four regional contractors assumed the risk for all services.[385] To limit their actual financial risk, contractors may have limited patient access to services. As a Medicus Systems official explained, "Utilization increased 41% in five years. However, appropriations increased incrementally. Arguably, in order to maintain profitability, access [was] denied."[386]

Cost-shifting also troubled the program. Under the original CMS Program, patients entered the program through a clinic or a hospital emergency room.[387] Seeking to limit their financial risk, regional contractors often failed to qualify eligible emergency room patients.[388] As a consequence, hospitals bore the costs of providing care to individuals who were eligible for the CMS Program but had not been qualified by the regional contractors. This resulted in ill will towards the program and uncollectible debts for the hospitals.[389]

The original CMS Program also lacked sufficient control over provider payments. The four regional contractors had the authority to contract with providers, including hospitals, clinics, and physicians, at varying rates.[390] The resulting lack of uniformity among reimbursement rates caused providers confusion and dissatisfaction with the CMS Program.[391] Finally, inconsistent care management policies vexed the CMS Program in its early years. Each individual contractor had a unique style of managing indigent patients' access to the health care system.[392] As a result, management of care techniques varied within the four regions.[393]

As one Medicus official explained, the regionalized, decentralized CMS Program mirrored the Medicaid program to the extent that program policies were centrally formulated but regionally executed, resulting in varying levels of access, service, and reimbursement.[394] This frustrated the CMS Program and left it unprepared

384. *Id.* at 116.
385. *Id.*
386. *Id.*
387. *Id.*
388. *Id.*
389. Threatt, *supra* note 378, at 115.
390. *Id.*
391. *Id.*
392. *Id.*
393. *Id.*
394. *Id.*

to handle a growth in the number of individuals receiving care coupled with a rapid decrease in financial resources.[395]

Solutions to the Early Problems

In 1989, San Diego County dismantled the original CMS Program and implemented the current centrally-administered, county-wide program.[396] Under this program, the four regional contractors have been replaced by the CMS Program's Department of Community Services.[397] CMS bears budget, policy, contract administration, and patient eligibility responsibilities. Centralization of these duties reduces duplication of services and resources. The day-to-day management functions lie with Medicus Systems, which continues to administer the program.[398] To address certain problems associated with indigent patient managed care, especially inconsistent reimbursement levels, the revised CMS Program reimburses its providers from three funding pools.[399] The three pools are: the primary care reimbursement pool, the institutional services reimbursement pool, and the specialty/ancillary reimbursement pool.[400] Each reimbursement pool encourages cost-effective behavior. Specifically, because each pool contains a fixed dollar amount, over-utilization results in a lower reimbursement rate for providers.[401] If, however, funds remain at the end of the year, providers share them.[402]

Primary care clinics receive monthly prospective payments based on expected visits and supplemental charges.[403] Payments are evaluated and restructured three times annually and reconciled at the end of each year.[404] The final reimbursement value of a clinic visit is determined at the end of the fiscal year based on the total number of clinic visits and other expenses reimbursed from the pool.[405] For fiscal year 1995, the primary care risk pool was funded

395. *See* MEDICUS SYSTEMS CORPORATION, CMS PROGRAM: OPERATIONS OVERVIEW 14 (1995).
396. *Id.*
397. Threatt, *supra* note 378, at 116.
398. MEDICUS SYSTEMS CORPORATION, *supra* note 376, at 14.
399. Threatt, *supra* note 378, at 116.
400. PUBLIC ADMIN. SERV., MANAGEMENT REVIEW OF THE DEPARTMENT OF HEALTH SERVICES: COUNTY OF SAN DIEGO, CALIFORNIA 270-71 (1995).
401. MEDICUS SYSTEMS CORPORATION, *supra* note 376, at 9.
402. *Id.*
403. *Id.* at 271.
404. *Id.*
405. Letter from Robert K. Ross, M.D., to Leonard E. Klein, *supra* note 377, CMS attachment.

at $4.5 million.[406] The institutional services reimbursement pool pays hospital and emergency department physicians for services provided to patients during an acute in-patient stay or an emergency department visit.[407] Hospitals receive monthly prospective payments for their services based on historical utilization.[408] Payments are adjusted to reflect actual claims submitted by hospitals. For fiscal year 1995, the institutional services risk pool was funded at $7.3 million.[409]

The specialty/ancillary reimbursement pool reimburses physicians and ancillary service providers for in-patient physician, outpatient physician, and outpatient specialty ancillary services.[410] Physicians and ancillary providers are reimbursed on a fee-for-service basis.[411] The Medi-Cal fee schedule provides interim reimbursement rates that are adjusted to reflect utilization and available funds.[412] For fiscal year 1995, the specialty/ancillary risk pool was funded at $12.8 million.[413]

Current San Diego Program

San Diego County's CMS Program incorporates elements necessary for the success of any indigent care program. Through a system of managed care, the program attempts to combat deficiencies that plague the poorest patients, such as inadequate access to care, overuse of emergency rooms, insufficient preventive care, and meager methods of measuring quality.[414]

Most potentially eligible patients enter the CMS system because they require immediate medical attention.[415] The CMS Program is made available to patients at emergency rooms, hospital admission departments, and community clinics.[416] Potentially eligible persons are given applications and undergo face-to-face interviews and ver-

406. PUBLIC ADMIN. SERV., *supra* note 400, at 270.
407. Letter from Robert K. Ross, M.D., to Leonard E. Klein, *supra* note 377, CMS attachment.
408. *Id.*
409. PUBLIC ADMIN. SERV., *supra* note 400, at 270.
410. Letter from Robert K. Ross, M.D., to Leonard E. Klein, *supra* note 377, CMS attachment.
411. PUBLIC ADMIN. SERV., *supra* note 400, at 271.
412. Letter from Robert K. Ross, M.D., to Leonard E. Klein, *supra* note 377, CMS attachment.
413. PUBLIC ADMIN. SERV., *supra* note 400, at 270.
414. Jeannie Mandelker, *Government Purchasers See Value in Managed Care*, 11 BUS. & HEALTH 40 (1993).
415. Letter from Robert K Ross, M.D., to Leonard E. Klein, *supra* note 377, CMS attachment.
416. MEDICUS SYSTEMS CORPORATION, *supra* note 376, at 7.

ification processes to ensure compliance with eligibility requirements.[417]

The CMS Program employs a managed care approach to coordinate the delivery of services to patients at the most appropriate and cost-effective level of care.[418] Care is actively managed through an innovative medical-social case management approach.[419] To control utilization and to assure timely access to services, patients arrange for their own primary care through an extensive network of clinics.[420] Access to specialty and ancillary care, however, is controlled by Medicus by means of prior authorization procedures and a system of referrals.[421]

In addition, a patient may be assigned to a CMS case manager to assist the patient with special medical and social needs including: homelessness, chronic illness, high medical needs, potential eligibility for other public programs, and appropriate transition to a less intensive form of care.[422] The case manager assesses the patient's needs, plans and coordinates the delivery of services to meet those needs, and evaluates and monitors services.[423] Case management serves as an important cost-containment tool. CMS claims that case management has helped reduce the number of hospital admissions and decrease the average length of hospitals stays, resulting in substantial savings to the program, which spends nearly $369 per day on every hospitalized patient.[424]

Patient Characteristics

To qualify for the CMS Program, individuals must be medically needy and ineligible for Medi-Cal.[425] In addition, individuals must be 21 through 64 years of age, a U.S. citizen, San Diego County residents, have limited property and resources, and meet CMS Program income limits.[426] According to program officials, two-thirds of the nearly 70,000 CMS applicants meet these eligibility require-

417. *Id.*
418. Letter from Robert K Ross, M.D., to Leonard E. Klein, *supra* note 377, CMS attachment.
419. *Id.*
420. MEDICUS SYSTEMS CORPORATION, *supra* note 376, at 7.
421. *Id.*
422. *Id.* at 8.
423. *Id.*
424. *Id.*
425. MEDICUS SYSTEMS CORPORATION, *supra* note 395, at 17. To be eligible for Medi-Cal, individuals must be blind, aged, disabled, or eligible for AFDC. *Id.*
426. *Id.* CMS Program income limits currently coincide with Medi-Cal financial guidelines. *Id.*

ments and receive program approval.[427] CMS patients fall into two major groups: young men aged 21-39 who enter the program as a result of trauma injuries, and older women aged 50-64 who receive services for chronic and acute illnesses, including diabetes, gastrointestinal disorders, and cancer.[428]

Services and Providers

Through the CMS Program, qualified patients receive primary, emergency, and in-patient care, pharmaceuticals, durable medical equipment, selected social support services, emergency dental care, home health care, physical and occupational therapy, and ambulance services.[429] The program does not cover routine physical exams, pregnancy, family planning, and infertility. Services for alcoholism, services for drug addiction, orthodontia, and organ, limb and bone marrow transplants also are excluded.[430]

Private providers furnish care to CMS patients. Specifically, fifteen hospitals, eighteen clinics, and approximately 2,000 physician and ancillary service providers participate in the CMS Program.[431] Experts consider these private providers as central to the success of the CMS Program because they do not face the same challenges as public entities. For example, hospitals and clinics can raise funds from a variety of sources.[432] As the executive director of one clinic explained, "The clinics hustle [for funding], no doubt about it."[433]

Program Administration

Medicus Systems has served as the CMS Program administrator since its inception.[434] Today, its responsibilities include serving as the program's fiscal intermediary, managing provider reimbursement pools, and preauthorizing specialty and ancillary care.[435] In addition, Medicus processes all claims, collects and analyzes financial and quality outcome data, manages utilization review re-

427. MEDICUS SYSTEMS CORPORATION, *supra* note 376, at 16.

428. *Id.* at 10.

429. *Id.* at 4.

430. PUBLIC ADMIN. SERV., *supra* note 400, at 269.

431. MEDICUS SYSTEMS CORPORATION, *supra* note 376, at 17.

432. John J. Goldman & Tony Perry, *Streamlined Approach Key to San Diego Health System*, L.A. TIMES, Nov. 2, 1995, at A1.

433. *Id.*

434. *See supra* notes 397-402 and accompanying text.

435. PUBLIC ADMIN. SERV., *supra* note 400, at 270-71.

sources, and handles patient grievances.[436] In 1995, Medicus received $2.9 million for its services.[437]

Success of the CMS Program

The CMS Program has achieved notable success. In its first ten years of operation the program had saved San Diego County more than $160 million in health care costs.[438] Savings can be attributed in part to the medical and social case management program adopted in 1989. Through case management techniques, the CMS Program has reduced the ratio of outpatient treatments to hospital admissions from 19:1 in 1990, to 15:1 in 1992.[439] In addition, case management techniques have enabled the program to decrease the length of hospital stays. In 1994, the CMS Program had an average hospital stay of 5.3 days compared to the national average of 8.5 days.[440] By reducing both the number and the length of costly hospital stays, the CMS Program has realized significant savings.

The privatization of health care services has also yielded significant savings. According to Dr. Robert K. Ross, director of San Diego County's health services, the advantages of privatization have manifested themselves in four ways: (1) private entities stretch dollars farther than their public counterparts; (2) they make better use of volunteers; (3) they raise their own money; and (4) they avoid costly contract settlements with civil service employees.[441] By making effective use of financial and human resources and securing funds including local donations and foundation grants, CMS providers deliver $1.4 0 of health care for every dollar of county resources.[442]

The CMS Program has effectively met the needs of the community. For example, clinics, which are controlled by a board of local ethnic, community, religious, business, and medical leaders,[443] tailor their services to their neighborhoods. Doctors, nurses, and other health care practitioners at one clinic speak Spanish, Hmong, Vietnamese, Laotian, and Cambodian, and are trained to provide

436. *Id.* at 271.
437. *Id.* at 270.
438. Mandelker, *supra* note 414, at 41. Savings are based on the per-patient cost of care versus the per-patient cost of care for Medi-Cal patients. *Id.*
439. *Id.* at 42.
440. Threatt, *supra* note 378, at 116.
441. James O. Goldsborough, *Los Angeles Pays for Waiting Too Long*, SAN DIEGO UNION TRIB., Aug. 28, 1995, at B7.
442. Joel Kotkin, *Privatizing Health Care for the Poor*, WALL ST. J., Aug. 23, 1995, at A12.
443. *Id.*

culturally sensitive and personalized service.[444] As a result, the clinic is equipped to assess community health care needs and to devise ways to meet those needs in a cost-effective manner.[445]

Limitations of the CMS Program

The major limitations of the San Diego CMS Program stem from a lack of funds. Cuts in funding have forced the program to tighten eligibility criteria, leaving many working poor outside the program.[446] In 1993, for example, in the face of budget constraints the program excluded undocumented aliens, saving an estimated $7.5 million annually.[447] Experts also predict that if funds available for the program continue to be insufficient to meet demand, provider reimbursement rates may be reduced to such a level that providers will refuse to participate in the program.[448]

Currently, a lack of external methods for measuring medical outcomes also hampers the CMS Program.[449] Experts believe that the development of a mechanism to provide medical oversight of the program by those with medical or nursing backgrounds would address this problem.[450]

Implementing a CMS-Type Program in Other Cities

The implementation of a CMS-type approach to providing health care to indigent populations would impact greatly the traditional role of counties.[451] Currently, counties often serve as a provider of last resort, serving those who have no alternatives means of securing health care.[452] Consequently, county hospitals typically bear the burden of caring for the poor, who are easily forgotten by the public and political bodies. In San Diego, however, the county only arranges for indigent health care services, it does not provide care directly.

As brokers of care, San Diego and other California counties (e.g ., Orange County, California) have succeeded in savings large sums of money while simultaneously providing a safety net for low-in-

444. *Id.*
445. *Id.*
446. Jack Cheevers, *Privatizing Hospitals: A Simple Cure?*, L.A. TIMES, Aug. 17, 1995, at A1.
447. *Id.*
448. PUBLIC ADMIN. SERV., *supra* note 400, at 273.
449. *Id.*
450. *Id.*
451. Bruce Bronzan, *The Revolution in Health Care*, CAL. J., Aug. 1, 1995, at 18, 22.
452. *Id.*

come individuals.[453] Whether other counties have the ability to emulate these programs remains unclear. For example, Los Angeles is under immense pressure to privatize its public health system.[454] Opponents argue, however, that privatization would not work in Los Angeles, which has the nation's highest rate of uninsurance.[455] They claim that outside providers are likely to save money by turning indigent individuals away and reducing staffing levels.[456] Critics also fear that private hospitals may be unwilling to serve injured gang members, homeless persons, and substance abusers.[457] Nevertheless, privatization remains a viable option for Los Angeles and other counties struggling with ensuring health care for indigent populations.

Policy makers interested in implementing a community-based death care system in other localities must consider two key questions, namely, the need to obtain financing for community based health care and legal issues affecting local reform efforts.

Obtaining Financing for Community-Based Health care Programs

Analysis of the financing options for community-based health care programs turns on raising revenues or curtailing costs. This section considers three topics, namely, state and local taxing power, public-private funding options, and cost containment schemes.

State and Local Taxing Power

The authority of the states to provide and finance health care is basic to their sovereignty and derives from their general police power.[458] Sub-state jurisdictions have this authority by virtue of delegation from their states.[459] State and local discretion in imposing and collecting taxes is extremely broad.[460] Nevertheless, state and local taxation for the purpose of financing health care reform

453. Cheevers, *supra* note 446, at A1.
454. *Id.*
455. *Id.*
456. *Id.*
457. *Id.*
458. Jacobson v. Massachusetts, 197 U.S. 11 (1905); Industrial Comm'n v. Navajo County, 167 P.2d 113 (Ariz. 1946); Jerauld County v. St. Paul-Mercury Indem. Co., 71 N.W.2d 571 (S.D. 1955).
459. *Jacobson*, 197 U.S. at 25. *See generally* FRANK P. GRAD, PUBLIC HEALTH LAW MANUAL (1973).
460. *See, e.g.*, Oregon Waste Systems, Inc. v. Dep't of Envtl. Quality, 511 U.S. 93 (1994).

may not be structured in such a manner as to constitute regulation of a field preemted by federal law. Moreover, in order for a state or local tax levied on a business conducting interstate commerce to be valid, there must exist a "substantial nexus" between the taxed entity and the state or locality imposing the tax.[461] Beyond these general guidelines, five funding sources exist: general revenue funds, provider taxes, payroll taxes, health insurance taxes, and "sin" taxes.

General Revenue Funds

Legally, states and localities are free to appropriate general funds to pay for health care reform. However, both states and localities are already operating under extremely tight budget constraints and any effort to increase health care coverage will almost certainly require additional revenue or spending cuts in other areas. Popular resistance to increased income and property taxes suggests that taxes targeted at providers, employers and insurers, as well as certain "sin" taxes are more feasible alternatives.

Provider Taxes

Several states have considered or attempted imposing a revenue tax on health care providers to fund state subsidized insurance and other health reform efforts. Such taxes shift the cost of health reform to private insurance plans that health care providers.

One such proposal would assess a "patient" or "bed" tax on hospitals.[462] Hospitals providing financial support to community clinics or running their own clinics[463] would be allowed to deduct such costs from their tax liability.[464] Such a system of taxation and deduction would encourage hospitals to participate in community-based health reform. The burden of the tax on hospitals would be offset in several ways. First, to the extent that subsidized insurance would increase the number of paying patients, hospitals would benefit. Second, the deduction system would relieve pressure on hospital emergency rooms by encouraging the development of primary care clinics.[465] The overwhelming burden of providing primary care in expensive emergency rooms currently strangles the budgets

461. Complete Auto Transit, Inc. v. Brady, 430 U.S. 274, 279 (1977); Quill Corp. v. North Dakota, 504 U.S. 298, 304 (1992).

462. Erik J. Olson, *No Room at the Inn: A Snapshot of an American Emergency Room*, 46 STAN. L.REV. 449, 488 (1994).

463. *See supra* notes 145-156 and accompanying text.

464. Olson, *supra* note 462, at 489.

465. *See supra* notes 145-156 and accompanying text.

of many hospitals, especially those in poor and underserved areas. Increased development of community clinics would help such hospitals by reducing the amount of expensive, uncompensated primary care they currently provide and by allowing them to dedicate resources to more profitable practices.[466]

The MinnesotaCare program represents an additional example of a provider tax scheme. Minnesota has enacted legislation to expand publicly-subsidized health coverage for low income, uninsured persons. The subsidization is financed in part through the imposition of several taxes, including a 2% revenue tax on health care providers.[467] The Minnesota statute grants the state the power to tax any health care provider that actually does business in-state or provides out-of-state services to twenty or more Minnesotans in any year.[468] The statutory provisions attempting to reach out-of-state business have come under attack from scholars and businesses, however, on Dormant Commerce Clause grounds.[469]

In *Complete Auto Transit, Inc. v. Brady*,[470] the U.S. Supreme Court held that a state tax on the operation of interstate commerce is preempted by Congress's plenary power to regulate interstate commerce unless a four-prong test is met. The tax (1) must be applied to an activity having a substantial nexus with the taxing state; (2) must be fairly apportioned; (3) must not discriminate against interstate commerce; and (4) must be fairly related to the services provided by the state.[471]

The "substantial nexus" requirement has been interpreted by the Court to require something more than the "minimum contact" re-

466. Olson, *supra* note 462, at 489. *See also supra* notes 145-156 and accompanying text.

467. MINN. STAT. § 295.52 (1992). The 2% tax is imposed on hospitals, doctors, and certain drug providers. The statute also imposes a 1% revenue tax on HMOs and nonprofit providers. § 256.9352. Additional funding is derived from a tax on cigarettes. §§ 297.02, 297.03.

468. The statute reaches any provider that "regularly solicits business from potential customers in Minnesota." MINN. STAT. § 295.51(4) (1992). There is a statutory provision that a hospital or health care provider "is presumed to regularly solicit business within Minnesota if it receives gross receipts for patient services . . . from 20 or more patients domiciled in Minnesota in a calendar year." *Id.*

469. The Commerce Clause of the U.S. Constitution has been read to prevent states from taxing interstate commerce when the nexus between the taxed entity and the state imposing the tax is not substantial enough to justify the state burden on interstate commerce. U.S. CONST. art I, § 8, cl. 3; *see* Eric H. Chadwick, Comment, *MinnesotaCare: Workable Financing or Just Wishful Thinking?*, 19 WM. MITCHELL L. REV. 961 (1993).

470. Complete Auto Transit, Inc. v. Brady, 430 U.S. 274 (1977).

471. *Id.* at 279.

quired by due process,[472] but not necessarily to require physical presence of the taxed entity within the state.[473] Nevertheless, an entity is presumed not to have "substantial nexus" if its only connection with the taxing state is through the postal system.[474] Moreover, although an entity's activities may have a connection with a taxing state, any state taxation may be prohibited upon a finding that the nexus between the two does not justify the burden.[475]

The MinnesotaCare tax appears to fail the substantial nexus requirement. The mere fact that twenty Minnesota residents leave the state to receive health care creates neither a substantial nexus between the health care provider and Minnesota nor justifies taxation of the service.[476] The MinnesotaCare tax also appears to fail the requirement that the tax be fairly related to the service provided by the state. Because the health care provider receives little or no benefit from Minnesota, the tax is not fairly related to any state-provided services.[477] In light of the potential constitutional challenge to MinnesotaCare's tax on out-of-state providers, state taxation schemes must be drafted carefully to avoid such challenges, and states must consider carefully the role of out-of-state providers on health care reform within their borders.

State provider taxes are also vulnerable to challenges insofar as the taxes are found to "relate to" an ERISA plan by passing along the costs of reform to such plans.[478] The MinnesotaCare provider tax was upheld by a federal district court against an ERISA challenge.[479] The court reasoned that the tax did not "relate to" ERISA plans because the tax did not: (1) negate plan provisions; (2) have a significant effect on ERISA entities; (3) affect the administration of ERISA plans; or (4) have any but a tenuous economic impact on ERISA plans.[480] However, other courts have held that

472. Quill Corp. v. North Dakota, 504 U.S. 298, 312-17 (1992).

473. *Id.* at 314.

474. *Id.* at 315.

475. *Id.* at 313.

476. Chadwick, *supra* note 469, at 983.

477. *Id.* at 986.

478. § 1144(a) of ERISA declares that ERISA shall supersede any and all state laws insofar as they relate to any employee benefit plan. 29 U.S.C. § 1144(a) (1994). For a more detailed discussion of ERISA and its potential preemption of state health care reform efforts, *see infra* notes 522-533 and accompanying text.

479. Boyle v. Anderson, 849 F. Supp. 1307 (D. Minn. 1994), *aff'd*, 68 F.3d 1093 (8th Cir. 1995), *cert. denied sub nom.*, Boyle v. Smith, 116 S.Ct.1266 (1996).

480. *Id.* at 1313-17.

provider taxes are in fact preempted by ERISA.[481] Consequently, state efforts to tax health care providers must be carefully crafted to avoid ERISA challenges.

Payroll Taxes

Another potential source of funding for local health care reform is an employer payroll tax. A general payroll tax on all employers within a state would fall within the state's taxing powers and would not be preempted by ERISA. However, such a tax would erode employer incentives to insure by imposing equal burdens on employers who do provide health benefits and those who do not. Commentators have, therefore, proposed allowing employers to deduct their contributions to employee benefit plans from their tax liability.[482] Seemingly, such a system of taxation and deduction could circumvent ERISA challenges. The tax in this instance would be imposed on employers themselves, not the benefit plans. Moreover, because it would apply to insured and self-insured plans alike, the scheme would not impermissibly burden ERISA plans.

Health Insurance Taxes

Until recently, attempts to assess taxes on health insurance plans were susceptible to challenges insofar as the taxes were found to "relate to"an ERISA plans. However, in *New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co.*, the U.S. Supreme Court upheld a state surcharge on bills of patients whose commercial insurance coverage was purchased by employee health plans governed by ERISA.[483] The Court concluded that such provisions did not "relate to" employee benefit plans within the meaning of ERISA and therefore suffered no preemption.[484]

"Sin" Taxes

Targeted user taxes on products such as cigarettes and alcohol serve as another potential source of funding. For instance, Min-

481. *See* James E. Holloway, *ERISA, Preemption and Comprehensive Federal Health Care: A Call for "Cooperative Federalism" to Preserve the States' Role in Formulating Health Care Policy*, 16 CAMPBELL L. REV. 405, 423 (1994).

482. *See* Randall R. Bovbjerg & William G. Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857, 908 (1986).

483. New York State Conference of Blue Cross and Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995).

484. *Id.*

nesotaCare is partially financed by a cigarette tax.[485] "The political price to be paid for passage of such taxes is slight in most jurisdictions . . . and the correlation between tobacco and alcohol consumption and ill health serves as a compelling argument for using this source as a funding tool."[486] In addition, state revenue derived from legalized gambling may also serve as a potential source of funding.

Public-Private Funding Options

As discussed later in this article, ERISA preempts state attempts to mandate benefits and requires employers provide health insurance to their employees, insofar as such efforts apply to self-insured plans.[487] Prior to the enactment of ERISA, however, Hawaii had sought to achieve universal coverage through an employer mandate.[488] Congress, therefore, exempted Hawaii from the reach of ERISA.[489] Because Hawaii was the only state that had adopted the employer mandate prior to the enactment of ERISA, it is unlikely that Congress will extend the waiver to any other state. As any change to the original state statute requires Congressional action, Hawaii's flexibility in administering and altering its program has been hampered significantly.[490] To date, Hawaii has not been successful in securing permission to make changes to its program.[491] Despite a lack of encouragement from the Hawaii example, states are gambling that Congress will allow them to experiment with employer mandates. At least three states have enacted such legislation, and another six are contemplating such measures.[492]

Other states have opted to circumvent the ERISA obstacle by enacting individual coverage mandates. Minnesota, for example,

485. The Minnesota Health Right Act, 1992 Minn. Sess. Law Serv. ch. 549, art. 9, § 17 (West).

486. Paul Anders Ogren, *Health Care Reform in the States: Where Do We Go From Here?*, STATE HEALTH CARE REFORM, June 1994, at 8.

487. *See infra* notes 522-533 and accompanying text.

488. Hawaii Prepaid Health Care Act, HAW. REV. STAT. § 393 (1993).

489. 29 U.S.C. § 1144(b)(5)(A) (1994) (exempting HAW. REV. STAT. §§ 393-1 to 393-51).

490. INTERGOVERNMENTAL HEALTH POLICY PROJECT, HEALTH CARE REFORM: 50 STATE PROFILES (July 1994) [hereinafter 50 STATE PROFILES].

491. *Id.*

492. INTERGOVERNMENTAL HEALTH POLICY PROJECT, MAJOR HEALTH LEGISLATION IN THE STATES: 1994 at 23-24 (January 1995). Hawaii, Iowa and Minnesota have enacted mandates. HAW. REV. STAT. § 393-1 (1995); IOWA CODE ANN. § 505.21 (West 1996); MINN. STAT. ANN. § 256 (West 1996).

enacted an individual mandate effective July, 1997, subject to the state's securing financing to subsidize premiums for low-income persons.[493] Absent a mandate, states could encourage increased voluntary coverage through similar subsidization programs. To control costs, states should carefully tailor eligibility requirements for such subsidization to target those individuals who are unlikely to self-insure, without attracting otherwise insurable individuals.

Cost Containment Schemes: Global Budgeting

Global budgeting involves setting overall targets or caps on expenditures over a defined period.[494] Several states have enacted or are studying some form of global budgeting to control health care costs.[495] For example, Washington, Minnesota, and Vermont incorporate statewide expenditure caps into their reform plans as a means of controlling health care inflation. Washington caps premiums, Minnesota uses a mix of premium caps and global limits, and Vermont specifies global budget by sector.[496] The principles of global budgeting are particularly attractive in the context of community-based reform efforts. For example, Professor Shortell's HPARs would establish an overall area-wide health care budget based on community rating of the entire population.[497] Within the framework of this budget, the HPARs would contract with health plans.[498] As an incentive to control costs, health plans that operated within their defined budgets would be allowed to keep a significant percentage of the savings.[499]

Legal Issues Affecting Community-Based Reform Efforts

The reform of health care delivery and finance at the local level will necessarily involve new forms of partnerships between health care providers, state and local governments, and insurers, thereby raising a complicated thicket of legal issues. The formation of integrated delivery systems raises antitrust considerations and therefore should be structured in conjunction with legislative efforts designed to protect such joint ventures from federal antitrust liability. In addition, ERISA poses a considerable challenge to any

493. MINN. STAT. ANN. § 256 (West 1996).
494. 50 STATE PROFILES, *supra* note 490, at 15.
495. *Id.*
496. MINN. STAT. ANN. § 62J.04 (West 1996); VT. STAT. ANN. tit. 18, § 9406 (1995); WASH. REV. CODE ANN. § 43.72.800 (West 1995).
497. Shortell, *supra* note 356, at 119.
498. *Id.* at 112.
499. *Id.*

state-based effort at reform. Specifically, federal law may preempt state reforms affecting employment-based welfare benefits, and obtaining federal ERISA waivers for such reforms may be infeasible.

Moreover, relationships between health care providers must be structured around complicated federal fraud and abuse laws and state corporate practice of medicine rules. Further, the structure of primary care initiatives may have tax implications for charitable organizations. Finally, states attempting to reform their Medicaid programs may face barriers in the form of the federal Medicaid waiver process.

Antitrust Issues

Federal antitrust laws affecting the formation of health care delivery systems include: sections 1 and 2 of the Sherman Act,[500] section 17 of the Clayton Act,[501] and the Federal Trade Commission (FTC) Act.[502]

The Sherman Act

The Sherman Act is most relevant to the development of integrated health care delivery systems. Section one of the Sherman Act prohibits contracts, combinations, and conspiracies in restraint of trade.[503] Courts have interpreted section 1 to prohibit only "unreasonable" restraints of trade and have employed one of two standards of unreasonableness: per se unreasonable practices and the "rule of reason" test.

Certain practices are deemed per se unreasonable, including price fixing, market division, concerted refusals to deal, and tying arrangements.[504] Exceptions to the per se unreasonable standard include joint ventures and the "new product doctrine." Under the joint venture exception, physicians who "would otherwise be competitors" are considered a "joint venture" if their integration provides for risk-sharing.[505] Physician groups that contract on a capitated bases[506] share risk and would therefore be considered

500. 15 U.S.C. §§ 1-2 (1994).
501. 15 U.S.C. § 2 (1994).
502. 15 U.S.C. §§ 41-51 (1994).
503. 15 U.S.C. § 1 (1994).
504. Northern Pac. Ry. v. United States, 356 U.S. 1,5 (1958).
505. Arizona v. Maricopa County Medical Soc'y, 457 U.S. 332, 356 (1982).
506. Under a capitation contract, physicians receive a per capita payment that is independent of the number of services provided to the patient or the costs incurred by the physician in furnishing those services. CRS REPORT FOR CONGRESS, HEALTH CARE FINANCING AND HEALTH INSURANCE: A GLOSSARY OF TERMS (1988).

joint ventures. Groups that operate on a fee-for service basis, however, are susceptible to claims of price-fixing and other per se unreasonable practices.[507] Furthermore, under the "new product doctrine" exception, integration that produces otherwise unobtainable benefits, such as a socially desirable product or a decrease in costs is not per se unreasonable.[508]

If an agreement is not per se unreasonable, courts apply the "rule of reason" standard to determine whether it unlawfully restrains trade. Under this standard, courts define the relevant geographic and product markets, weigh the anticompetitive effects and procompetitive efficiencies of the agreement within that market, and evaluate any collateral agreements to determine whether the agreement is reasonable.[509]

State and local reform efforts may escape Sherman Act scrutiny in two ways: the state action doctrine, and the sovereign immunity doctrine. Under the state action doctrine, a state health care reform initiative is exempt from Sherman Act antitrust liability if it passes the two-part test announced by the U.S. Supreme Court in *California Retail Liquor Dealers Ass'n v. Midcal*.[510] The first prong of the *Midcal* test requires the state to explicitly consider the anticompetitive consequences of the legislation.[511] The legislative history must specifically refer to and acknowledge that certain anticompetitive activity will occur under the legislative scheme being considered.[512] The second prong requires states to participate actively in oversight of the trade restraint.[513] The state may be required to conduct ongoing review and to retain ultimate decision-making authority over private interests.[514] If the anticompetitive restraint passes muster under the *Midcal* test, even the conduct of private parties acting pursuant to the state action is immune from antitrust liability.[515]

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507. *See* Carl Hitchner et al., *Integrated Delivery Systems: A Survey of Organizational Models*, 29 WAKE FOREST L. REV. 273, 277 (1994).

508. NCAA v. Board of Regents of the Univ. of Oklahoma, 468 U.S. 85, 101 (1984). *But see Maricopa*, 457 U.S. at 351 (finding that a PPO product was not unique).

509. DOJ and FTC Antitrust Enforcement Policy Statements in the Health Care Area, Antitrust & Trade Reg. Rep. (BNA) No. 1631, at S-3 to S-5 (Sept. 16, 1993).

510. 445 U.S. 97 (1980).

511. *Id.* at 105.

512. FTC v. Ticor Title Ins. Co., 504 U.S. 621 (1992).

513. *Midcal*, 445 U.S. at 105.

514. *Ticor*, 504 U.S. at 624.

515. *See* Southern Motor Carriers Rate Conference v. United States, 471 U.S. 48, 56 (1985).

Absent a clearly articulated state policy indicating an intention to replace competition with regulation, this same immunity has not been extended to subdivisions of state governments, such as counties and other municipalities.[516] Local governments are, however, immune from damage suits under the federal antitrust laws by virtue of the Local Government Antitrust Act of 1984.[517] To secure antitrust immunity, therefore, health reform initiatives must meet either the *Midcal* test (for states) or the *Hallie* test (for local entities), or fall within the purview of the Local Government Antitrust Act.[518] Alternatively, a state or locality seeking to avoid an antitrust challenge to its health care reform plan could seek out a special congressional exemption from federal antitrust laws for anticompetitive activities arising under its reform effort.[519]

To create antitrust shelter through the doctrine of sovereign immunity, the American Hospital Association has successfully disseminated a model certificate of public advantage program that protects certain types of joint action from federal antitrust scrutiny under the Sherman Act.[520] Similarly, fifteen states have enacted cooperative agreements acts or certificate of public advantage programs, which provide oversight and certification agreements in order to create antitrust shelter through the doctrine of sovereign immunity.[521]

ERISA Issues

Generally considered to be the greatest hurdle to state or locally-based health care reform, the Employee Retirement Income Security Act (ERISA)[522] effectively prohibits states and localities from regulating self-insured health plans. Specifically, ERISA regulates pension and welfare benefit plans, and exempts all such employee benefit plans, including health plans, from state or local regulation.

516. *See* Town of Hallie v. City of Eau Claire, 471 U.S. 34, 40-47 (1985). The *Hallie* Court also held that the second prong of the *Midcal* test was inapplicable to municipalities. *Id.* at 46.

517. 15 U.S.C. §§ 34-36 (1994).

518. Robert D. Ray & Brian Lester Smith, *Selected Legal Issues Affecting a State's Movement Towards Health Care Reform*, 42 DRAKE L. REV. 711, 727 (1993).

519. *Id.* at 730 n.98.

520. Kala Ladenheim, *State Oversight of Accountable Health Plans: Prospects and Limits*, 7 THE HEALTH LAWYER 15 (Winter 1994-95).

521. *Id.* at 18.

522. 29 U.S.C. §§ 1001 et seq. (1994).

ERISA Preemption Doctrine

Employee welfare and pension benefits are subject to federal regulation under ERISA. Welfare benefits are defined to include health care benefits provided through the purchase of insurance or self-insurance by an employer.[523] Under the ERISA preemption clause, state or local public sector action that "relates to" any employee benefit plan is preempted by ERISA.[524] However, if the plan chooses to purchase insurance, it becomes subject to state and local regulation of the business of insurance and is saved from preemption under ERISA's "savings clause."[525] Self-insured plans are not covered by the savings clause, and state and local action affecting such plans is preempted by ERISA's "Deemer Clause."[526] It is estimated that more than half of all employees with private health insurance are enrolled in self-insured plans.[527]

Preemption Analysis

In determining whether a state or local law is preempted by ERISA, the analysis first considers whether the law "relates to" an employee benefit plan. The preemption clause has been interpreted broadly by the courts to cover any state or local action that is consistent with the substantive requirements of ERISA.[528]

Next, the analysis focuses whether the state action regulates the "business of insurance" and is therefore saved from preemption. According to the McCarran-Ferguson Act test, the "business of insurance" is a practice that (1) has the effect of transferring or spreading a policyholder's risk; (2) is an integral part of the policy relationship between insurer and insured; and (3) is limited to entitles within the insurance industry.[529]

The final issue is whether the Deemer Clause applies. The Deemer Clause is broadly interpreted by the courts. Specifically, "if the plan is uninsured, the State may not regulate it."[530]

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523. 29 U.S.C. § 1002(1) (1994).

524. 29 U.S.C. § 1144(a) (1994).

525. 29 U.S.C. § 1144(b)(2)(A); *see* Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 732 (1985).

526. 29 U.S.C. § 1144(b)(2)(B) (1994).

527. *See* Fernando R. Laguarda, Note, *Federalism Myth: States as Laboratories of Health Care Reform*, 82 GEO. L.J. 159, 174 (1993).

528. *See, e.g.*, Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990) (failed attempt to limit reach of preemption clause).

529. *Metropolitan Life Ins. Co.*, 471 U.S. at 725-33 (state law requiring mental health benefits "saved" from preemption under the McCarran-Ferguson Act test).

530. FMC Corp. v. Holliday, 498 U.S. 52, 64 (1990).

Implications for State and Local Reform Efforts

State or local laws mandating coverage, mandating certain types of benefits, requiring coverage for certain providers, or regulating providers may be in conflict with ERISA.[531] Such laws will be upheld as applied to insurance policies, but not as applied to self-funded plans. Thus, an integrated health care delivery system may, for instance, be unable to recover payment from self-insured plans for mandated benefits.

Commentators have suggested that self-funded plans should not be able to take advantage of the Deemer Clause to circumvent the provisions of state and local health care reform efforts.[532] They argue that this should be limited, however, to situations in which there is clear and convincing evidence that the law was enacted to further the goals of the state's or locality's reform program and not merely to benefit certain interests.[533]

Anti-Kickback and Self-Referral Laws

The Federal Anti-Kickback Statute prohibits knowing solicitation or offer of payment in return for a referral for services covered by Medicaid or Medicare.[534] The Federal Self-Referral Statute prohibits physician referrals of Medicaid patients to entities furnishing designated services in which the physician has a financial interest.[535]

The original purpose of these statutes was to prevent over-utilization and to contain Medicaid and Medicare costs.[536] The laws were designed, however, to address the problems of a fragmented health care industry and now contradict the current theories of health care reform by complicating and frustrating the integration of physicians into organized delivery systems. Enforcement of these two laws has intensified despite their fading relevance to current reimbursement strategies.[537]

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531. *See supra* notes 478-484 and accompanying text.

532. Ray & Smith, *supra* note 518, at 727.

533. *Id.*

534. 42 U.S.C. § 1320a-7b(b) (1994).

535. 42 U.S.C. § 1395nn (1994).

536. Amy L. Woodhall, *Integrated Delivery Systems: Reforming the Conflicts Among Federal Referral, Tax Exemption, and Antitrust Laws*, 5 HEALTH MATRIX 181, 213 (1995) (discussing the congressional intent of the anti-kickback and self-referral statutes).

537. Thaddeus J. Nodzenski, *Expanded Enforcement of the Fraud and Abuse Laws*, 23 J. HEALTH & HOSP. L. 1 (1990).

The Anti-Kickback and Self-Referral laws are interpreted broadly by courts,[538] and are criticized for failing to recognize the nature of managed care and provider economic risk sharing.[539] In response to such criticism, U.S. Department of Health and Human Services has promulgated safe-harbor regulations and more have been proposed. Existing safe harbors include qualified investments in small entities, sales of physician practices, employment relationships, personal service and management contracts, and managed care organizations.[540] Proposed safe-harbor regulations would create a distinction between the substance and the form of health care transactions and prevent "sham transactions" from obtaining shelter under the safe harbors.[541]

The complexity of the Anti-Kickback and Self-Referral statutes and the lack of guidance as to legal arrangements have a chilling effect on the integration of health care providers into organized delivery systems. Any financial relationship between a hospital and a physician group which may refer patients to the hospital, or vice versa, leaves the parties vulnerable to federal fraud and abuse charges.

It has been argued, however, that hospitals should be permitted to lend financial support to physician groups for "legitimate business reasons unrelated to referrals, including the promotion of cost-effective managed care."[542] In fact, many hospitals have chosen to assume the risk, and thus far these activities have been unprosecuted.[543]

538. *See, e.g.*, United States v. Bay State Ambulance & Hosp. Rental Serv., Inc. 874 F.2d 20 (lst Cir. 1989) (upholding the convictions of a hospital employee and the president of an ambulance company for receiving and providing automobiles and other compensation in return for recommending a hospital contract for ambulance company services); United States v. Kats, 871 F.2d 105 (9th Cir. 1989) (upholding the conviction of a physician for receiving a 50% kickback for referral of blood and urine samples to a laboratory).

539. *See* Hitchner et. al., *supra* note 507, at 277.

540. *See* 42 C.F.R. § 1001.952 (1993); 59 Fed. Reg. 37,202 (1994) (to be codified at 42 C.F.R. pt. 1001) (proposed July 21, 1994); 58 Fed. Reg. 49,008 (1993) (to be codified at 42 C.F.R. pt. 1001) (proposed Sept. 21, 1993).

541. *See* 59 Fed. Reg. 37,202, 37,203, 37,208 (1994) (to be codified at 42 C.F.R. § 1001.954) (proposed July 21, 1994). The proposed rule states "[a]ny transaction or other device entered into or employed for the purpose of appearing to fit within a safe harbor when the substance of the transaction or device is not accurately reflected by the form will be disregarded, and whether the arrangement receives the protection of a safe harbor will be determined by the substance of the transaction or device." *Id.* at 37,208.

542. Hitchner et al., *supra* note 507, at 279.

543. *Id.*

Corporate Practice of Medicine Doctrine

Some states prohibit the "corporate practice of medicine"[544] Under this doctrine, only licensed professionals may practice medicine, and therefore neither lay persons nor organizations, including hospitals, may hire physicians or control the professional aspects of their practices.[545] Only other physicians or professional corporations or associations may employ physicians.[546]

The corporate practice of medicine doctrine may therefore create a barrier to the establishment of alliances between hospitals and physicians designed to integrate efficiently primary care delivery and to control costs. Recognizing the fading relevance of the corporate practice of medicine doctrine in light of modern health care concerns, many states with such laws on the books have chosen not to enforce them.[547]

Because alliances between hospitals and physician groups may be an essential component of community- based health care reform, any reform effort should include a revision of corporate practice of medicine laws, either by the individual states or by federal preemption of the field.

Federal Tax-Exemption

Charitable nonprofit organizations are exempt from federal income tax.[548] To be eligible for tax-exemption, the organization must organize and operate exclusively for an exempt, charitable purpose.[549] The two-part test relating to this exclusivity requirement has an organization prong and operational prong.

Under the organization prong, the entity's charter must be limited to one or more exempt purposes and cannot empower the entity to engage, otherwise than as an unsubstantial part of its activities, in nonexempt activities and its assets must be dedicated to an exempt purpose.[550] Under the operational prong, the entity must primarily engage in activities directed toward the accomplish-

544. In some states, the prohibition is statutory. *See, e.g.*, KY. REV. STAT. ANN. §§ 311.375, 311.376, 313.020 (Michie/Bobbs-Merrill 1993); UTAH CODE ANN. §§ 16-11-3, 16-11-4, 58-12-30 (1993). In others, the prohibition is found only in case law. *See, e.g.*, Kerner v. United Medical Sources, 200 N.E. 157 (Ill. 1936) (lay corporation's operation of low cost clinic violated corporate practice of medicine doctrine).

545. Hitchner et al., *supra* note 507, at 276.

546. *Id.*

547. *Id.*

548. I.R.C. § 501(a) (1994).

549. I.R.C. § 501(c)(3) (1994).

550. Treas. Reg. § 1.501(c)(3)-l(b) (as amended in 1990).

ment of its exempt purpose. If more than an unsubstantial part of its activities is not so directed, or if net earnings inure to private individuals, the organization fails the operational.[551]

Although the IRS, which enforces the tax laws, has been somewhat supportive of integrated delivery system development, it has nonetheless been criticized for its application of hospital-oriented standards to new modes of delivery, for restraining physician practices, and, more generally, for establishing health care policy and enforcing health care laws.[552]

The creation of integrated delivery systems at the local level poses potential confiict with tax-exemption laws. Specifically, while promoting health has long been recognized as a charitable purpose and has given may hospitals tax-exempt status, if an exempt hospital's net earnings inure to the benefit of physicians, or if the hospital's operations are deemed to benefit physicians more than incidentally, the hospital's exempt status may be jeopardized.[553] However, according to the IRS, a joint venture between a hospital and physicians, may be viewed as enhancing the hospital's charitable activity, rather than diminishing it, to the extent that it creates a new service or "product" in the community served and did not result in more than an incidental private benefit to the physicians.[554]

Medicaid Waiver Process

States have the opportunity to obtain an administrative waiver from the federal government to experiment with different approaches to financing and delivering health care.[555] The source of authority for state-based Medicaid demonstration projects is section 1115 of the Social Security Act.[556] Section 1115 authority was designed to permit states to conduct short term experimental policy projects.[557] The demonstration waiver serves as an important

551. Treas. Reg. § 1.501(c)(3)-l(c)(l) (as amended in 1990).

552. Woodhall, *supra* note 536, at 199.

553. Hitchner et al., *supra* note 507, at 282.

554. Gen. Couns. Mem. 39,862 (Nov. 22, 1991).

555. *See* Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855, 873 (1990).

556. 42 U.S.C. § 1315 (1994). This waiver authority is the general demonstration provision of the Social Security Act. The waiver provision was enacted as part of the Public Welfare Amendments of 1962, Pub. L. No. 87-543, 76 Stat. 192 (1962), and made applicable to Medicaid when it was enacted in 1965.

557. *See* Elizabeth Anderson, *Administering Health Care: Lessons From the Health Care Financing Administration's Waiver Policy-Making*, 10 J.L. & POL. 215, 224 (Winter 1994).

tool, however, as the states increasingly seek to effect broad, long-term reforms in health care.

The legislative history and subsequent interpretation of section 1115 both indicate that the provision was not intended to allow the states to reform as they saw fit, but rather to allow the federal government to orchestrate a federal research agenda aimed at improving health policy.[558] In its early stages, the waiver review process took into account neither the effect of proposed projects on Medicaid recipients, nor program costs.[559]

More recently, however, concerns for program beneficiaries and costs have grown and further complicated the review process.[560] States are now required to prepare comprehensive analyses of the proposed program's budget neutrality.[561] In addition, proposed state programs are now subject to several layers of federal review in a process that often takes more than two years. The complexity of the current review process has chilled demonstration efforts significantly.[562] The Omnibus Reconciliation Act of 1981 created two additional sources of waiver authority. Under a freedom of choice waiver, a state may waive the otherwise applicable right of beneficiaries to free choice of providers.[563] Under a home and community-based services waiver, a state may provide a wide range of services not otherwise available under its Medicaid plan, targeted exclusively to individuals who are institutionalized or at risk of institutionalization.[564] Both the freedom of choice waiver and the home and community-based service waiver are intended to facilitate more permanent policy or program changes.[565]

Although the process for obtaining these programmatic waivers is relatively simple and clearly defined, states raise a legitimate complaint about the time period for which they are approved. Freedom of choice waivers last for only two years, while home and community-based service waivers last for only three years.[566] As a result, states are burdened with renewal applications every few years.

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558. *Id.* at 225.
559. *Id.* at 226.
560. *Id.* at 227.
561. *Id.* at 224.
562. *Id.* at 226-27.
563. 42 U.S.C. § 1396n (1994).
564. *Id.*
565. Anderson, *supra* note 557, at 233.
566. *Id.* at 236.

Conclusion

This article has considered how a decentralized, community-based approach to health care reform can address our nation's current health care crisis. A "bottom-up" approach would enable localities to see what works best in providing the noninsured and the underinsured with preventive and primary health care in an efficient, effective manner. It would also facilitate the decentralization of the American political economy and encourage participation in local institutions.