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Loyola University Chicago School of Law

BRINGING YOU THE LATEST DEVELOPMENTS IN HEALTH LAW

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**THE *ONLINE* HEALTH POLICY AND LAW REVIEW OF
LOYOLA UNIVERSITY CHICAGO SCHOOL OF LAW**

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ANNALS OF HEALTH LAW
ADVANCE DIRECTIVE

Editor's Note

The *Annals of Health Law* is proud to present the third Issue of our online journal, *Advance Directive*. Consistent with our goal of promoting student health law scholarship, this Issue features articles addressing the theme of Health Care Disparities: Effectiveness, Rationing, and the Road to the Future, which expands upon discussions presented at the Third Annual Beazley Symposium on Access to Health Care.

This Issue begins with a look at future changes to improve the United States' healthcare system. First, our authors examine ways to reform the healthcare system by implementing an explicit rationing of healthcare; and using the current Veterans Health Administration as a model for healthcare reform. Second, our authors explore potential solutions to decreasing the cost of healthcare through reasonably priced retail health clinics; and changing physician compensation, such as through pay-for-performance models.

Next, the Issue transitions into examining solutions to improve access and quality to healthcare. Specifically, our authors suggest that the pay-for-performance compensation model can improve access and quality of healthcare for the poor and ethnic/racial minorities; how decreasing the cost of medical school for physicians can increase access to health care in rural communities; implementing technological innovations, such as Electronic Health Records (EHRs), can improve quality of care; using charity care can improve access to healthcare for the uninsured; and that consumer driven healthcare is not a solution for improving access to healthcare for the poor, uneducated, and chronically ill.

Finally, the Issue delves into the current disparities needing access to healthcare in the United States. In particular, our authors investigate access to healthcare for the mentally ill through the Mental Health Parity Act; health disparities resulting from the effects of food deserts on low-income individuals; access to healthcare relating to obesity; and health disparities relating to HIV/AIDS at Historical Black Colleges and Universities (HBCUs).

We would like to thank Mallory Golas, our *Advance Directive* Senior Editor, Amy Fuetterer, our Symposium Editor, and Themistocles Frangos, our Technical Production Editor, for their invaluable contributions in launching this Issue. We would like to specially thank our *Annals* Editor-in-Chief, Kendell Coker, for his dedication and perseverance in increasing access to *Advance Directive*. We also are grateful to our *Annals* Executive Board members—Kevin Lichtenberg and Victor Allen—for their editorial assistance. Our *Annals* members deserve particular recognition for writing timely, thoughtful articles and for editing the work of their peers. Finally, we extend our warmest appreciation to the Beazley Institute and our faculty advisors, Professors Lawrence Singer and John Blum, for their continued support, encouragement, and mentorship.

We hope you enjoy our third Issue of *Advance Directive*.

Sincerely,

Jana E. Harris
Advance Directive Editor
Annals of Health Law
Loyola University Chicago School of Law

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Rationing as a Necessity

*Amanda Swanson**

In the current debate over healthcare reform, the mere mention of rationing has brought only fear and opposition. Some have argued vehemently that the American people will not tolerate proposals that would enable the government to limit the availability of effective treatment to them simply because of the cost.¹ Perhaps this stems from the belief that letting monetary considerations play a role in saving lives is immoral.² Perhaps this comes from a fear of the implications that a practice like this would have on the individual and his family. No matter which lens you look through, the fact remains that healthcare is indeed a scarce resource, and its rationing is unavoidable.³

While the United States does not have an explicit system of rationing in place as some nations do, the delivery of healthcare depends on an implicit form of rationing. There may not be waiting lists or lotteries impeding one's ability to access the care they seek, but the ability to receive needed services is dependant

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¹ See Sally C. Pipes, *Obama Will Ration Your Health Care*, WALL ST. J., Dec. 30, 2008, at A11.

² Peter Singer, *Why We Must Ration Health Care*, N. Y. TIMES, Jul. 19, 2009, at MM38.

³ *Id.*

upon one's ability to pay or obtain insurance.⁴ This applies even to those with insurance, as they experience rationing through the policies of their insurance provider (including physician discretion and evaluations of the medical necessity of a treatment, among other mechanisms).⁵ Healthcare under Medicaid and Medicare is rationed both through the long waits and patient co-payments that discourage patients from seeking care, and low physician reimbursement, which discourages doctors from serving these types of patients.⁶ A study of those injured in automobile accidents in Wisconsin found that those without health insurance received 20% less care than those with health insurance and had a 37% higher death rate.⁷ While other countries have chosen to provide universal coverage and limit the range of healthcare services available, the United States has chosen a system that offers high-technology, comprehensive care that is not guaranteed to all.⁸

Healthcare costs are on the rise and will continue to increase as more high-technology treatments are made available.⁹ This trend will only get worse in the coming years. The efforts to reduce healthcare costs by cutting waste and inefficiency from the system, leaving market competition and consumer driven care to drive down prices, and to eliminating futile treatments all will be unable to

⁴ RICHARD D. LAMM & ROBERT H. BLANK, *CONDITION CRITICAL: A NEW MORAL VISION FOR HEALTH CARE* 39 (2007).

⁵ *Id.* at 40.

⁶ Singer, *supra* note 2.

⁷ Singer, *supra* note 2.

⁸ LAMM & BLANK, *supra* note 4, at 42.

⁹ See Ruud ter Meulen, *Is Rationing the Inevitable Consequence of Medical Advance?*, 27 *MED. & L.* 71, 76-77 (2008).

significantly affect the gross cost of healthcare.¹⁰ It is time the United States implemented an explicit rationing of healthcare. Doing so will not only effectively curb the rising costs of healthcare, but will improve the health of the United States population.

I. RISING HEALTHCARE EXPENDITURES ARE UNAVOIDABLE

Current projections show that by 2040 total healthcare spending in the United States will claim over a third of the national GDP.¹¹ If this projection is correct, by 2040 Medicare and Medicaid spending as a share of GDP would equal the combined amount of all income and property taxes today.¹² Such figures are certainly worrisome, and there are a number of factors that have been identified as contributing to this effect.¹³ While often leading to chronic conditions, changing health behaviors of the population, such as smoking, stress, over consumption of food, and lack of exercise, have also been identified as accounting for 40-50% of morbidity and mortality.¹⁴ Changing treatment thresholds for many chronic diseases have resulted in more asymptomatic patients who are at risk for a number of diseases, like diabetes or hypertension, being treated both to prevent the onset of disease and as an effort to reduce the severity should the disease manifest

¹⁰ See LAMM & BLANK, *supra* note 4, at 68-79.

¹¹ Henry J. Aaron, *Health Care Rationing: What it Means*, POL'Y BRIEF, Dec. 2005, at 2.

¹² *Id.*

¹³ See Kenneth E. Thorpe, *The Rise in Health Care Spending and What To Do About It*, 24 HEALTH AFF. 1436, 1437 (2005); Meulen, *supra* note 9, at 76-77.

¹⁴ Thorpe, *supra* note 13, at 1437.

later.¹⁵ This has contributed to a rise in treated disease prevalence in the United States population and consequently an increase in total spending on healthcare.¹⁶

Economic research has consistently shown that advances in medical technology are the single most influential factor in the rise of healthcare costs, causing more than half of the rise in costs in the past decade.¹⁷ In addition to the obvious effect of making more procedures available, innovation also raises costs by enabling a greater array of patients to become eligible for treatments who in the past were not.¹⁸ For example, the development of laparoscopic *cholecystectomy* as an alternative to open surgery to remove the gall bladder has decreased operation costs by 25%.¹⁹ However, since the new procedure was less traumatic, more patients became eligible, and the number of operations increased by 60%, thus increasing total healthcare expenditures nationally.²⁰

Medical advances have saved many lives, but the increase in life expectancy has resulted in higher healthcare costs.²¹ For instance, those whose lives were saved by medical advances may require high cost medical treatments for the rest of their lives if they suffer permanent injuries.²² Additionally, as all people increase in age they will continuously suffer more of the effects of any chronic illnesses they may have.²³ That is not to say that innovation ought to be

¹⁵ *Id.* at 1438-39.

¹⁶ *Id.* at 1437.

¹⁷ Meulen, *supra* note 9, at 76-77.

¹⁸ *Id.* at 75.

¹⁹ *Id.*

²⁰ *Id.* at 75-76.

²¹ *Id.* at 77.

²² Meulen, *supra* note 9, at 77.

²³ *Id.*

suppressed, however, as the benefit of the advancement of medical technologies cannot be denied. Yet the resulting increases in healthcare costs remain an inevitable consequence.²⁴ Rationing of healthcare provides the only effective way to curb these rising costs.

II. ALTERNATIVES TO RATIONING FALL SHORT

Alternatives to rationing have been proposed to cut health care costs, but none will be unable to sufficiently curb the increasing costs resulting from changing human behaviors and the advancement of medical technologies. First, much of the American public stresses a need to cut wasteful spending and inefficiency from the healthcare system.²⁵ While such measures would result in some cost savings, it is unlikely to impact the increasing costs of developing new technologies.²⁶ For instance, personal care, such as washing and feeding, is required for many chronic and debilitating conditions, and is unlikely to be made more efficient.²⁷ Even if inefficient procedures can be identified and eliminated, certain symptoms will then require alternative treatments, which will cost money to develop.²⁸ Moreover, researching the effectiveness of any treatment will be costly and will not always clearly determine whether a particular drug or treatment is ineffective.²⁹ Once a treatment has been determined to be effective,

²⁴ *See, Id.* at 75-78.

²⁵ LAMM & BLANK, *supra* note 4, at 69.

²⁶ *See* Meulen, *supra* note 9, at 73.

²⁷ *Id.* at 78.

²⁸ *See* LAMM & BLANK, *supra* note 4, at 71-72.

²⁹ *Id.* at 72.

the pressures to make it available to patients will be great, leaving the treatment to remain a burden to healthcare budgets.³⁰

Alternatively, many economists assert that competition and market forces will be able to contain healthcare costs, but neither will have much of an impact due to the very unique nature of healthcare as a commodity.³¹ For a market-based health system to work, three things are required: (1) the consumer must make all of the decisions; (2) the consumer must know the actual value and costs of the goods available; and (3) the consumer must receive the full value and pay the full costs of the goods purchased.³² This can never be satisfied in healthcare because patients are forced to rely upon the medical knowledge of their doctors in determining treatment.³³ Further, an insured patient usually only pays for monthly premiums, deductibles, and copayments and never has to worry about the full value or cost of the treatment received, which is bargained by the insurance company and healthcare providers.³⁴ Efforts to make healthcare more consumer-driven through cost sharing will also fall short for these same reasons. Additionally, studies have shown that cost sharing reduced the likelihood that individuals would receive effective care because many did not want to spend money and as a result did not receive timely treatment.³⁵

³⁰ Meulen, *supra* note 9, at 74.

³¹ LAMM & BLANK, *supra* note 4, at 73.

³² *Id.*

³³ *Id.*

³⁴ *See Id.*

³⁵ *Id.* at 76.

Moreover, there is a market phenomenon unique to healthcare in which supply creates demand known as Roemer's law.³⁶ Many studies that have been conducted to understand this occurrence reveal that, when the resources are available, doctors will increase the number of treatments or procedures performed without necessarily targeting those patients who need them most.³⁷ This does not mean prescribing such treatments is an abuse of physician discretion, but rather that when more resources are available physicians exercise their discretion in an overly cautious or in an unreasonably hopeful way.³⁸ Those patients for whom it is uncertain whether the treatment is necessary or even beneficial will not be given the treatment when resources are more limited, but will be given the treatment when the resources are available.³⁹ For example, one study examined catheterizations throughout the United States.⁴⁰ The regions that had many more catheterization labs per person were those with the highest rates of catheterization and invasive cardiology procedures; and those with the fewest had the lowest rates.⁴¹ This study also found that there was no difference in mortality rates among the different regions.⁴²

Finally, reducing costs of end of life care by cutting futile treatment has also been proposed as a way to curb the rising healthcare costs, following from

³⁶ SHANNON BROWNLEE, OVERTREATED: WHY TOO MUCH MEDICINE IS MAKING US SICKER & POORER, 111 (Bloomsbury) (2007).

³⁷ *Id.* at 109.

³⁸ *Id.* at 113.

³⁹ *Id.*

⁴⁰ *Id.* at 108 (referring to Therese A. Strukel, F. Lee Lucas & David E. Wennberg, *Long Term Outcomes of Regional Variations in Intensity of Invasive vs Medical Management of Medicare Patients With Acute Myocardial Infarction*, 293 JAMA 1329-37 (2005)).

⁴¹ *Id.*

⁴² *Id.* at 109.

the fact that, on average, care received during the last year of life accounts for 18% of one's lifetime healthcare expenses.⁴³ Inherent to this argument is the understanding that futile treatments are not worth the cost because they are bound to fail.⁴⁴ With this belief, it may be easier for some people to embrace restrictions on the availability of such treatments as they would perceive no obligation to make them available.⁴⁵ This can prove to be very difficult; however, as the concept of futility itself is difficult to understand.⁴⁶ First of all, it is very difficult to predict when any individual medical treatment will not prove beneficial to a particular patient.⁴⁷ For example, advancing age is often one of many medical criteria used by physicians to predict a successful clinical outcome, but it is difficult to determine the extent to which the predictive validity of any single medical criteria has been demonstrated empirically.⁴⁸ Older people are very different from one another both psychologically and physiologically.⁴⁹ As such, any efforts to set an arbitrary age-based delineation of when a particular treatment is futile or beneficial would not only be unfair in failing to take into consideration other medical criteria, but could actually hasten death of patients for whom the treatments could help.⁵⁰

⁴³ LAMM & BLANK, *supra* note 4, at 76.

⁴⁴ *Id.* at 78.

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ Douglas J. Besharov & Jessica Dunsay Silver, *Rationing Access to Advanced Medical Techniques*, 8 J. LEGAL MED. 507, 522 (1987).

⁴⁹ George P. Smith, *The Elderly & Health Care Rationing*, 7 PIERCE L. REV. 171, 176 (Apr. 2009).

⁵⁰ *Id.*

In addition, as the implementation of advance directives has shown, there is little evidence that cutting intensive and expensive treatments at the end of life will really save much money.⁵¹ Only a relatively small amount of costly advanced treatments are expended on unquestionably terminal patients.⁵² In contrast, critically ill patients, those for whom death is possible but not probable, receive most of this costly care.⁵³ While these patients may die even with the most aggressive and expensive treatments available, the treatments may still be beneficial because the patient may survive.⁵⁴

III. LESS CARE (AND LESS EXPENSIVE CARE) WILL MEAN BETTER HEALTH

The idea of explicit rationing of healthcare is frightening to many people who worry that poor health outcomes will result. However, studies have shown that paying more for healthcare does not result in longer life expectancy, a result commonly used as a measure of better health outcomes.⁵⁵ In the United Kingdom, a country recognized for healthcare rationing, spent only 8.6% of its GDP on healthcare in 2004.⁵⁶ In contrast, the United States devoted 16 % of its GDP to healthcare that year.⁵⁷ One study showed that although United States spending on healthcare was almost double that of the United Kingdom, the average life expectancy was significantly lower. The average life expectancy in

⁵¹ LAMM & BLANK, *supra* note 4, at 77.

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ Meulen, *supra* note 9, at 78.

⁵⁶ *Id.*

⁵⁷ *Id.*

the United States was 69.5 years for men and 76.3 years for women, as compared to 76.5 years and 81.3 years, respectively, in the United Kingdom.⁵⁸ Even when comparing different spending rates within the United States, one study found that patients who went to the highest spending hospitals were 2-6% more likely to die than patients at the lowest spending hospitals.⁵⁹ Research also suggests that hospitals with more specialists order more consultations, which results in additional tests and procedures, and consequently more days in the hospital.⁶⁰ This also increases the chance for complications and latent errors that may accumulate into disastrous adverse events.⁶¹

One study compared amenable mortality rates⁶² of the United States with fourteen European countries, Canada, New Zealand, Australia, and Japan over a six year period from 1997 to 2003.⁶³ The United States spent the most GDP on healthcare, but by 2003 the United States also had the highest amenable mortality rate in the study.⁶⁴ Amenable mortality rates declined in all countries an average of 17% over the study period, while the United States had a decline of only 4%.⁶⁵

⁵⁸ *Id.*

⁵⁹ BROWNLEE, *supra* note 36, at 50.

⁶⁰ *Id.*, at 63.

⁶¹ *Id.*

⁶² Ellen Nolte & C. Martin McKee, *Measuring the Health of Nations: Updating an Earlier Analysis*, 27 HEALTH AFF. 58, 59 (Jan./Feb. 2008) (explaining that amenable mortality refers to deaths resulting from causes that should not occur with the administration of timely and effective healthcare).

⁶³ *Id.*

⁶⁴ *Id.* at 62.

⁶⁵ *Id.* at 59.

IV. EXPLICIT IMPLEMENTATION

No matter which way you look at it, it is apparent that Americans need an explicit rationing of healthcare. Advances in medical technologies result in more treatments available to patients, and a widening of the eligibility criteria for such procedures and treatments.⁶⁶ Romer's law has shown how the motivations of physicians, both the admirable goals of doing everything in their power to try to improve the health of their patients, and the less commendable interest in increasing revenue, will only further increase the number of services and treatments rendered to patients.⁶⁷ Additionally, as patients do not have the expert medical knowledge or full awareness of the cost and value of treatments required to make a truly informed decision, market forces will be unable to bring costs down. Explicit rationing is essential in providing Americans an equal right to healthcare, and is much more just than the forms of implicit rationing at play today.

⁶⁶ Meulen, *supra* note 9, at 75.

⁶⁷ BROWNLEE, *supra* note 36, at 113.

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***The Veteran's Health Administration as a
Model for Universal Healthcare***

*Wiliulfo Gonzalez**

I. INTRODUCTION

In America today, no issue divides citizens more than the debate over universal healthcare. American voters have enthusiastically ushered President Barack Obama into the White House on a platform of change, including a guarantee that all Americans would have access to healthcare.¹ This issue, which President Obama has invested much of his political capital, has yet to gain a consensus in Congress. Furthermore, this issue has grabbed the nation's collective attention and continues to serve as a call to action amongst people from across the political spectrum. "Single-payer," "socialized medicine," "eliminating fraud and reducing waste," "opting out," "rationing," and a host of other phrases have worked their way into the vernacular of many a lay person as casual conversations increasingly turn to the topic of healthcare. Some believe foreign nations' healthcare systems are excellent models on which to structure the United

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¹ SunTimes.com, *Obama Promises Universal Health Care by End of First Term*, CHI. SUN-TIMES, May 14, 2007, available at <http://www.suntimes.com/news/elections/385287,051407obama.article>.

States' healthcare system.² The poor quality of healthcare of other nations, however, is proof-positive that in the United States, we have the finest care available anywhere in the world.³ To decree that our healthcare system is irreparable would be disingenuous. Similarly, to claim the status quo is sustainable would lead this country to financial calamity.

Regardless of where any one group stands, it is clear a majority of Americans agree substantial changes are needed in the U.S. healthcare system.⁴ The question has ceased to be *if* healthcare changes are needed, but rather, *what* should be done? What can be done to realize the President's goal, and in fact the goal of a majority of Americans, to somehow change the healthcare system in the U.S.? Instead of looking outside our borders for the solution, the U.S. has within it a solid platform on which to begin the debate for the future of healthcare: the Veterans Health Administration.

II. BACKGROUND

In the past, for many Americans, the Veterans Health Administration (VA) conjured an image of a healthcare system that provided limited or substandard care, and up until the mid-1990s, such an image may not have been too far off the

² Generally, Kerry Capell, *Is Europe's Health Care Better?*, BUS. WK. Jun. 13, 2007, available at http://www.businessweek.com/globalbiz/content/jun2007/gb20070613_921562.htm.

³ See, e.g., Sarah Lyall, *Those Who Pay for Private Care Are Testing Britain's Health*, N.Y. TIMES, Feb. 21, 2008, at A12.

⁴ Rasmussen Reports, *54% Say Major Changes Needed in Health Care System, 45% Disagree*, Rasmussen Reports, Oct. 2, 2009, http://www.rasmussenreports.com/public_content/politics/current_events/healthcare/october_2009/54_say_major_changes_needed_in_health_care_system_45_disagree.

mark.⁵ The nation's VA hospitals faced a myriad of challenges, including, the World War II population. World War II veterans were passing away at a rate of 1,000 per day, and those who survived moved to the Sunbelt States, which led to idle staff and surgeons at hospitals throughout the Midwest and Northeast.⁶ On the other hand, hospitals in Florida faced overcrowding and overworked staff.⁷ A 1995 audit of the Department of Veterans Affairs even discovered that twenty-one of 153 VA surgeons had gone at least a year without spending time in the operating room.⁸ It became clear the VA needed drastic restructuring to meet the needs of the changing composition of America's veterans.⁹

In order to address this crisis, President Clinton selected Dr. Kenneth W. Kizer as the Under Secretary for Health for the Department of Veterans Affairs, charging him with restructuring the VA's healthcare system.¹⁰ Dr. Kizer was responsible for overhauling the VA's 172 hospitals and 132 nursing homes into twenty-two self-contained systems responsible for providing all patient care.¹¹ Coming from a background in both business and academia, Dr. Kizer was especially well suited for the task at hand.¹² Many credit Dr. Kizer with bringing

⁵ Adam Oliver, *The Veterans Health Administration: An American Success Story?*, 85 MILBANK Q. 5 (2007).

⁶ PHILLIP LONGMAN, *BEST CARE ANYWHERE: WHY VA HEALTH CARE IS BETTER THAN YOURS* 43 (PoliPointPress 2007).

⁷ *Id.*

⁸ OFFICE OF INSPECTOR GENERAL, U.S. DEP'T OF VETERAN'S AFFAIRS, *AUDIT OF VETERANS HEALTH ADMINISTRATION RESOURCE ALLOCATION ISSUES: PHYSICIAN STAFFING LEVELS*; NO. 5R8-A19-113, available at <http://www.va.gov/oig/52/reports/1995/5R8-A19-113--psrptasc.htm>.

⁹ *Id.*

¹⁰ Douglas Waller, *How VA Hospitals Became The Best*, TIME, Sep. 4, 2006, at 36.

¹¹ Gilbert M. Gaul, *Revamped Veterans' Health Care Now a Model*, WASH. POST, Aug. 22, 2005, at A1.

¹² Robert Wood Johnson Foundation, *Physician Faculty Scholars*, <http://rwjpfsp.stanford.edu/nac/kizer.html> (last visited Oct. 09, 2009).

about sweeping improvements throughout the VA.¹³ Specifically, electronic health records (EHRs) and continuous quality improvement serve as launch-points for the universal healthcare debate.¹⁴

III. ELECTRONIC HEALTH RECORDS

In February 2009, the federal government allocated \$1.2 billion to states and regions across the country in an effort to digitize medical records.¹⁵ According to Vice President Biden, this will make healthcare more affordable, efficient, and safer.¹⁶ But how can a seemingly obvious change in the way in which patient data is captured and stored make such a significant impact? For the answer, we need only to look to the VA, which mandated entry of health records into its electronic database, dubbed "VistA," by 1999.¹⁷ Arguably, this shift to EHRs was borne out of necessity rather than cost savings. Because the VA assumed lifetime care for veterans, it was crucial that wherever the veteran went, his records followed. The continuity of medical record availability was made possible through portability. Implementation of an EHR database for the general population, however, would be a far more challenging task because not only

¹³ *Id.*

¹⁴ *Id.*

¹⁵ Judith Burns, *UPDATE: Biden: \$1.2B From Stimulus To Computerize Medical Records-Report*, DOW JONES FACTIVA, Aug. 20, 2009.

¹⁶ *Id.*

¹⁷ Oliver, *supra* note 5, at 19.

would it require uniformity of software and digitization of existing records, but also because our current healthcare system inadvertently rewards inefficiency.¹⁸

Imagine the hypothetical case of a young couple embarking on a cross-country trip from Chicago to the west coast when suddenly tragedy strikes. Crossing through Colorado late at night, the driver dozes off and runs the vehicle off the highway. Although the injuries sustained were not fatal, they nevertheless required immediate medical care. In a world with EHRs, the emergency room doctors who tend to their injuries would be able to retrieve their medical history from some basic information provided by the couple. Even though they have never treated the patients before, they can glean from the records any information pertinent to their care.

The reality, however, is that only 1.5% of hospitals within the United States have a “comprehensive electronic-records system,” defined as one that is present in all clinical units, and 7.6% of hospitals have a “basic system” present in at least one of its units.¹⁹ Although these numbers are low, the greater obstacle for improving healthcare through electronic medical records is the lack of uniformity amongst the various EHR systems. For example, if your primary care provider adopted an EHR system and you were in the same accident in Colorado, the emergency room in which you were treated could only access your records if they too used the same software as your primary care provider for EHRs.

¹⁸ Ignacio H. Valdes, *The Coming Electronic Health Record Software Disaster*, LINUXMEDNEWS, Sep. 25, 2007, <http://linuxmednews.com/1190745985>; J.D. Kleinke, *Dot-Gov: Market Failure and the Creation of a National Health Information Technology System*, 24 HEALTH AFFAIRS 1246, 1250 (2005).

¹⁹ Ashish K. Jha Et Al., *Use of Electronic Health Records in U.S. Hospitals*, 360 NEW ENG. J. MED. 1628, 1628 (2009).

An essential part of VistA's effectiveness can be found in the uniformity of the VA hospitals, which use the exact same software.²⁰ Unless uniformity is mandated at the federal level, however, we can expect a slew of new software flooding the market until an industry standard is established.²¹ The result would be companies wasting significant amounts of money on soon-to-be obsolete products. Alternatively, if the federally mandated software is VistA and all healthcare providers are required to migrate to this system, opponents of "government-run health care" may argue that this provides the means through which the government can indirectly control healthcare by controlling the systems used by hospitals and having everyone's medical information readily accessible.²²

Just as challenging as the issue of software is inadvertent incentivisation of inefficiency. J.D. Kleinke, a medical economist noted: "Bad quality is good for business. And the surest road to bad quality is bad or no information."²³ Indeed, healthcare providers recognize that a patient they see today statistically will not be their patient a few years down the road.²⁴ Providers understand patients switch insurers because they switch jobs or their employers opt for different insurance policies.²⁵ On the other hand, the VA understands it must provide the veteran with long term care to which he or she is entitled, in effect

²⁰ See LONGMAN, *supra* note 6, at 22.

²¹ See Valdes, *supra* note 18.

²² Fred Lucas, *Stimulus Bill Raises Concerns Over Government Rationing of Health Care*, CNS NEWS, Feb. 11, 2009, <http://www.cnsnews.com/news/article/43358>.

²³ Kleinke, *supra* note 18, at 1250.

²⁴ LONGMAN, *supra* note 6, at 71-72.

²⁵ *Id.* at 76-77.

building a lifelong partnership.²⁶ As such, the VA has a vested interest in preventing chronic diseases which leads to lower costs toward the end of the patient's life. Utilizing VistA's graphing and charting abilities enables VA doctors to manage disease more effectively.²⁷ On the private side, preventing future disease essentially zaps the provider's bottom line.²⁸ In fact, outside the VA, nearly 20% of all medical tests are repeated because of lost patient records.²⁹ Dr. Jonathan Perlin, former Acting Under Secretary for Health, estimated that in 2005 it cost the VA approximately \$78 per year per patient to maintain electronic health records.³⁰ Dr. Perlin said this was roughly "the equivalent of not repeating one blood test."³¹

IV. CONTINUOUS QUALITY IMPROVEMENT

In 1999, the Institute of Medicine released a report that sent shockwaves through the medical community.³² In its report, *To Err is Human: Building a Safer Health System*, the Institute of Medicine discovered up to 98,000 people die annually in American hospitals due to medical error.³³ Furthermore, a study by the RAND Corporation found another 90,000 deaths were attributable to hospital infection, and 126,000 more were preventable through observance of evidence-

²⁶ *Id.* at 79.

²⁷ *Id.* at 75.

²⁸ *Id.* at 70.

²⁹ Oliver, *supra* note 5, at 19.

³⁰ Gaul, *supra* note 11, at A1.

³¹ *Id.*

³² See INSTITUTE OF MEDICINE, *TO ERR IS HUMAN, BUILDING A SAFER HEALTH SYSTEM* (Nat'l Academy Press 2000), available at http://www.nap.edu/catalog.php?record_id=9728#toc.

³³ *Id.*

based protocols for hypertension, heart attack, pneumonia, and colorectal cancer.³⁴ These statistics are disheartening to say the least; however, our current system promulgates a culture of protectionism. That is, there is a very real threat of malpractice that perpetually hangs over the head of every healthcare provider, thus making the motivation to conceal mistakes or the refusal to report safety violations outweighs the stigma attached to a doctor who has “broken ranks” with his colleagues in the name of patient safety.³⁵ Understanding that lawsuits threaten the livelihood and autonomy doctors, many organizations have recommended avenues through which patients’ safety is improved while simultaneously shielding doctors who attempt to mitigate the effects of errors from adverse action.³⁶ Suggestions from the American Medical Association, the Institute of Medicine, and even trial lawyers have proposed measures from voluntary and anonymous reporting within hospitals, to peer-review protections that would, in the case of malpractice litigation, shield from discovery doctors’ mortality and morbidity conferences.³⁷

Although the problems described above are certainly applicable to the VA, by the time this report was released, the VA had already enacted a unique approach to confront many of the mistakes prevalent within its system and had produced results much lower than the accident averages seen at many private

³⁴ RAND HEALTH, THE FIRST NATIONAL REPORT CARD ON QUALITY OF HEALTH CARE IN AMERICA 4 (2006) available at www.rand.org.

³⁵ Stephanie Mencimer, *The Casualties of Medicine*, LEGAL AFF., May/June 2003, at 60.

³⁶ *Id.*

³⁷ *Id.*

hospitals.³⁸ Before *To Err is Human* was released, Dr. Kizer had pushed for, and won, a policy of full disclosure of any medical errors which included anonymous reporting.³⁹ Important to note is the VA's policy of full disclosure was not intended as a form of punishment or as a method of placing blame, in fact it promised that only the most egregious of errors resulted in disciplinary action.⁴⁰ Instead, the VA used this process to look for systematic solutions to safety problems, leading to a thirty-fold increase in reported medical mistakes.⁴¹

Although the policy of full disclosure was a risky political decision (after all, what hospital discloses all of its mistakes?) it was based on the same solid principles which had been embraced by the aviation community for years.⁴² In furtherance of his belief in a policy of full disclosure, Dr. Kizer enlisted the aid of Dr. James Bagian, a former Air Force flight surgeon, astronaut, and NASA accident investigator, to lead the National Center for Patient Safety.⁴³ Dr. Bagian began with the premise that all parts of a system will fail at some point, and the challenge becomes discovering when and why they do and designing "fault tolerant" systems that minimize consequences.⁴⁴ Utilizing VistA once again, patients were fitted with bracelets that contained a unique barcode to identify the patient in the VistA system.⁴⁵ By scanning this barcode, VistA could retrieve the patient's EHR which would indicate the procedure for which he was in the

³⁸ LONGMAN, *supra* note 6, at 60, 62.

³⁹ *Id.* at 60.

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.* at 63.

⁴³ *Id.* at 62.

⁴⁴ *Id.*

⁴⁵ *Id.* at 37.

hospital or the type of medication and dosage he required.⁴⁶ Furthermore, just within the Kansas Health Care system, utilizing barcodes in conjunction with medication dispensing prevented over a half-million dispensing errors by 2001.⁴⁷

The VA Hospital system has come a long way in improving the safety with which it delivers care, however it is by no means perfect. In 2005, Leape and Berwick lamented, “[w]hy has it [proven] so difficult to implement the practices and policies needed to deliver safe patient care?”⁴⁸ Though the overall healthcare system in the United States lacked progress on the patient safety front, they identified the VA “as a bright star in the constellation of safety practice” for the processes it had implemented.⁴⁹ When compared to the complexity of the countless measures offered to improve the nation’s healthcare system, the processes enacted by the VA have produced effective and quantifiable results. This is not to suggest that all will be made well within healthcare by having providers admit fault and saying “I’m sorry.” Instead, the VA’s model promotes an atmosphere of continuous quality improvement by understanding that mistakes will be made, identifying what can be done to mitigate the impact of the mistake, reducing the probability of occurrence, and promoting a culture wherein providers do not fear reprisal, but instead seek to better themselves system of which they are a part.

⁴⁶ *Id.* at 64.

⁴⁷ *Id.* at 65.

⁴⁸ Lucian L. Leape, MD & Donald M. Berwick, MD, *Five Years After To Err is Human, What Have we Learned?*, 293 JAMA 2384, 2387 (2005).

⁴⁹ *Id.* at 2386.

V. CONCLUSION

The healthcare reform debate presses on to this day. Although Congress may soon reach a consensus as to the size and scope of the changes Americans demand, there are certain aspects of the current American healthcare system that can serve as models to be included in the final bill. Congress should strongly consider the VA system, which in fifteen years went from a fledgling conglomeration of healthcare facilities into an integrated hospital system that is far more advanced in the area of EHRs than most hospitals across the nation. The VA system has nurtured a culture in which quality care is essential and obtained through continuous improvement.

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Retail Health Clinics: The New Safety Nets?

*Christopher Carlson**

With news reports of the rising costs of health care and the rate of uninsured, the government is pushing to insure that all Americans have better access to reasonably priced healthcare services. One solution, popular with retailers, is to provide access to reasonably priced health care in retail health clinics (RHCs). RHCs, which first opened in 2000,¹ offer treatments for a limited number of acute illnesses on a walk-in basis through the care of non-physician providers² to patients over 18 months³ at prices below \$60.⁴ More than 70% of RHCs are located within drugstores⁵ near the pharmacy,⁶ with the remainder located in retailers, like Target or Wal-Mart, malls, or even airports.⁷

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¹ Ateev Mehrotra et al., *Retail Clinics, Primary Care Physicians, And Emergency Departments: A Comparison Of Patients' Visits*, 27 HEALTH AFF. 1272, 1273 (2008).

² Margaret Laws & Mary Kate Scott, *The Emergence of Retail-Based Clinics in the United States: Early Observations*, 27 HEALTH AFF. 1293, 1293 (2008).

³ Hedy Dumpel, *Public Health and Retail Clinics*, REGISTERED NURSE, Jan./Feb. 2008, at 20.

⁴ Annie Hsu, *Legal Issues Concerning Retail Clinics*, HEALTH LAWYER, June 2008, at 13,14.

⁵ Rena Rudavsky et al., *The Geographic Distribution, Ownership, Prices, and Scope of Practice at Retail Clinics*, 151 ANNALS OF INTERNAL MED. 315, 316 (2009).

⁶ Dumpel, *supra* note 3, at 20.

⁷ Rudavsky et al., *supra* note 5, at 316.

RHCs are beginning to appear as an affordable alternative for those with incomes that cannot keep up with the skyrocketing costs associated with visits to the emergency department (ED), urgent care clinic, or physician office. RHCs rely mostly upon Nurse Practitioners (NPs) to staff clinics because their schooling is focused more on disease prevention and an overall holistic approach to health,⁸ and because they tend to have lower salaries.⁹ The providers' prescribing ability is kept quite simple and limited to antibiotics, rash creams, and cough syrups,¹⁰ which is sufficient for the limited menu of illnesses that RHCs treat. Patients in need of more serious care are identified through the use of computer software programs or over-the-phone physician consultations and then referred to EDs or urgent care centers.¹¹

The overall convenience of RHCs has led them to increase ten-fold from 2006 through 2008, totaling more than 1,000 sites, and has resulted in an estimated three million patient visits since their inception.¹² This paper will explore the criticism that some physician groups have raised about the ever expanding RHC market, but more importantly explore the benefits of RHCs, including the types of services provided, those who benefit the most, the costs associated with RHC care, and how quality and regulatory measures apply to this budding industry.

⁸ Hsu, *supra* note 4, at 13.

⁹ Laws & Scott, *supra* note 2, at 1293.

¹⁰ Hsu, *supra* note 4, at 13.

¹¹ *Id.*

¹² Rudavsky et al., *supra* note 5, at 315. *The Medical Storefront*, 27 HEALTH AFF. 1271, 1271 (2008).

I. POPULATIONS SERVED AND SERVICES PROVIDED

RHCs are a popular choice for healthcare consumers because they are conveniently located, open extended hours seven days a week,¹³ and provide treatment for some of the most common acute conditions.¹⁴ These factors make them an appealing choice for those who work or are unable to make physician appointments during regular business hours. RHCs are also conveniently located in urban areas where an estimated 29.2 million Americans can access a RHC within a short five minute drive and another 80.7 million within ten minutes.¹⁵

The menu of conditions that RHCs treat, while limited, provides relief from easily treatable, everyday illnesses. The most common acute ailments RHCs treat include respiratory tract infections, otitis media and otitis externa (ear infections), pharyngitis (sore throat), conjunctivitis (pink eye), urinary tract infection, and even provides immunizations.¹⁶ These conditions account for 90% of visits to RHCs, 13% of adult primary care visits, 30% of pediatric primary care visits, and 12% of ED visits.¹⁷ RHCs can help to relieve the stress on EDs in having to care for these minor, acute conditions.¹⁸ With a growing shortage of primary care physicians and an estimated shortage of 200,000 physicians by the

¹³ Rik Kirkland, *Wal-Mart's RX for Health Care*, FORTUNE, Apr. 17, 2006, available at http://money.cnn.com/2006/03/31/news/companies/walmart_f500_fortune_041706/index.htm.

¹⁴ Mehrotra et al., *supra* note 1, at 1272.

¹⁵ Rudavsky et al., *supra* note 5, at 317.

¹⁶ Mehrotra et al., *supra* note 1, at 1274.

¹⁷ *Id.* at 1272.

¹⁸ *Id.* at 1280.

year 2020,¹⁹ RHCs can help fill a void for both patients with primary care physicians and those without insurance.

While the convenience of RHCs excites patients, it frustrates providers. Because patients often find it difficult to obtain appointments with primary care providers on short notice and find frustration in long wait times in the ED, they value the variety of conditions treated and the convenience that RHCs provide.²⁰ Yet, some physician groups disagree and believe that convenience disrupts the physician-patient relationship rather than actually helping the patient.²¹ However, three-fifths of patients who have visited RHCs did not have primary care physicians, making it clear that there is no relationship to disrupt.²² The American Medical Association and American Academy of Family Physicians (AAFP) are even encouraging physicians to adopt some of the practices that make RHCs successful, such as expanding office hours and decreasing wait times.²³ Proponents of the RHC industry seek to quiet the fears of physicians by assuring them that they do not intend to replace the role of primary care physicians, only to supplement or complement them.²⁴

Other physicians and physician groups still worry that the decrease in the number of visits to primary care physicians coupled with an increase in the

¹⁹ Hsu, *supra* note 4, at 13.

²⁰ Mehrotra et al., *supra* note 1, at 1279.

²¹ *Id.*

²² Mehrotra et al., *supra* note 1, at 1279; *see also* Ateev Mehrotra et al., *Comparing Costs and Quality of Care at Retail Clinics With That of Other Medical Settings for 3 Common Illnesses*, 151 ANNALS OF INTERNAL MED. 321, 326 (2009).

²³ Julie A. Muroff, *Retail Health Care: "Taking Stock" of State Responsibilities*, 30 J. LEGAL MED. 151, 177 (2009); Hsu, *supra* note 4, at 17.

²⁴ Muroff, *supra* note 15, at 163; Hsu, *supra* note 4, at 17.

number of visits to RHCs will eliminate the ability of primary care providers to manage chronic illnesses, provide preventative care, or cause follow-up visits to be delayed or absent.²⁵ Yet, one study conducted by Mehrotra et al. and published in *Health Affairs* revealed that in less than 12% of primary care visits dealing with conditions that could be treated at RHCs, the physician provided chronic illness management or preventative care.²⁶ So, while the concerns of these physicians and physician groups are important, they do not seem justified.

II. COSTS

Cost savings to the patient seems to be the second largest benefit of RHCs, behind convenience. With little more than half of Americans covered by health insurance through their employer (down from nearly 70% in 1980),²⁷ RHCs can provide a cost efficient alternative to an expensive physician office appointment, urgent care center visit, or ED admission. A recent study conducted by Mehrotra et al. in the *Annals of Internal Medicine* focused on the cost of visits to these various providers and found that RHC visits, at an average of \$66, are significantly lower than those in physician offices (\$106), urgent care centers (\$103), or EDs (\$358).²⁸ It was further discovered that three conditions, otitis

²⁵ Mehrotra et al., *supra* note 1, at 1275; Eileen Salinsky, *Medicine, Big Business, and Public Health: Wake Up and Smell the Starbucks*, PREVENTING CHRONIC DISEASE: PUB. HEALTH RES., PRAC., & POL'Y, Apr. 2009, at 1, 2.

²⁶ Mehrotra et al., *supra* note 1, at 1279.

²⁷ Kirkland, *supra* note 7 (the largest decline in coverage has been for workers earning around \$8.50 per hour, which fell from 46% to 26%).

²⁸ Mehrotra et al., *supra* note 14, at 324; *see also* Jennifer Gill, *The Nurse Will See You Now*, INC. MAG., June 2006, at 39, 40 (a recent review of claims for children treated for ear infections revealed a \$48 cost at MinuteClinic and \$102 for a trip to an urgent care center); Kirkland, *supra*

media (ear infection), pharyngitis (sore throat), and urinary tract infection, account for 48% of all RHC visits.²⁹ Of visits for these three conditions, the study found that costs at RHCs were 30 to 40% lower than at physician offices or urgent care centers, and 80% lower than EDs,³⁰ which proves that the cost savings can add up for both those with and without insurance.

Another great benefit of RHCs, unlike the physician's office, urgent care center, or ED, is that they provide pricing for services up front.³¹ For example, MinuteClinics, which are run by CVS, allow patients to obtain pricing from their computer before ever visiting the provider.³² With 95-98% of patients who visit an RHC presenting with a condition that RHC staff can treat,³³ money is not the only thing that patients are saving.

As they have continued to grow, RHCs have also begun accepting insurance - helping to keep costs even more affordable.³⁴ Another study conducted by Mehrotra et al. published in *Health Affairs* compared patient visits and discovered that 67% of patient visits to RHCs were covered by insurance and 90% of patients who visited a physician's office were covered.³⁵ Along with the

note 13 (a \$45 visit at a clinic includes all tests necessary to diagnose and treat everyday ailments, which is much cheaper than the \$95 office visit or \$400 ED visit).

²⁹ Mehrotra et al., *supra* note 14, at 322.

³⁰ *Id.* at 326.

³¹ Gill, *supra* note 20, at 40.

³² *Id.*

³³ Laws & Scott, *supra* note 2, at 1295.

³⁴ *Id.* at 1294.

³⁵ Mehrotra et al., *supra* note 1, at 1280.

cost savings RHCs provide, insured patients with primary care physicians can also benefit by having RHC visit records sent to their primary physician.³⁶

Health systems are also benefiting from forming partnerships with local RHCs.³⁷ These partnerships allow RHCs the prestige of using the name of a local, established hospital or physician practice and allow health systems a chance to “grab” new patients through referral processes that RHCs have set up.³⁸ Also, RHC staff understand when a patient’s condition is outside of their scope of practice and use the partnerships with local health systems to make referrals.³⁹ For example, one physician-run RHC in New York recently partnered with Continuum Health Partners, parent of the prestigious Beth Israel Medical Center, to give RHC providers admitting privileges and the ability to refer to its specialist providers.⁴⁰

The RHC “host” store also benefits from the clinic relationship, but there are worries about just how close the RHC and store have become. Of the patients that visit RHCs, 35% leave with a prescription, 95% of which are filled at the host store’s pharmacy.⁴¹ Between 55 and 80% of patients also tend to spend money on other merchandise in the host store, such as general merchandise or over-the-counter medicines.⁴² Physicians worry that the close proximity of RHCs to pharmacies, and even ownership by host stores, will lead providers to

³⁶ *Id.*; see also Hsu, *supra* note 4, at 21.

³⁷ Muroff, *supra* note 15, at 178.

³⁸ Hsu, *supra* note 4, at 18.

³⁹ *Id.* at 17. See also Laws & Scott, *supra* note 2, at 1296.

⁴⁰ Hsu, *supra* note 4, at 18 (explaining also that physician-run RHCs are a rarity as staffing a physician-run clinic can cost more than four times that of a traditional RHC)

⁴¹ *Id.* at 15, 21 (70% of new pharmacy customers become continuing pharmacy customers).

⁴² *Id.*

dramatically increase prescriptions, including over-prescription of antibiotics, in an effort to boost store sales.⁴³ However, researchers have looked closely at the prescribing habits of providers in RHCs, physician offices, and urgent care centers, and found that the rates of prescriptions, particularly for antibiotics, were no different among the three.⁴⁴

With such low costs and high benefits to both the patient and host store, RHCs are already looking at how they can expand to provide more services, including the addition of simple testing capabilities, such as glucose (blood sugar) and cholesterol testing.⁴⁵ However, if the number of services an RHC provides becomes too extensive, then patient care may become too complex leading them to raise prices and abandon the cost effective model that is now in place.⁴⁶

III. QUALITY & REGULATION

The need to keep costs down seems to be the key RHC success. However, quality is also important to RHCs, and they strive to maintain top marks in quality ratings by employing various types of oversight. MinuteClinic, for example, has established a national advisory council of healthcare experts to monitor its policies and practices.⁴⁷ The Convenient Care Association (CCA), a national

⁴³ Gill, *supra* note 20, at 41. See also Mehrotra et al., *supra* note 14, at 326.

⁴⁴ Mehrotra et al., *supra* note 14, at 326. See also Daniel Costello, *Report From the Field: A Checkup for Retail Medicine*, HEALTH AFF., Sept./Oct. 2008, at 1299, 1302 (“[A] one-year study published . . . in the *American Journal of Medical Quality* showed that retail clinic practitioners adhered to clinical guidelines in 99.15 percent of patient visits by not prescribing unneeded antibiotics for patients who’d received a negative rapid strep test.”).

⁴⁵ Hsu, *supra* note 4, at 15.

⁴⁶ Muroff, *supra* note 15, at 164.

⁴⁷ *Id.* at 155.

trade organization made up of healthcare professionals who measure patient quality and safety through peer review and data measures, has emerged as the driving force in quality among RHCs.⁴⁸ The CCA has disseminated ten mandatory standards for its members that reflect many of the state regulations in place for such things as proper handling of biohazard materials and other safety issues.⁴⁹ In rebuttal to arguments that RHCs are unregulated, unlicensed, and lack standards, MinuteClinic has earned accreditation from the Joint Commission, reflecting its compliance with national standards and performance measures in both patient safety and quality.⁵⁰

Dumpel, in her 2008 article published in *Registered Nurse*, notes that RHCs lack controls for infectious disease, reporting of communicable diseases, and other patient safety and quality standards that other healthcare providers are subject to.⁵¹ States such as Massachusetts, however, have taken steps to correct these problems through the implementation of new state regulations that specifically target RHCs.⁵² If providers and the healthcare field feel strongly that RHCs pose a great threat to the patients they treat, then they should advocate for stronger state regulation of these RHCs, including holding them to the standards of traditional healthcare settings, creating alternative forms of regulation, or creating exceptions to the way they are regulated.⁵³

⁴⁸ *Id.* at 156.

⁴⁹ *Id.* See also Hsu, *supra* note 4, at 19.

⁵⁰ Muroff, *supra* note 15, at 160.

⁵¹ Dumpel, *supra* note 3, at 26.

⁵² Muroff, *supra* note 15, at 157.

⁵³ *Id.*

While national physician organizations are not necessarily endorsing RHCs, some are providing their own standards for clinics to adopt.⁵⁴ For instance, the American Academy of Pediatrics and AAFP have both issued standards, that they hope RHCs will adopt, to provide care for a narrow scope of services that uses evidence and team-based medicine and that uses referrals and electronic records appropriately to provide for continuity of care.⁵⁵ Yet, without these standards, the quality measures of RHCs meet or exceed the quality ratings of traditional care settings.⁵⁶ A national survey indicated that 90% of patients were satisfied with the quality of care, convenience, and cost of the services at RHCs.⁵⁷

IV. CONCLUSION

“Approximately 50[%] of visits to family physicians are prompted by acute, episodic afflictions, many of which now can be treated by nurse practitioners in RHCs,”⁵⁸ which makes RHCs more efficient and a better alternative to an urgent care clinic or ED visit.⁵⁹ Many RHC patients report that without a RHC they would have chosen the ED or an urgent care center for treatment.⁶⁰ RHCs, therefore, appear to be serving a valuable purpose and expanding access and decreasing the number of patients that use the ED as a form

⁵⁴ Hsu, *supra* note 4, at 17.

⁵⁵ Muroff, *supra* note 15, at 154. *See also* Hsu, *supra* note 4, at 17.

⁵⁶ Mehrotra et al., *supra* note 14, at 325-26.

⁵⁷ Laws & Scott, *supra* note 2, at 1295.

⁵⁸ Muroff, *supra* note 15, at 163.

⁵⁹ *Id.* at 172.

⁶⁰ *Id.* *See also* Hsu, *supra* note 4, at 14.

of primary care. Some RHCs have begun to target those patients that would normally use EDs as their primary care, and are attempting to eliminate healthcare disparities in low-income neighborhoods by reducing costs to serve a broad, more diverse patient population.⁶¹ Even where patients have insurance, RHCs, in cooperation with insurance companies, are attempting to make care more affordable by encouraging patients to use inexpensive RHCs and offering rewards, such as waiving co-payments.⁶² While RHCs tackle only minor health problems and do little to reduce overall health costs, they help save a patient's money and time⁶³ and provide access to care for those who might have otherwise gone without,⁶⁴ which are benefits that far outweigh any current concerns.

⁶¹ Muroff, *supra* note 15, at 171-72.

⁶² *Id.* at 173.

⁶³ Hsu, *supra* note 4, at 15. *See also* Gill, *supra* note 20, at 41 (noting that 20% of the population accounts for 80% of healthcare spending.).

⁶⁴ Mehrotra et al., *supra* note 14, at 327.

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Transforming the Way We Pay Doctors

Cody Vitello *

I. INTRODUCTION

As President Obama and the 2009 Legislature take on the issue of comprehensive healthcare coverage, a corollary and inextricably linked measure has been widely adopted,¹ but not without much controversy: paying portions of physicians' compensation based off of their performance, or patient outcomes. The cost of providing more Americans with healthcare access cannot thoughtfully be resolved without addressing one of the healthcare industry's most fundamental questions: How do we compensate physicians to obtain the most efficient and cost effective outcomes while increasing patient access and health? This article intends to answer that question. Part II will provide general statistics regarding the contemporary healthcare system in America, the realities of medical cost disparities, and physician salaries. Part III will review the two primary methods and models currently employed to compensate physicians in America, emphasizing fee-for-service. Finally, Part IV will analyze the pay-for-

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¹ RAND Corporation, *Overview of Physician Pay for Performance Policy Options*, http://www.randcompare.org/options/mechanism/physician_p4p (last visited Oct. 15, 2009).

performance physician compensation model that is enthusiastically sweeping America, its benefits, and criticisms.

II. INTRODUCING THE STATUS QUO OF OUR HEALTHCARE SYSTEM

The American healthcare system is fraught with incontrovertible “inefficiencies and gaps in patient care,” as documented by the Institute of Medicine, the Agency for Healthcare Research and Quality, and the National Committee for Quality Assurance.² These inefficiencies manifest themselves through “over-utilization of expensive and unnecessary procedures, the system’s focus on treatment rather than prevention of costly chronic diseases, costly end-of-life care, and fraud and abuse.”³ An estimated 90% of American healthcare expenditures go to treat patients, while the remaining 10% go to keeping people well.⁴ Additionally, an estimated \$390 billion a year is needlessly squandered on outmoded and inefficient medical procedures.⁵ Moreover, poor-quality care leads to an estimated 66.5 million avoidable sick days each year.⁶ These statistics are not what one would expect from the world’s most expensive healthcare system and it has increasingly become apparent that throwing more money at the problems does not result in better care.⁷

² Rachel Groman, *Linking Physician Payments to Quality Care*, AMERICAN COLLEGE OF PHYSICIANS, Oct. 28, 2005, at 6, available at http://www.acponline.org/advocacy/where_we_stand/policy/link_pay.pdf.

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.* at 6-7.

⁷ *Id.* at 7.

Aside from some of the overall inefficiencies and perversions of our healthcare system as a whole, a closer look yields drastic procedure and price disparities.⁸ A survey by America's Health Insurance Plans, which represents 1300 health insurance companies, showed how two different patients, one insured by a private carrier and the other a member of Medicare, pay drastically different prices for the same procedure.⁹ To illustrate: an Illinois patient paid \$12,712 for cataract surgery and Medicare paid only \$675; a California patient was charged \$20,120 for knee surgery where Medicare would only pay \$584; and a New Jersey patient was billed \$72,000 for a spinal fusion procedure when Medicare would pay only \$1629.¹⁰ Medicare was used as the controlling standard in the study because, on average, about 80% of what private insurers pay, Medicare pays.¹¹ For this reason, Jonathan S. Skinner, a health economist at Dartmouth, calls the price levels of medical procedures in the American healthcare system the "wild, wild West."¹²

Consequently, American physicians make substantially more money than physicians in other industrialized countries.¹³ Accounting for physician pay by adjusting salaries for purchasing-power parity shows American doctors are at the

⁸ See generally Gina Kolata, *Survey Finds High Fees Common in Medical Care*, N.Y. TIMES, Aug. 12, 2009, at A15, available at http://www.nytimes.com/2009/08/12/health/policy/12insure.html?_r=2.

⁹ *Id.*

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

¹³ Catherine Rampell, *How Much do Doctors in Other Countries Make?*, N.Y. TIMES, July 15, 2009, available at <http://economix.blogs.nytimes.com/2009/07/15/how-much-do-doctors-in-other-countries-make/?apage=2>.

top of the group.¹⁴ Unsurprisingly, measuring physician pay by comparing their salaries to those of the average citizen¹⁵ (GDP per capita) or to those of other professionals¹⁶ in that country produces the same result. Thus, the gap between physician income and other professionals in the U.S. as compared to Germany, Canada, France, and the United Kingdom is much larger.¹⁷ American physician salaries, however, are in large part due to the exceedingly high cost of medical school in the U.S.; and unfortunately, reducing American physician salaries would not affect the overall cost of healthcare.¹⁸ In the American system, understanding *how* physicians get paid, and not how *much*, is important when trying to produce more efficient and better patient outcomes.¹⁹

III. AMERICAN PHYSICIAN COMPENSATION MODELS

A. Salary

A common way to compensate physicians is by providing a salary based on a fixed amount of predetermined hours according to qualifications, years of practice, seniority, and scope of responsibility.²⁰ Typically salaried physicians are

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ Christopher Beam, *Let's Pay Doctor: Couldn't We Fix the Health Care System by Paying Doctors Less?*, SLATE, Sept. 10, 2009, <http://www.slate.com/id/2227965/>.

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ Jon R. Gabel & Michael A. Redisch, *Alternative Physician Payment Methods: Incentives, Efficiency, and National Health Insurance*, 57 MILBANK MEMORIAL FUND Q.: HEALTH & SOC'Y 38, 41 (1979).

associated with a type of institution, such as a hospital, clinic, medical school, or health maintenance organization.²¹

Salary compensation models contain both beneficial and adverse consequences for patients. The favorable effects of salaried physicians are: there is no incentive to deny access to any patient and thus, patient access is high; there is no incentive to provide excessive treatment, tests, or referrals; and the physician's income is consistent and secure.²² However, the harmful effects of salaried physicians are: there is no incentive to provide the optimal or desired level of care; there is no incentive to limit increasing operating costs from requested services; there is no incentive to monitor patient care; and there is no incentive to build and foster close patient relationships.²³ Thus, the biggest pitfall of a salary compensation model, while simple to implement and easy to monitor, is that physicians have no incentive to do more than the bare minimum of what is required to keep their jobs.²⁴

B. Fee-for-Service

The United States employs many different types of physician compensations models, but the predominant system utilized in the U.S., and a common model elsewhere, is fee-for-service.²⁵ Fee-for-service is a method where the physician charges a fee for each individual service, such as an office visit, X-

²¹ *Id.*

²² MUKESH CHAWLA ET AL., PAYING THE PHYSICIAN: REVIEW OF DIFFERENT METHODS 7 (1997), available at <http://www.hsph.harvard.edu/ihs/publications/pdf/No-70.PDF>.

²³ *Id.* at 7-8.

²⁴ *Id.* at 8.

²⁵ Gabel & Redisch, *supra* note 20, at 39.

ray, treatment, or consultation.²⁶ When third parties are responsible for paying the bill, such as insurance companies, they either reimburse the physician based off of predetermined schedules or the customary, prevailing, and reasonable (CPR) reimbursement method.²⁷ Fee schedules are established by surveying the average charges for a certain procedure or negotiated with the physician to establish the maximum the third party is willing to pay.²⁸ The CPR method establishes a separate fee schedule for each physician and reimburses services based on the lowest actual charge, customary charge, or the geographic area's prevailing charge.²⁹

Fee-for-service compensation models contain both beneficial and adverse consequences for patients. The favorable effects of the fee-for-service system are: the ease for a patient to change or compare prices between doctors; patients that require many treatments or complex operations are unlikely to be turned away; and incentives for a physician to increase the quality of care to produce returning patients.³⁰ However, the harmful effects of fee-for-service models are: physicians have a strong financial incentive to increase the amount of services billed to the patient and thus, increase healthcare costs; and “physicians have a strong incentive to induce demand.”³¹ In fact, it has been found that the cross-price elasticity of demand for services between doctors is inelastic; thus, physicians can

²⁶ *Id.*

²⁷ *Id.* at 39-40.

²⁸ *Id.* at 40.

²⁹ *Id.*

³⁰ CHAWLA ET AL., *supra* note 22, at 17.

³¹ *Id.*

discretionarily recommend additional services, at a price they determine, and patients will likely stay with the physician.³² This is particularly troubling because the more physicians can induce demand, the less responsive they will be to price incentives, and thus, pay-for-performance models.³³ Furthermore, the administrative costs borne by fee-for-service programs are relatively high for both physicians and third party payers.³⁴ Finally, experience indicates that fee-for-service models generally create swift increases in overall healthcare costs.³⁵

IV. PAY-FOR-PERFORMANCE COMPENSATION MODELS

A. Introduction

Existing deficiencies³⁶ in the fee-for-service model, the American majority model,³⁷ which rewards doctors based on quantity rather than quality, have convinced many policymakers to support pay-for-performance models,³⁸ which have been implemented in more than half of all private sector healthcare contracts.³⁹ For instance, the Centers for Medicare and Medicaid Services (CMS) implemented pay-for-performance measures in its programs beginning in 2007.⁴⁰ Widespread adoption of pay-for-performance models have not come without

³² Gabel & Redisch, *supra* note 20, at 43.

³³ *Id.* at 45.

³⁴ CHAWLA ET AL., *supra* note 22, at 18.

³⁵ *Id.*

³⁶ RAND, *supra* note 1.

³⁷ Gabel & Redisch, *supra* note 20, at 39.

³⁸ Bonnie Darves, *Physician Pay-for-Performance Programs Taking Hold*, NEW ENG. J. MED. (2007), available at <http://www.nejmjobs.org/printpage.aspx?fid=pay-for-performance&af=/content/career-resources/pay-for-performance.htm>.

³⁹ RAND, *supra* note 1.

⁴⁰ Darves, *supra* note 38.

criticism. Specifically, the American Medical Association (AMA) and various other specialty societies have publically opposed many early pay-for-performance programs, questioning their effectiveness, methodologies, and motives.⁴¹ So, why is it that pay-for-performance plans, some paying out as much as \$55 million in 2006⁴² (CMS paid \$36 million in 2007⁴³), are here to stay? The CEO of Bridges to Excellence (BTE), an organization promoting efforts to recognize and reward high-performing physicians,⁴⁴ has answered that question stating: “The bottom line is simple: P4P [pay-for-performance] works.”⁴⁵

B. Structure

Pay-for-performance compensation systems can be organized in many different ways, but are primarily set up to provide monetary, and non-monetary, incentives to physicians for attaining predetermined goals.⁴⁶ The American Academy of Family Physicians (AAFP) supports pay-for-performance goals that: “[f]ocus on improved quality of care . . . [s]upport the physician/patient relationship . . . [u]tilize performance measures based on evidence-based clinical guidelines . . . [i]nvolve practicing physicians in program design . . . [u]se reliable, accurate, and scientifically valid data . . . [and] [o]ffer voluntary

⁴¹ *Id.*

⁴² *Id.*

⁴³ Centers for Medicare & Medicaid Services, *Physician Quality Reporting Initiative 2007 Reporting Experience*, DEP’T OF HEALTH AND HUMAN SERVICES, Dec. 3, 2008, at 10, available at <http://www.cms.hhs.gov/PQRI/Downloads/PQRI2007ReportFinal12032008CSG.pdf>.

⁴⁴ Cary Conway, *Research Shows that Physician Pay-for-Performance Programs Work with Appropriate Incentives*, BRIDGES TO EXCELLENCE, May 7, 2009, available at <http://www.bridgestoexcellence.org/Content/ContentDisplay.aspx?ContentID=195>.

⁴⁵ *Id.*

⁴⁶ Karen Llanos & Joanie Rothstein, *Physician Pay-for-Performance: A Guide for States*, CENTER FOR HEALTH CARE STRATEGIES, INC. 5 (2007), available at http://www.chcs.org/usr_doc/Physician_P4P_Guide.pdf.

physician participation.”⁴⁷ Similarly, the AMA supports pay-for-performance goals of an analogous nature.⁴⁸

Pay-for-performance programs often utilize both, financial and non-financial, incentives to encourage physicians to achieve the plan’s goals.⁴⁹ Non-financial incentive models include: public disclosure of performance reports and public recognition; technical assistance; assignment of patients; reduced administrative requirements; and patient assignment sanctions.⁵⁰ Financial incentive models include: payments for participation in the program or its related workshops; payments for timely conducted and recorded procedures; bonuses for achieving certain levels of care with all patients; tiered bonuses for high rankings relative to other physicians; bonuses for improvement; forfeiture of Medicaid fee schedule increases until reaching a threshold; and withholding compensation until meeting certain thresholds.⁵¹ Pay-for-performance plans should also send, with the actual bonus check, a voided check of what the physician could have received had performance been better – incentivizing participation.⁵²

C. Outcomes

Studies seem to agree that pay-for-performance programs do accomplish desirable physician practices. A 2009 study published in *The American Journal*

⁴⁷ American Academy of Family Physicians, *Pay-For-Performance*, (2009) <http://www.aafp.org/online/en/home/policy/policies/p/payforperformance.html>.

⁴⁸ See generally American Medical Association, *Principles for Pay-for Performance Programs*, July 21, 2005, available at <http://www.ama-assn.org/ama1/pub/upload/mm/368/principles4pay62705.pdf>.

⁴⁹ Llanos & Rothestein, *supra* note 46, at 7.

⁵⁰ *Id.* at 8.

⁵¹ *Id.* at 12.

⁵² *Id.* at 22.

of *Managed Care* reports that pay-for-performance benefits all stakeholders, including physicians, health plans, and patients.⁵³ The study further finds that participation increases with larger rewards or incentives.⁵⁴ Additionally, a study published in *Health Services Research* concluded similar results, finding a “strong correlation between quality of patient care and physician participation in a quality-based incentive program.”⁵⁵ This correlation, the study finds, grew even stronger over time ultimately resulting in patients experiencing significantly better quality of care.⁵⁶ Finally, a study published in *Medical Care* found that compensation incentives can be used by physicians to influence desired patient care procedures.⁵⁷ Moreover, the study found that using a more “nuanced portfolio approach to compensation,” as in mixed incentives, produced more desirable outcomes.⁵⁸

D. Criticisms and Improvements

Despite the overwhelming success and pervasive movement towards implementing pay-for-performance compensation models into physician contracts not everyone is happy. For example, the American College of Physicians (ACP) is worried that these programs will: motivate doctors to avoid treating difficult

⁵³ Francois S. de Brantes & B. Guy D’Andrea, *Physicians Respond to Pay-for-Performance Incentives: Larger Incentives Yield Greater Participation*, 15 THE AM. J. OF MANAGED CARE 305, 305 (2009), available at http://www.ajmc.com/media/pdf/AJMC_09May_deBrantes305to310.pdf.

⁵⁴ *Id.* at 308.

⁵⁵ ScienceDaily, *Doctor ‘Pay-for-performance’ Improves Patient Care, Study Shows*, Jan. 11, 2008, <http://www.sciencedaily.com/releases/2008/01/080110123913.htm>.

⁵⁶ *Id.*

⁵⁷ Stephen M. Shortell ET AL., *Implementing Evidence-Based Medicine: The Role of Market Pressures, Compensation Incentives, and Culture in Physician Organizations*, 39 MED. CARE I62, I70 (2001), available at <http://www.jstor.org/stable/3767914>.

⁵⁸ *Id.* at I72.

patients; cause some doctors to focus on “gaming” the system rather than actually improving care; misalign the perceptions between patients and physicians; and increase unnecessary care and medical costs.⁵⁹ More specifically, physicians fear that patients with chronic illnesses will be disfavored for treatment.⁶⁰ Chronic illnesses, such as asthma, diabetes, and obesity depend so much on the patient’s lifestyle that doctors worry that they will be unfairly penalized for failing to meet certain outcomes or standards.⁶¹ Other physicians worry about the costs of implementing the data recording systems required to track and reward physicians under the pay-for-performance models.⁶²

Fortunately for pay-for-performance advocates, many of the program’s criticisms are relatively easy to address. Incentive programs can be tailored for individual markets and or regions to address certain local nuances. Moreover, incentives can recognize and account for chronic illnesses by rewarding “high performance, in addition to continuous quality improvement.”⁶³ Additionally, Congress has recognized the prohibitive costs to such programs and passed the Health Information Technology for Economic and Clinical Health Act, which invests \$20 billion in health information technology⁶⁴ and provides other financial

⁵⁹ Lois Snyder and Richard Neubauer, *Pay-for-Performance Principles that Promote Patient-Centered Care: An Ethics Manifesto*, ANN. OF INTERNAL MED. 792, 793 (2007), available at <http://www.annals.org/cgi/reprint/147/11/792.pdf>.

⁶⁰ Silvia Brandt, *Against Physician Pay-for-Performance*, THE WASH. POST. July 30, 2009, available at http://voices.washingtonpost.com/hearing/2009/07/against_physician_pay-for-perf.html.

⁶¹ *Id.*

⁶² Groman, *supra* note 2, at 19.

⁶³ *Id.* at 16.

⁶⁴ MAJORITY STAFF OF THE COMMITTEES ON ENERGY AND COMMERCE, WAYS AND MEANS, AND SCIENCE AND TECHNOLOGY, HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL

incentives to hospitals and doctors to implement such data collection systems.⁶⁵ Finally, pay-for-performance programs work in conjunction with traditional compensation models and can be adjusted and customized readily to avoid undesirable outcomes.

V. CONCLUSION

The American healthcare system, although superior in many aspects, has been plagued with much inefficiency. Specifically, the fee-for-service method of compensating physicians has decreased the quality of care and dramatically raised costs. Pay-for-performance methods of physician compensation have been introduced into the status quo to combat such inequities. Although these models are not without their critics, they are receiving widespread adoption and recognized success. Ultimately, the forces behind pay-for-performance compensation models have yielded a surprising, and much needed, turnaround in patient outcomes and physician practices. Finally, the key to choosing and adopting a pay-for-performance model is to adequately research and implement the model's goals, incentives, and concurrent compensation method, such as salary or fee-for-service; doing so has been shown to benefit all involved.

HEALTH ACT OR HITECH ACT, Jan. 16, 2009, *available at* <http://waysandmeans.house.gov/media/pdf/110/hit2.pdf>.

⁶⁵ *Id.*

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Disparity in Patient Care and a Physician Pay-For-Performance Compensation Model as a Possible Solution

Daniel Avants *

Disparity is prevalent in the American healthcare system and creates unequal care for the poor as well as racial and ethnic minorities. Although this problem is recognized, and some efforts have been made to improve the situation, disparities continue to worsen. The poor and other minorities have seen their quality of care and access to care decrease over the last decade. A proposed solution to this difficulty is to encourage physicians to provide care for these individuals. One way in which physicians may be encouraged is by either increasing or decreasing pay based upon a compensation model. Although various compensation models exist in the United States, the pay-for-performance model, if properly executed, would substantially improve the access to and quality of healthcare for the poor and minorities in the United States.

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I. DISPARITY IN HEALTHCARE

Healthcare disparities in the United States is defined as the difference in care provided to one population group as compared to another, specifically being measured by access to healthcare and the quality of healthcare received.¹ According to the National Healthcare Quality Report, Americans often do not receive necessary care or they receive care that causes harm.² All Americans deserve an opportunity to experience positive health outcomes by receiving timely and appropriate healthcare.³

Looking first towards the quality of care received, the report found that between 2000 and 2006, healthcare disparities based on socioeconomic status stayed the same or worsened in over 60% of the studied measures.⁴ This trend was also true for Blacks, Asians, American Indians, Hispanics, and the poor.⁵ Moreover, each of these groups received a quality of healthcare which was lower than Whites in the United States over the same time period.⁶

These statistics demonstrate that racial minorities and the poor receive inferior healthcare compared to White Americans of good financial standing. Additionally, there is not a significant trend of improvement in healthcare for these populations, as less than 40% of the study's quality measures improved

¹ AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, NATIONAL HEALTHCARE DISPARITIES REPORT 2008 1-2 (2008).

² *Id.* at 1.

³ *Id.* at 2.

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

across these groups as a whole.⁷ Even more concerning is that by 2006, the quality of care received by Blacks, Asians, and the poor actually worsened rather than improved.⁸ This means that an individual belonging to one of these populations who received some type of healthcare in 2006 was more likely to receive worse care than they would have received in 2000.

In regards to access to healthcare, a similar study from 2000 to 2006 demonstrates that these same racial, ethnic, and socioeconomic disparities produced similar trends in healthcare access.⁹ Access, in healthcare, refers to a person's right and ability to receive the care necessary to maintain a healthy life. When looking at core healthcare access measures, Blacks, Asians, Hispanics, and poor Americans had 40% of conditions worsen.¹⁰ Only one group, American Indians, avoided this trend, and experienced no conditions worsening and saw improvement in 75% of the core access measures.¹¹ Nevertheless, the remaining groups saw no such improvement.

A number of barriers exist that may lead to difficulty in accessing healthcare, such as a lack of health insurance or a lack of healthcare providers in a geographical region.¹² Blacks, Asians, Hispanics, and the poor all experienced an equal or greater difficulty accessing appropriate healthcare in 2006 as compared

⁷ *Id.*

⁸ *Id.*

⁹ *Id.* at 3.

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.*

to 2000.¹³ As this suggests, improvements in healthcare access are being negated by an equal or greater number of barriers to access.¹⁴

Together, these statistics suggest that poor Americans, and those from racial minorities, are facing great difficulties obtaining appropriate healthcare, as measured by two key components—access and quality. Some scholars and economists suggest that looking to improved physician compensation methods will encourage physicians to provide better access to and a higher quality of healthcare.¹⁵

II. PHYSICIAN COMPENSATION MODELS – PAY FOR PERFORMANCE

Across the United States, there are numerous models and pilot programs that are used by healthcare providers to pay physicians, aimed at improving the quality of care and increasing efficiency.¹⁶ We can look to these models to see which, if any, can or may reduce the disparity in American healthcare as highlighted above, such as state-based capitation and pay-for-performance.¹⁷ Each of these models utilizes unique forms of physician compensation.

Capitation is a model that involves prepaying physicians for healthcare services.¹⁸ These payments are made per month based upon the number of

¹³ *Id.*

¹⁴ *Id.*

¹⁵ Rodney G. Hood, *Pay-for-Performance---Financial Health Disparities and the Impact on Healthcare Disparities*, 99 J. NAT'L MED. ASS'N 1, 1 (2007).

¹⁶ Meredith B. Rosenthal, *Beyond Pay for Performance—Emerging Models of Provider-Payment Reform*, 359 NEW ENG. J. MED. 1197, 1198-1199 (2008).

¹⁷ *Id.* at 1198.

¹⁸ PETER R. KONGSTVEDT, *ESSENTIALS OF MANAGED HEALTH CARE* 106 (4th ed., 2001).

members enrolled in the program.¹⁹ This type of model is often used by Health Management Organizations.²⁰ The rates can vary based on the member's age, gender, health, and geography; however, the rates do not change based on volume of services provided.²¹ Benefits to this model include incentives for physicians to reduce expenses and streamline care.²² Nevertheless, this is a performance-based compensation model where a physician is paid for the services provided.²³

Although pay-per-performance structures often vary, many are organized the same way.²⁴ Under this model, organizations will pay physicians bonuses for improvements that are made to the quality measures of the organization, which do not include a change to the health plan.²⁵

Organizations will also pay physicians if their performances improve. Similarly, individual health plans, Medicaid or Medicare will pay individual physicians for improved performance.²⁶ A drawback to this model is that physicians are only rewarded for the improvements related to the number of patients that may have a particular medical condition, thereby creating a possibility for minimal monetary incentives for the physicians who treat few patients with the condition.²⁷ Depending on how the particular program is structured, physicians may not be rewarded for all improvements or in their

¹⁹ *Id.*

²⁰ *Id.* at 105.

²¹ *Id.* at 106, 108.

²² *Id.* at 109-10.

²³ *Id.* at 109.

²⁴ Thomas Bodenheimer et al., *Can Money Buy Quality? Physician Response to Pay for Performance*, 3 IND. HEALTH L. REV. 445, 446-47 (2006).

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

largest treatment area. Some private health plans, however, along with Medicare, pay the physician's organization rather than the physician.²⁸ This allows the organization to pool funds and create greater rewards for physicians through bonuses or quality enhancements.

III. USING COMPENSATION MODELS TO REDUCE DISPARITY

Although the capitation system is a good system overall to improve the quality of care and control costs, the capitation system does not provide the compensation-based incentives necessary to significantly decrease the healthcare disparity.²⁹ Capitation models allow for indirect discrimination through rate changes based on age, sex, and genders, as well as other factors, depending on the type of plan that is used.³⁰ This type of model has been popular in the United States for over twenty years, however, as new models are introduced, HMOs and other providers are switching to alternative models.³¹

The pay-for-performance model likely provides the best method of decreasing the disparity that exists in the American healthcare system. Many models can be tweaked or designed to significantly incorporate the goals of disparity reduction, but pay-for-performance is best adapted. Moreover, pay-for-performance is becoming increasingly popular among physicians' organizations.

²⁸ *Id.*

²⁹ KONGSTVEDT, *supra* note 18, at 109.

³⁰ *Id.* at 108, 153.

³¹ Meredith B. Rosenthal et al., *Pay for Performance in Commercial HMOs*, 355 NEW ENG. J. MED. 1895, 1897 (2006).

By improving an existing popular model, we will have a greater success in reaching our goals.

According to a recent study by The New England Journal of Medicine surveying 252 HMOs across forty-one metropolitan areas, more than 50% of HMOs use a pay-for-performance model.³² Based upon the sizes of those HMOs, 80% of members enrolled in an HMO utilize a pay-for-performance structure.³³ Of the 126 plans that use pay-for-performance, 90% had programs for physicians and 38% had programs for hospitals.³⁴ Therefore, it is evident that pay-for-performance programs are becoming an increasingly popular model for the country's most popular healthcare structures.

When initially designed, the pay-for-performance model did not consider the effects on disparity.³⁵ Policymakers argue about the true effects of the model, but there are no conclusive studies that suggest that the pay-for-performance model, as currently aligned, significantly improves or worsens the disparity that exists.³⁶ One study shows that physicians, who are highly ranked through a combination of quality and efficiency variables, are no more likely to care for the poor or racial and ethnic minorities than physicians that are ranked poorly.³⁷ In contrast, another study shows that hospitals that care for a disproportionate number of poor and ethnic and racial minorities may be less able to earn the

³² *Id.* at 1895.

³³ *Id.*

³⁴ *Id.*

³⁵ Alyna T. Chien & Marshall H. Chin, *Incorporating Disparity Reduction into Pay for Performance*, 24 J. GEN. INTERNAL MED. 135, 135 (2008).

³⁶ *Id.*

³⁷ *Id.*

bonus payments under Medicare's pay-for-performance program.³⁸ By looking to the future of pay-for-performance, some improvements can be made on the current system, which will help to eliminate healthcare disparity.

To improve the care of minority patients, it is important to analyze what is causing the disparity. There are two primary possibilities: (1) healthcare providers are providing inferior treatment for different members within the same group or (2) minority patients are often cared for by lower quality providers.³⁹ If it is determined that disparity exists because providers treat minority patients differently from White patients, then physician payments can be correlated to high quality and racially equitable healthcare.⁴⁰ If it is determined that disparity exists because minorities are more often cared for by lower quality providers, then pay-for-performance programs can be designed to encourage high quality providers to care for the poor and ethnic and racial minorities.⁴¹ Alternatively, providers could be enticed with additional incentives to pursue equality improvement efforts. Providers that disproportionately serve poor and minority patients are sometimes overwhelmed with the demand, are under-resourced, or lack access to specialty referrals.⁴² Improving any of these conditions would help eliminate the healthcare disparity.

Once the source of the healthcare disparity is known, pay-for-performance models should employ measures that reduce this disparity. One way this can be

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.*

done is by targeting specific medical conditions known to have large disparities and rewarding physicians that demonstrate an equal ability to diagnose and treat the condition.⁴³ For example, there is a significant gap between the number of White and Black women that are treated for breast cancer in its early stages.⁴⁴ Even though diagnostic rates are similar, they are not treated at an equally proportional rate.⁴⁵ An improved pay-for-performance model would reward physicians that are able to treat a proportionate number of White and Black breast cancer patients.⁴⁶ Another way to improve the existing disparity is to reward physicians that incorporate the medical traditions of different cultures into the treatment process.⁴⁷ For example, many minority populations value group decision-making processes, especially when the decisions relates to health conditions.⁴⁸ Additionally, the pay-for-performance model can simply reward any direct improvements in the disparity of the healthcare provided.⁴⁹ A physician would be rewarded for reducing disparity in the treatment of a specific disease, for increasing his patient diversity, or any other number of disparity measures.

Finally, pay-for-performance models could reward improvements and achievement made by the physician's organization.⁵⁰ After making the choice of what type of disparity improvements should be rewarded, as noted above, it will

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.* at 136.

be important to also determine the degree of performance required.⁵¹ Policymakers have noted that pay-for-performance models that set high benchmarks as the sole incentive often yield more negative consequences than positive ones with respect to disparity.⁵² If gradual increases are rewarded, however, such as increasing minority screening rates for a certain disease by 50%, then physicians are more likely to reach the target and more patients will receive the care.⁵³ It is essential that the model recognizes both absolute achievements and gradual improvements along the way.⁵⁴

IV. CONCLUSION

Healthcare disparity is a significant issue in the United States because the poor, as well as ethnic and racial minorities, are not able to access the same quality of healthcare as well-situated white Americans. By utilizing a popular physician compensation model and making minor revisions to its compensation processes, it may be possible to entice physicians to care for more diverse groups of patients and to improve that quality of care.

⁵¹ *Id.*

⁵² *Id.*

⁵³ *Id.* at 135.

⁵⁴ *Id.*

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Medical School Costs and Its Impact on Rural Medicine

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I. INTRODUCTION

President Obama's plan to reform healthcare by ensuring that every American is able to afford health insurance is an admirable attempt to fix the healthcare crisis that faces our country. However, this alone cannot solve the crisis. While the number of Americans seeking healthcare will dramatically increase, the number of physicians available to serve them, particularly in rural areas, will not follow suit. Providing an adequate number of primary care physicians, particularly in these underserved areas, is critical to improving the national healthcare system since they help to contain the cost of healthcare and improve the general health of society.¹ Medical school costs, however, are reaching staggering heights² and rural communities across the country are feeling the impact.

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¹ Kristine Marietti Byrnes, *Is there a Primary Care Doctor in the House? The Legislation Needed to Address a National Shortage*, 25 RUTGERS L.J. 799, 806-08 (1994).

² See ASS'N OF AM. MED. COLL., MEDICAL STUDENT EDUCATION: COSTS, DEBT, AND LOAN REPAYMENT FACTS 1 (2008), <http://www.aamc.org/programs/first/debtfactcard.pdf> [hereinafter AAMC, FACTS].

Unless we relieve the financial pressures on medical students and young doctors, they have no incentives to enter primary practice in rural communities.³ This contributes to the disparities in medicine that those living in rural communities face.⁴ There are two ways to decrease the financial pressures on medical students and young doctors, and consequently decrease the resulting impact on rural medicine. First, the cost of medical school should be decreased in order to increase the number of physicians entering primary practice. Second, the number of loan reimbursement and scholarship programs should be increased in order to lure doctors to underserved rural communities.

To guarantee that the proposed healthcare reforms are successful and to alleviate disparities in rural medicine, we must provide financial incentives to make practicing medicine in these communities possible. Therefore, this article seeks to understand how increasing medical school debt impacts disparities in rural medicine and how to prevent these disparities. As such, Part II discusses the dramatically increasing cost of medical school and the associated debt that graduates face. Additionally, this section explains the impact that these increasing costs have on physician career choices. Part III then describes how physician career choices impact access to medicine in rural communities and the treatment disparities that people in these communities face. Next, Parts IV and V examine ways to alleviate the deleterious impact that increasing costs have on

³ See Stephanie Gunselman, *The Conrad "State-30" Program: A Temporary Relief to the U.S. Shortage of Physicians or a Contributor to the Brain Drain?*, 5 J. HEALTH & BIOMEDICAL L. 91, 94 (2009).

⁴ *Id.* at 95.

rural medicine. Part IV analyzes the need to decrease the cost of medical school as a means of making primary practice a more financially feasible option. Thereafter, Part V considers how loan reimbursement and scholarship programs can be used to lure physicians to underserved rural communities.

II. THE IMPACT OF THE INCREASING COST OF MEDICAL SCHOOL

According to the Association of American Medical Colleges, in 2008, 87% of medical students graduated with debt.⁵ On average, medical students graduate with about \$155,000 of debt.⁶ On the other hand, the average salary of a first year resident is only \$45,569.⁷ As a result, “young physicians struggling to pay off their educational debt over the standard [ten]-year period could find these payments consuming over half of their after-tax income.”⁸ According to another report from 2007, if the current trends continue, borrowers using the standard ten-year repayment period will spend half their income allotted for personal spending to pay off their medical education debt.⁹ If, on the other hand, they opt for the twenty five-year repayment period, they will still be paying off loans in their fifties.¹⁰

⁵ AAMC, FACTS, *supra* note 2, at 1.

⁶ *Id.*

⁷ *Id.*

⁸ ASS'N OF AM. MED. COLL., MEDICAL SCHOOL TUITION AND YOUNG PHYSICIAN INDEBTEDNESS: AN UPDATE TO THE 2004 REPORT 3 (2007), https://services.aamc.org/publications/showfile.cfm?file=version103.pdf&prd_id=212&prv_id=256&pdf_id=103.

⁹ *Id.* at 7.

¹⁰ *Id.*

It is no surprise then that education related indebtedness is one of the most significant factors influencing a physician's career choice.¹¹ As a result, young physicians frequently take into account income, hours worked, and loan repayment when considering a specialty.¹² "Differentials in physician income levels cause students to pursue careers in higher-paying specialties."¹³ Consequently, a "small[er] number of medical graduates [are] planning to work as primary care physicians or general surgeons."¹⁴ Instead, they "tend to choose more lucrative specialties, in part to repay the high cost of attending medical school in the United States."¹⁵ This trend is on the rise. In 1994, "[f]ewer than one-third of American physicians [were] generalists, and fewer and fewer medical school graduates [chose] primary care careers."¹⁶ By 2008, only 2% of fourth year medical students planned careers in general internal medicine.¹⁷

III. DISPARITIES IN RURAL MEDICINE

For a significant number of Americans, access to healthcare is denied simply because of a shortage of physicians.¹⁸ Although there is a surplus of physicians, they are concentrated in affluent sections of major cities and primary

¹¹ Byrnes, *supra* note 1, at 804.

¹² Carol S. Weissert & Susan L. Silberman, *Sending a Policy Signal: State Legislatures, Medical Schools, and Primary Care Mandates*, 23 J. HEALTH POL. POL'Y & L. 743, 746 (1998).

¹³ Byrnes, *supra* note 1, at 804.

¹⁴ Gunselman, *supra* note 3, at 94.

¹⁵ *Id.*

¹⁶ Carol Weissert et al., *Education and the Health Professions: Explaining Policy Choices Among the States*, 19 J. HEALTH POL. POL'Y & L. 361, 361 (1994).

¹⁷ AM. MED. ASS'N, MEDICAL STUDENT DEBT 3 (2009), http://www.ama-assn.org/ama1/pub/upload/mm/15/cola_debt_pres.pdf [hereinafter AMA, DEBT].

¹⁸ Byrnes, *supra* note 1, at 799.

care physicians are still in short supply.¹⁹ “Approximately [sixty-five] million Americans lack access to a primary care provider because of shortage – many of whom are rural Americans.”²⁰ According to the National Health Service Corp (NHSC), “nearly [fifty] million Americans currently live in health professions shortage areas (HPSAs) – underserved communities which lack adequate access to primary care services – and that 27,000 primary care professionals are needed to adequately serve the people living in HPSAs.”²¹

However, “[t]his shortage of physicians disproportionately affects patients living in rural areas.”²² Although “[20%] of the United States population lives in rural areas, only [9%] of physicians practice in rural areas.”²³ People in small, rural communities are “left with few doctors and long waiting periods to see a physician.”²⁴ Additionally, they must often drive long distances for basic healthcare and wait in crowded emergency rooms to get treatment for minor problems.”²⁵ Consequently, this vulnerable population suffers from consistently poor health and regularly has no access to necessary healthcare.²⁶

¹⁹ *Id.* at 800.

²⁰ WhiteHouse.gov, How Health Insurance Reform Will Help Rural Americans, http://www.whitehouse.gov/assets/documents/Pages_from_Health_Insurance_Reform_PDF-6.pdf (last visited October 10, 2009).

²¹ AM. COLL. OF PHYSICIANS, IMPROVE FUNDING FOR PRIMARY CARE WORKFORCE AND HEALTH CARE RESEARCH AND QUALITY IN FY2010 2 (2009), <http://www.acpservices.org/leadday09/agenda/18.doc>.

²² Gunselman, *supra* note 3, at 95.

²³ *Id.*

²⁴ *Id.* at 91.

²⁵ Byrnes, *supra* note 1, at 800.

²⁶ *Id.*; Gunselman, *supra* note 3, at 95.

IV. DECREASING MEDICAL SCHOOL COSTS TO
INCREASE PRIMARY PRACTITIONERS

In general, “although the United States is headed for a significant physician surplus, inequity in access to high-quality primary care still remains.”²⁷ Primary care physicians are “doctors who provide ‘first-contact’ care, or the generalized services patients receive on an ongoing basis.”²⁸ In many areas, such as rural communities, primary care as opposed to specialty care is provided most of the time.²⁹ Therefore, “primary care physicians play a key role in the delivery of health care because they provide truly accessible, continuing, comprehensive, and coordinated care for most problems of unscreened patients.”³⁰ Generalists could treat approximately 85% of all medical conditions.³¹ Their services are more utilitarian because of their ability to treat a wide variety of patients.³² However, “the majority of medical school graduates [are] not entering primary care fields but [are] opting for specialty practice instead.”³³ Given primary care practitioners’ vital role in the healthcare system, the decreasing number of physicians choosing this field is particularly problematic.

While the decreasing numbers of primary care doctors is alarming, it is not difficult to understand why this problem is occurring. As discussed above, the average medical student is graduating with an almost insurmountable amount of

²⁷ Robert Politzer et al., *The National Health Service Corps for the 21st Century*, 23 J. AMBULATORY CARE MANAGE 70, 70 (2000).

²⁸ Byrnes, *supra* note 1, at 801.

²⁹ *Id.*

³⁰ *Id.* at 801-802 (internal citations omitted).

³¹ *Id.* at 802.

³² *Id.*

³³ *Id.*

debt.³⁴ Consequently, debt is a very influential factor in specialty choices for many young physicians.³⁵ Because there are extreme inconsistencies in physician income levels, students tend to choose more lucrative specialties to repay the high costs of medical school.³⁶ According to the American Medical Association, “[p]rimary care doctors on average make only 55% of what all other specialists make.”³⁷ Therefore, as fewer and fewer physicians choose to practice primary medicine, rural communities are suffering the repercussions.³⁸

By decreasing the cost of medical school, young physicians would be less burdened by debt. As a result, physicians who would otherwise be limited by financial constraints would have more freedom to choose primary medicine over higher paying specialties. Thus, rural communities would benefit from an increased number of primary care doctors. Although doctors’ salaries in rural communities are somewhat lower than those in urban areas,³⁹ it would be less prohibitive for young physicians looking to practice primary medicine, particularly in rural communities, if they were weighed down by less debt.⁴⁰

³⁴ AAMC, FACTS, *supra* note 2, at 1 (Students graduate with an average of \$155,000 of debt and will likely be strapped with monthly loan payments that eat almost half of their expendable income or end up paying their loans into their fifties.).

³⁵ AM. MED. ASS’N, FINAL DRAFT 2003 REPORT OF THE AMERICAN MEDICAL ASSOCIATION – MEDICAL STUDENT SECTION TASK FORCE ON MEDICAL STUDENT DEBT, 8 (2003), http://www.ama-assn.org/ama1/pub/upload/mm/15/debt_report.pdf.

³⁶ Byrnes, *supra* note 1, at 804; Gunselman, *supra* note 3, at 94.

³⁷ Chris Silva, *Medicare advisory agency to back 1.1% physician pay raise for 2010*, AMERICAN MEDICAL NEWS, Feb. 9, 2009, <http://www.ama-assn.org/amednews/2009/02/09/gvl10209.htm>.

³⁸ AMA, DEBT, *supra* note 17, at 3 (In 2008, only 2% of medical students planned to practice general internal medicine.); Gunselman, *supra* note 3, at 95.

³⁹ JAMES D. RESCHOVSKY & ANDREA STAITI, PHYSICIAN INCOMES IN RURAL AND URBAN AMERICA, 2 (2005) http://www.medicuspartners.com/pdfs/Rural_vs_City_2-5_Article.pdf.

⁴⁰ AMA, DEBT, *supra* note 17, at 15.

V. INCREASING DEBT REPAYMENT AND SCHOLARSHIP PROGRAMS
TO LURE DOCTORS TO RURAL COMMUNITIES

In addition to decreasing the cost of medical school, increasing the number of debt repayment and scholarship programs would help ease the harmful impact that increasing costs have on rural medicine. These programs provide financial incentives to debt-ridden medical students in order to lure them into practicing rural medicine. While there are already a few federal and state programs offering loan repayment and scholarship payment in exchange for several years of service in an underserved community, we must commit more resources to these programs in order to affect the growing disparities in rural medicine.⁴¹

Generally, health professionals in rural areas earn less than their urban counterparts, “making it difficult to repay school loans, buy malpractice insurance, and earn a decent living.”⁴² As a result, “hard-to-fill posts . . . will probably never independently attract physicians.”⁴³ This furthers the extreme shortages in primary care providers that rural communities face. However, loan repayment and scholarship programs will, at least in the short term, provide physicians to underserved areas.⁴⁴

Programs already in existence include the federal government’s NHSC and a number of state programs. The NHSC, which was “created in 1970 to provide primary health care clinicians for the underserved, aims at spreading

⁴¹ See *id.* at 14.

⁴² Weissert et al., *supra* note 16, at 367.

⁴³ Byrnes, *supra* note 1, at 845.

⁴⁴ *Id.* at 845-46.

clinicians more evenly.”⁴⁵ Under the program, “[i]dealistic young doctors and other health workers would serve voluntarily in ‘doctor-deficient areas.’”⁴⁶ The program, however, has “strings or substantial penalties if the student defaults on his or her promise to serve in an underserved area for the specified period of time.”⁴⁷

The NHSC has two programs to fund medical school and simultaneously provide primary practitioners to underserved rural communities.⁴⁸ First, the NHSC Scholarship program pays tuition for scholars while they are in school and, as repayment, the scholars commit to serving as physicians in an underserved community after graduation. Specifically, the scholarship pays tuition, required fees, and some other education costs tax free, as well as a monthly living stipend for up to four years.⁴⁹ Thereafter, the scholars are committed to serve as primary care physicians one year for each year of support (minimum of two years service) at an approved site in a high-need HPSAs.⁵⁰

Second, the NHSC Loan Repayment program is for recent graduates, who have already accrued debt. The Loan Repayment program “provides \$50,000 (or the outstanding balance of qualifying student loans if they are less than \$50,000),

⁴⁵ Politzer et al., *supra* note 27, at 71.

⁴⁶ *Id.* at 73.

⁴⁷ Weissert & Silverman, *supra* note 12, at 748.

⁴⁸ HHS.gov, Key Facts About the National Health Service Corps, <http://www.hhs.gov/recovery/programs/nhsc/nhscfactsheet.html> (last visited November 6, 2009).

⁴⁹ Nhsc.hrsa.gov, National Health Service Corps Scholarship, <http://nhsc.hrsa.gov/scholarship/> (last visited November 6, 2009).

⁵⁰ *Id.*

tax free, to primary care medical, dental, and mental health clinicians in exchange for two years of service at an approved site in a [HPSA].”⁵¹

Additionally, there are a number of state programs that provide scholarships or loan repayment in exchange for service as a primary practitioner in a rural community. The terms of these programs differ in each state.⁵²

This year, with the American Recovery and Reinvestment Act (ARRA), the government significantly increased the amount of funding the NHSC received.⁵³ According to Secretary Sebelius, of the U.S. Department of Health and Human Services, the “new funds are expected to double the number of Corps clinicians and make 3,300 awards to clinicians that serve in health centers, rural health clinics, and other health care facilities that care for uninsured and underserved people.”⁵⁴

While it is commendable that the government has increased funding available to the NHSC through the ARRA, in order to end the disparities in rural medicine, even more resources should be committed to these programs. “[T]he

⁵¹ Nhsc.hrsa.gov, National Health Service Corps Loan Repayment, <http://nhsc.hrsa.gov/loanrepayment/> (last visited November 6, 2009).

⁵² See generally AAMC.org, Loan Repayment/Forgiveness and Scholarship Programs, http://services.aamc.org/fed_loan_pub/index.cfm?fuseaction=public.welcome&CFID=610499&CFTOKEN=11355292 (last visited November 6, 2009).

⁵³ See HHS.gov, News Release Secretary Sebelius Makes Recovery Act Funding Available to Bolster Health Care in Needy Communities, Relieve Providers’ Student Debt, <http://hhs.gov/news/press/2009pres/06/20090605a.html> (last visited November 6, 2009) [hereinafter “HHS, News Release”] (Under the American Recovery and Reinvestment Act, nearly \$200 million were made available to support student loan repayment through the NHSC.); AM. MED. STUDENT ASS’N, PROTECTING THE HEALTH CARE WORKFORCE – NATIONAL HEALTH SERVICE CORPS, 19 (2008) <http://www.amsa.org/npcw/NHSC%20ppt%20notes%20and%20animations.ppt> (last visited Oct. 10, 2009) (The average NHSC appropriations between 1998 and 2007 was \$134 million dollars.).

⁵⁴ HHS, News Release, *supra* note 53.

NHSC meets only a fraction of the overall need for health professionals.”⁵⁵ According to the Association of American Medical Colleges, “[w]hile the NHSC supports a field strength of over 4,000 practitioners, the Health Resources and Services Administration estimates that an additional 30,000 practitioners are needed to achieve the target HPSA practitioner/population ratios.”⁵⁶ Thus, although 3,300 practitioners will help to end the primary practitioner shortage in underserved communities, it is by no means enough.

VI. CONCLUSION

There is no denying that rural communities face disparities in access to medical care. Providing healthcare coverage for people in rural communities, as the health reform plan proposes to do, however, is not enough. As a country, we must also ensure that there are a sufficient number of physicians to serve everyone in these communities. The cost of a medical education is increasing at an astounding rate. Therefore, the debt has become prohibitive and forces young physicians to choose specialties, not based on what they would like to do, but on how they can most easily pay off debt.

However, decreasing the cost of medical school and providing additional funding to scholarship and loan repayment programs can provide incentives to encourage physicians to choose primary practice in rural communities by relieving the financial pressures on medical students and young physicians.

⁵⁵ Politzer et al., *supra* note 27, at 71.

⁵⁶ MATTHEW SHICK, RECOMMENDATION FOR FY 2009 NATIONAL HEALTH SERVICE CORPS FUNDING, 1 (2009), <http://www.aamc.org/advocacy/library/educ/2009nhsc.pdf>.

While this will likely not be the ultimate solution, it will nonetheless help to end the inequality in access to medicine that rural communities face.

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***DNA & EHR – Six Letters Spelling the
Future of Health Care***

*Drew McCormick**

In an effort to provide quality healthcare to millions of uninsured Americans, President Obama recently pledged to allocate \$10 billion per year for the next five years as an incentive for healthcare providers to adopt Electronic Health Record (EHR) systems.¹ Proponents suggest that EHR implementation has the propensity to simultaneously reduce cost and improve the quality of care; thus, ultimately resulting in broader access to the United States healthcare delivery system.² Alternatively, as many politicians and healthcare industry representatives are quick to cite, the potential for rapid EHR implementation could exacerbate existing problems and pose enormous risks if the systems are

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¹ *Barack Obama and Joe Biden's Plan to Lower Health Care Costs and Ensure Affordable, Accessible Health Coverage For All* (2008), <http://www.barackobama.com/pdf/issues/HealthCareFullPlan.pdf>.

² Steve Lohr, *Electronic Health Records: How to Spend the Money Wisely*, N.Y. TIMES, available at <http://bits.blogs.nytimes.com/2009/02/10/electronic-health-records-how-to-spend-the-money-wisely/?emc=eta1> (last visited Oct. 1, 2009).

adopted in haste and without adequate systemic structures in place to receive them.³

This article will discuss the role EHRs will play in the efficacy of 21st century medical care innovations and provide an overview of the intersection of genetic information (GI), defined as heritable biological information determined by nucleotide sequencing tests for purposes of this paper⁴, and EHR. Part one identifies and explores the therapeutic and research applications of genetics and EHR. Part two appraises the potential benefits of those applications, such as reducing healthcare costs and improving access to care.

The final part examines potential concerns that arise from implementing GI in EHR systems. Specifically, it discusses the legal framework and its role to maximize interface benefits, while preventing potential abuse and gesturing toward the deficiencies in the current system. Finally, this article identifies the tension between genetics and EHR. This intersection can improve access to care by reducing error, improving care and eliminating diseases, but could also facilitate discrimination by insurers in the absence of adequate protections, thereby reducing access to care.

³ See Jane Gross, *Keeping Patients' Details Private, Even From Kin*, N.Y. TIMES, July 3, 2007, at B5.

⁴ DEPARTMENT OF HEALTH AND HUMAN SERVICES (HHS), "GINA": THE GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008, INFORMATION FOR RESEARCHERS AND HEALTH CARE PROFESSIONALS, Apr. 6, 2009, <http://www.genome.gov/Pages/PolicyEthics/GeneticDiscrimination/GINAInfoDoc.pdf>.

I. GENETICS & EHR: APPLICATIONS

There are several applications for electronically available GI in the modern medical environment.⁵ Generally, these applications can be divided into two subcategories: those that facilitate diagnostic and therapeutic clinical medicine and those facilitate research. Although we can conceptually divide the clinical setting from the research setting to dissect each, this is an artificial dichotomy. Because clinical care for the individual patient is facilitated and improved by EHRs, this enables health information to be used in research and thus, results in diagnostic and treatment advances that improve patient care.⁶

First, the ability to diagnose unexpressed genetic conditions before the individual becomes symptomatic enables preventative treatment for several conditions.⁷ For instance, some genetically inherited diseases can be delayed if not entirely avoided by preemptive interventions.⁸ Recent research indicates that if detected early, the onset of Alzheimer's disease can potentially be delayed through health behavior counseling.⁹ These types of medical interventions are facilitated by incorporating genetic profiles into vast databases that aid physicians to identify "at risk" individuals and populations for the prophylaxis and screening

⁵ See *infra* p.3.

⁶ See Chris Van Weel & Walter W. Rosser, *Improving Health Care Globally: A Critical Review of the Necessity of Family Medicine Research and Recommendations to Build Research Capacity*, 2 ANNALS OF FAMILY MED. S5, S5 (2004).

⁷ See *supra* p. 2.

⁸ See, e.g., Mohit Joshi, *Physical Exercise Could Delay Onset of Huntington's Disease*, <http://www.topnews.in/health/physical-activity-could-delay-onset-huntingtons-disease-21709>.

⁹ Giulio Maria Pasinetti & Jacqueline A. Eberstein, *Metabolic Syndrome and the Role of Dietary Lifestyles in Alzheimer's Disease*, 106 J. NEUROCHEM. 1503, 1503-05 (2008).

programs.¹⁰ Interventions in early disease stages reduce healthcare costs, improve outcomes for patients,¹¹ and reduce the stress on the healthcare system.

Second, GI electronic applications allow clinicians to have access to a patient's GI along with other relevant health information that is imperative in the U.S. healthcare delivery system, which has gradually become more fragmented.¹² For example, due to the psychological and cognitive elements of the disease, an Alzheimer's patient diagnosed by a general practitioner would benefit from a mental health professional having the same access to the patient's GI because it may facilitate anticipation, assessment, and treatment of certain symptoms.¹³

Furthermore, when applying GI electronically in a therapeutic setting, the availability of this information plays a crucial role in genetics research.¹⁴ Information in individual patient files, such as genetic data and clinical scenarios, can be stripped of identifiable information and pooled into massive databases.¹⁵ These massive databases are used for dense statistical research projects as well as diagnostic tools that are essential to future medical progress.¹⁶

¹⁰ John Glaser, V.P and C.I.O., Partners Healthcare, Presentation at the Digital Healthcare Conference: Integrating the Genome into the Electronic Health Record: The Next Leap Forward, May 8, 2008.

¹¹ EZEKIEL J. EMANUEL, HEALTH CARE, GUARANTEED: A SIMPLE, SECURE SOLUTION FOR AMERICA 126 (PublicAffairs 2008) (2008); See UPI.com, Early Alzheimer's Diagnosis Reduces Costs (May 25, 2009), http://www.upi.com/Health_News/2009/05/25/Early-Alzheimers-diagnosis-reduces-costs/UPI-84341243274487/.

¹² See Jeannie L. Haggerty et al., *Continuity of Care: A Multidisciplinary Review*, 327 BRIT. MED. J. 1219, 1219 (2003).

¹³ Interview with Lama Eldahdah, Genetics Counselor, Reproductive Genetics Institute, in Chicago, IL. (Mar. 27, 2009).

¹⁴ See *infra* pp. 3-4.

¹⁵ See Gary Baldwin, *EHRs Enabling Genetic Research*, HEALTH DATA MGMT. MAG., Dec. 1, 2008, at 42, available at http://www.healthdatamanagement.com/issues/2008_59/27367-1.html?zkPrintable=true.

¹⁶ *Id.*

In the United States, academic and research institutions, such as Vanderbilt University and Marshfield Clinic, have developed systems to pool EHRs by de-identifying GI obtained during clinical diagnosis and treatment. To obtain access to the information, opt-out provisions in annual Health Information Portability and Accountability Act (HIPAA) mandated consent forms are used.¹⁷ These systems utilize complex algorithms to strip the “shadow” versions of the main EHR databases from all identifying information.¹⁸ Last year, Vanderbilt’s system contained information for over 50,000 patients, and acquired an average of 700 new records per week.¹⁹ Vanderbilt’s system is comprised by two distinct, but mutually supporting databanks where the EHR system and the “shadow-databank” DNA repository had de-identified information compiled through discarded blood samples.²⁰ Similar to Vanderbilt’s design system, the Marshfield Clinic Genetic Biobank is at the center of a Wisconsin-wide genetics research initiative that began in October of 2007.²¹ The initiative goals include using database information to target certain diseases, including attempting to determine genetic components to increased risk for heart attack, as well as diabetes and its complications.²²

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

²⁰ *Id.*

²¹ *Id.*

²² *Id.*

II. APPRAISING THE BENEFITS

The essential benefits of electronically stored GI are similar to the general benefits of EHRs, which include a greater efficiency and the potential to reduce medical error.²³ As noted above,²⁴ the accessibility to an individual's health information improves the care coordination across a variety of providers and points of access.²⁵ Thus, electronically stored GI has the potential to eliminate many costly risks of conflicting orders, duplication of treatments, and medical errors that harm patients, which can increase treatment costs.²⁶ This is crucial protection in a society where four out of every five physicians are specialists, and a Medicare patient with a single chronic condition will see on average seven physicians per year.²⁷

Another primary justification to adopt EHR systems is the ability to reduce institutional costs.²⁸ Studies suggest that successful EHR implementation can reduce costs in a variety of ways.²⁹ For example, direct cost-savings occur, such as administrative costs associated with redundant medical tests, when the EHR system is substituted for the traditional paper system.³⁰ Costs-savings are enhanced by indirect benefits, such as care coordination or reduced patient safety risks that improve the quality of care, and therefore, results in long-term cost-

²³ EMANUEL, *supra* note 11, at 60-61.

²⁴ *See supra* p. 3.

²⁵ John Halamka, *The Perfect Storm for Electronic Health Records*, 20 J. OF HEALTH CARE INFO. MGMT. 25, 25-26 (2006).

²⁶ Richard Hillestad et al., *Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, and Costs*, 24 HEALTH AFF. 1103, 1103 (2005).

²⁷ EMANUEL, *supra* note 11, at 61.

²⁸ *See supra* p. 3.

²⁹ Hillestad et al., *supra* note 26, at 1103-04.

³⁰ Halamka, *supra* note 25, at 25-26.

savings to the patient.³¹ These healthcare cost reductions have the potential to reduce the immense stress on our current healthcare system and consequently, improve access to care.³²

Furthermore, the availability of EHR allows patients to become more actively involved in their own care.³³ Allowing patients to observe documented changes in their health behaviors, such as lower cholesterol because of diet change and exercise, provides immediate, positive reinforcement, and encourages compliance.³⁴ This also provides physicians a forum to supply “information therapy,” making pre-screened information available to patients, thereby aiding their understanding medical conditions, treatments, and other relevant information.³⁵ This improves the physician-patient dynamic, facilitates communication by helping to identify additional health concerns, allows the freedom to choose the maximally effective treatments, and engages the patient in their care.³⁶

Similar potential exists for greater care coordination, increased patient involvement, and enhanced patient autonomy with regard to electronically available GI.³⁷ Because access to GI facilitates reproductive autonomy, this

³¹ Samuel J. Wang et al., *A Cost-Benefit Analysis of Electronic Medical Records in Primary Care*, 114 AM. J. MED. 397, 397 (2003).

³² See EMANUEL, *supra* note 11, at 126.

³³ Laura Landro, *Online Records Get Patients Involved in Care*, WALL ST. J., Mar. 18, 2009, at D1.

³⁴ See Laurie Barclay, *Web-Based Electronic Medical Records Offer Portability, Disaster Protection*, Oct. 12, 2005, available at <http://www.medscape.com/viewarticle/514455>.

³⁵ Steve Lohr, *A Hospital is Offering Digital Records*, N.Y. TIMES, Apr. 6, 2009, at B3.

³⁶ Landro, *supra* note 33, at D1.

³⁷ See *supra* pp. 5-6.

enables parents to make more informed decisions about health risks that might affect potential children.³⁸ For instance, Preimplantation Genetic Diagnosis, (PGD) enables genetics professionals to evaluate embryos for genetic markers before in vitro fertilization is performed.³⁹ Furthermore, amniocentesis, a prenatal testing procedure that identifies the probability of genetic abnormalities, facilitates reproductive autonomy by allowing parents to choose whether to terminate a pregnancy when the fetus has a high likelihood or confirmed diagnosis of a genetic disease.⁴⁰

“Information therapy,” a patient resource supported by patient-accessible records that utilizes internet applications, is a valuable tool for educating patients about already expressed genetic conditions, and can guide patients in making decisions based on GI.⁴¹ Patients who possess genetic risk factors for certain diseases may need a lot of support to make informed reproductive decisions.⁴² In addition, difficult decisions about prophylactic treatments, such as radical mastectomies for patients that carry certain mutations that indicate a high likelihood that they will develop breast cancer (also known as “BRCA analysis”),

³⁸ See BONNIE STEINBOCK, PREIMPLANTATION GENETIC DIAGNOSIS AND EMBRYO SELECTION 175 (Justine Burley & John Harris eds., Blackwell 2004) (2002).

³⁹ *Id.*

⁴⁰ See RAYNA RAPP, TESTING WOMAN, TESTING THE FETUS: THE SOCIAL IMPACT OF AMNIOCENTESIS IN AMERICA 28-29 (Routledge 2000) (1999).

⁴¹ Guilherme Del Fiol et. al., *Integrating Genetic Information Resources With an EHR*, ANNUAL SYMPOSIUM PROCEEDINGS ARCHIVE, AM. MED. INFO. ASS’N, 904 (2006).

⁴² Interview with Lama Eldahdah, *supra* note 13.

require a patient to understand complicated information regarding different treatment options prior to making life-altering treatment decisions.⁴³

Furthermore, electronic GI can improve coordination within clinical genetics.⁴⁴ In many instances, genetic counselors provide pre-testing counseling, and then request that a physician write an order for genetic testing.⁴⁵ Increased coordination of GI exchanges in the clinical setting would avoid situations where physicians incorrectly receive laboratory test results for patients that they did not counsel, and thereby eliminate the risk of giving an inaccurate interpretation or misapplication.⁴⁶ This situation is especially problematic when the results are interpreted by a physician without training in genetic counseling.⁴⁷

In other scenarios, physicians without adequate genetics knowledge order tests without consulting genetic professionals.⁴⁸ EHRs increase the ability for geneticists and other genetic professionals who work in laboratory settings to discover orders for inappropriate tests, which can avoid unnecessary fiscal costs to the patients and make genetic testing more affordable.⁴⁹ The Mayo Clinic adopted an EHR system that includes its genetics laboratories to avoid the negative outcomes in the aforementioned clinical genetics scenarios.⁵⁰ This can also spare patients the unnecessary emotional strain of being informed that they

⁴³ See Dimosthensis Ziogas & Dimitrios H. Roukos, *Genetics and Personal Genomics for Personalized Breast Cancer Surgery: Progress and Challenges in Research and Clinical Practice*, 16 ANNALS SURGICAL ONCOLOGY, 1771, 1771 (2009).

⁴⁴ See *infra* p. 7.

⁴⁵ Interview with Lama Eldahdah, *supra* note 13.

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ See Mayo Clinic, <http://www.mayoclinic.org/emr/>, (last visited Sept. 25, 2009).

tested positive for an unpreventable condition due to a test that was performed against the patient's wishes.⁵¹

III. ASSESSING THE RISKS & DEVELOPING THE LAW

The development of treatments and prevention for genetic diseases, which enhance social justice by eliminating genetic disease and acting to level the genetic playing field, is aided by technology such as EHRs.⁵² However, these technologies are susceptible to being manipulated as a justification for discriminatory motives,⁵³ such as the potential denial of insurance coverage.

Moreover, professional ethical questions arise from the significant uncertainty surrounding the meaning of many genetic diagnostic tests.⁵⁴ For instance, many genetic tests enable physicians to inform patients of their rough statistical likelihood of developing a particular condition based on their genetic profile.⁵⁵ For instance, a BRCA analysis determines a woman's genetic predisposition and statistical probability of developing breast and ovarian cancer by identifying certain mutations.⁵⁶ BRCA analysis alerts high risk women in early adulthood so that they can benefit from earlier and more regular screening.⁵⁷ However, these test results may also induce women to have imprudent

⁵¹ Interview with Lama Eldahdah, *supra* note 13.

⁵² ALLEN BUCHANAN ET AL., *FROM CHANCE TO CHOICE: GENETICS & JUSTICE*, 16 (Cambridge University Press 2000) (2000).

⁵³ Karen H. Rothenberg & Sharon F. Terry, *Before It's Too Late—Addressing Fear of Genetic Information*, 297 *SCIENCE*, 196, 196-97, (July 2002).

⁵⁴ See BUCHANAN ET AL., *supra* note 52, at 313.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ *Id.*

prophylactic mastectomies, which have serious physical, psychological, and emotional consequences.⁵⁸ Beyond intrapersonal costs, these unnecessary procedures are increased and result in avoidable monetary resource expenditures for both the patient and insurance companies.

Many practical considerations must be made prior to implementing widespread electronic GI into the medical profession.⁵⁹ For instance, there is a need to make sections of patients' health records confidential and protected through restricted access.⁶⁰ Thus, several infrastructural shortcomings must be addressed to ensure patient privacy is not violated and not to provide pharmaceutical companies a vehicle to conduct market research.⁶¹

In 1996, HIPAA imposed restrictions to the availability of individual identifiable health information, or health information that is traceable to the patient.⁶² HIPAA has provisions for genetic-specific protections against discrimination and prevents insurers from precluding eligibility because of GI⁶³ Furthermore, the "Privacy Rule" enforces requirements for information distribution that is classified as protected health information.⁶⁴ Under HIPAA, "protected health information" is individually identifiable health information

⁵⁸ *Id.*

⁵⁹ See Gross, *supra* note 3.

⁶⁰ *Id.*

⁶¹ E.g., Matt Fedoruk, *DeCodeing Iceland's DNA*, 4 THE SCI. CREATIVE Q. Aug. 2003, <http://www.scq.ubc.ca/decodeing-icelands-dna/>.

⁶² See generally Health Information Portability and Accountability Act of 1996, 42 U.S.C. § 201 (1996).

⁶³ *Id.* at § 702(b)(1)(B).

⁶⁴ See U.S. Department of Health and Human Services, *The Privacy Rule*, <http://www.hhs.gov/ocr/privacy/hipaa/administrative/privacyrule/index.html> (last visited Sept. 30, 2009).

created or received by a “covered entity” such as healthcare providers, employers, life insurers, healthcare clearinghouses, and others⁶⁵. Protected health information also relates to a patient’s physical or mental health condition and payment information.⁶⁶

Congress enacted the Genetic Information Nondiscrimination Act (GINA) to facilitate the development of genetic technologies, to continue research, to enhance basic genetic knowledge, and to protect individuals from discriminatory misuse of GI for health insurance and employment purposes.⁶⁷ GINA prohibits group health plans and health insurance providers offering group health insurance coverage from establishing rules of eligibility or continued eligibility for an individual to enroll under a plan based on several factors, including GI.⁶⁸ Furthermore, this legislation prohibits a group health plan to require higher premiums, collect contribution payments from individuals with certain genetic conditions, and require genetic testing.⁶⁹

GINA prohibits discrimination against enrollees in large group health plans on the basis of GI⁷⁰ However, it does not offer protection for individuals seeking private or small business health insurance, life insurance, disability insurance, long-term care insurance, nor does it address discrimination against patients that are already symptomatic of a genetic disorder, and those that learn

⁶⁵ *Id.*

⁶⁶ *See id.*

⁶⁷ *See* Genetic Information Nondiscrimination Act of 2008, 42 U.S.C. § 2000 (2008).

⁶⁸ *Id.*

⁶⁹ *Id.*

⁷⁰ *Id.*

they have a condition through non-genetic predictive testing.⁷¹ Thus, large segments of the population, including approximately twelve million individuals who have private insurance at any given time, will not be protected from discrimination that may bar them from health insurance.⁷²

When GINA's first health insurance regulations take effect in May of 2009,⁷³ followed by employment regulations in November of 2009,⁷⁴ it will become more evident where its protections fall short. Without sufficient protection from GI discrimination, improvements in access to care that might be achieved through the increased continuity of care, reduction of error, and the benefits of preventative treatment⁷⁵ might be supplanted by the reduced access caused by discriminatory insurance practices.

IV. CONCLUSION

This article demonstrated that electronic applications of genetic technology afford many opportunities for modern societies to reduce or eliminate genetic diseases that drain limited healthcare resources.⁷⁶ First, the intersection of genetics and EHR presents the potential to foster enhanced individualized

⁷¹ *See id.*

⁷² *See* GARY CLAXTON, HOW PRIVATE INSURANCE WORKS: A PRIMER 1(Kaiser Family Foundation 2002) (Apr. 2002).

⁷³ GINA, *supra* note 4.

⁷⁴ Sarah Tountas & Miller Johnson, *New GINA Regulations Will Require Changes to Many Wellness Programs*, Oct. 13, 2009, http://www.martindale.com/health-care-law/article_Miller-Johnson_818924.htm.

⁷⁵ *See supra* pp. 2-6.

⁷⁶ BUCHANAN ET AL., *supra* note 52, at 8-11.

medicine.⁷⁷ For instance, by combining genetic knowledge with EHR, physicians gain the ability to utilize vast GI databases to aid them in treating patients.⁷⁸ Second, these databases would facilitate otherwise impossible research, allow scientific advancements, and potentially eradicate devastating genetic diseases⁷⁹ that result in decreased personal and healthcare costs.⁸⁰

However, these tremendous potentials for growth and improvement are harboring hidden risks of discrimination, privacy violations, and a slew of other negative consequences. Thus, continued development of protective legislation and public policy, led by robust public discourse, must guide the course of this technology. This is particularly evident with the EHR application as a way to store and exchange GI, where the great potential to reduce the stress on the healthcare system is tempered by concerns about opportunities for discrimination, particularly on the basis of health insurance.⁸¹

⁷⁷ Hillestad et al., *supra* note 26, at 1113.

⁷⁸ Glaser, *supra* note 10.

⁷⁹ *Id.*

⁸⁰ *See supra* p. 5.

⁸¹ *See supra* pp. 6-10.

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***The Balance of Charity Care:
Meeting the Needs of the Uninsured***

*Katy Minnick**

Charity care appears to be a relatively simple concept: the government subsidizes health care for those that cannot afford it through tax exemption incentives to nonprofit hospitals. In reality, however, charity care involves a complex interaction of hospital economics, social and regulatory expectations, and a direct impact on access to care for the under and uninsured. The very definition of charity care is a hotly debated issue at both the federal and state levels that has resulted in lawmakers questioning the qualifications for nonprofit hospital status and hospitals rushing to justify the exemptions on which they depend. This debate directly impacts the under and uninsured. Legislators and nonprofit hospitals should share the ultimate goal of improving access to care using this charitable tool because removing the exempt status of nonprofit hospitals could negatively affect the very population it is meant to support.

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I. OVERVIEW OF CHARITY CARE

In order to qualify as a tax exempt organization for the purposes of the Internal Revenue Service (IRS), a hospital must be organized and operated exclusively for “religious, charitable, scientific ... literary or educational purposes.”¹ Hospitals that qualify as charitable organizations can receive federal tax exemption, issue tax free bonds, and collect charitable contributions.² In turn, these hospitals provide “community benefits,” which the IRS broadly defines as promoting health care for the general benefit of the community as a whole.³ Charity care is the provision of free or reduced cost inpatient and outpatient healthcare services.⁴ It is one component of what makes up the concept of community benefits for tax exempt, nonprofit hospitals.⁵

Federal lawmakers have been wrestling with how exactly to measure the charity care being offered in relation to the benefits of exemption. The basic issue of what qualifies as charity care for exemption purposes is subjective and leaves a great deal of interpretation up to hospitals.⁶ Individual hospitals across the industry use multiple methods to calculate what they consider to be charity care, thus making the determination of a true cost for charity care difficult.⁷ Hospitals

¹ Lynnore Seaton & Beth C. Koob, *Tax-Exempt Hospitals and Community Benefit*, 21 No. 5 HEALTH L. 37, 39 (2009) (quoting Section 501(c)(3) of the IRS Code).

² *Id.*

³ Anthony P. Merza, *Hospital Charity Care and the Corporate Campaign: Labor Union Exploitation of Dysfunctional Tax Exemption Laws*, 11 DEPAUL J. HEALTH CARE L. 203, 206 (2008).

⁴ Seaton & Koob, *supra* note 1, at 37.

⁵ *Id.*

⁶ Merza, *supra* note 3, at 215-16.

⁷ PricewaterhouseCoopers' Health Research Institute, *Acts of Charity: Charity Care Strategies in a Changing Landscape* 9, <http://www.pwc.com/us/en/healthcare/publications/acts-of-charity.jhtml> (last visited Oct. 4, 2009).

argue that more of their financial losses from bad debt (unpaid patient invoices) and shortfalls (under-reimbursed government health programs) should count towards the charity care they provide.⁸ Other organizations, such as the Catholic Health Association, oppose the inclusion of bad debt and shortfalls, saying these losses are elements of doing business and not charitable as intended.⁹ In considering how best to calculate charity care, the IRS has begun to gather information from exempt hospitals on community benefits standards to assist in future decision making.¹⁰

A similar debate is taking place at the state level as legislators struggle to justify local tax exemptions.¹¹ The definition of what constitutes community benefits and charity care at the state level is not necessarily the same at the federal level and requirements differ further among individual states. Texas was the first state to require hospitals to allocate a certain percentage of their revenue to charity care in order to qualify for local exemptions.¹² A few other states, such as Pennsylvania, Utah, and West Virginia, require hospitals to provide a minimum amount of community benefits for their exempt status.¹³ Most states have avoided legislation creating a standardized obligation and have instead opted to require nonprofit hospitals to conduct community health needs assessments and

⁸ Seaton & Koob, *supra* note 1, at 39-40.

⁹ *Id.*

¹⁰ Lisa Kinney Helvin, *Caring for the Uninsured: Are Non-For-Profit Hospitals Doing Their Share?*, 8 YALE J. HEALTH POL'Y L. & ETHICS 421, 447 (2008).

¹¹ *Id.* at 426.

¹² *Id.* at 452.

¹³ *Id.*

develop community health benefit plans to qualify for exempt status, reporting the amount of charity care provided to their respective state agency.¹⁴

II. CHARITY CARE STANDARDS IN ILLINOIS

The Illinois legislature passed the Illinois Community Benefits Act in 2003 requiring metropolitan hospitals with more than 100 beds to report to the state ten categories of community benefits, including charity care.¹⁵ The other nine categories include: bad debt; government sponsored indigent care; government sponsored program services; subsidized health services; education; research; language assistance services; donations; and volunteer services.¹⁶ Illinois hospitals argue that they are subsidizing a significant burden for the government by providing these services and care to the uninsured.¹⁷ Hospitals would like all of the contributions they make to their communities to count, not just a narrowly defined amount of charity care.¹⁸ They contend that when all of these categories are taken into consideration, nonprofit hospitals have earned their tax exemptions.¹⁹

¹⁴ *Id.* at 452-53.

¹⁵ Metropolitan Chicago Healthcare Council, *Caring for Their Communities: A Comprehensive Report on the Community Benefits Provided by Tax-Exempt Hospitals in the Metropolitan Chicago Region* (August 2007), www.mchc.org.

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.*

In 2006, legislators attempted to pass a bill requiring Illinois hospitals to spend 8% of their annual earnings on charity care.²⁰ Hospitals argued that the differences in the needs between communities make a “one size fits all” method of standardized charity care impractical and takes away hospitals’ ability to manage their resources to meet those unique needs.²¹ The 2006 legislation was not successful, but it cannot be assumed that similar legislation will not be presented again in the future.²²

Illinois courts have also participated in the debate about what qualifies as charity care. The state’s concern is property tax exemption for nonprofit hospitals. In *Provena Covenant Medical Center v. Illinois Department of Revenue*, the Illinois Supreme Court heard arguments on the issue of whether a nonprofit hospital has provided enough charity care to justify the state’s charitable purpose property tax exemption.²³ In short, Provena appealed a decision by the Department of Revenue finding that Provena failed to meet the exemption requirements because only approximately 0.7% of its total revenue had been provided in charity care (not including any other unreimbursed costs), which was insufficient to qualify for the exemption.²⁴ Provena appealed, and, initially, the

²⁰ Bethany Jaeger, *Health Care and Public Officials Look to the State Supreme Court to Clarify what Nonprofit Hospitals Need to do to Qualify for Property Tax Exemptions* (September 2009) <http://illinoisissues.uis.edu/archives/2009/09/charitycare.html>.

²¹ *Id.*; Metropolitan Chicago Healthcare Council, *supra* note 15.

²² Jaeger, *supra* note 20.

²³ Joseph Hylak-Reinholtz, *The Charitable Purpose Exemption and Illinois Hospitals: It’s Time to Retire the Methodist Test*, 21 DCBA BRIEF 39, 39 (2009).

²⁴ Keith Emmons et al., *Survey of Illinois Law: Health Care*, 32, S. ILL. U. L.J. 999, 1003-04 (2008).

trial court found in favor of Provena.²⁵ The Fourth District Appellate Court later reversed the decision, upholding the department's original determination that the hospital had not met the standard.²⁶

The Department of Revenue claimed that Provena had received more in tax benefits than the hospital had given in charity care, but the very question at issue is what constitutes charity care for the purposes of the exemption?²⁷ Provena argued that it provides a variety of "community benefits," including charity programs and absorbing under reimbursed costs from government health programs, which should count towards its charity care for purposes of the exemption.²⁸ The Department of Revenue argued that the amount of charity care in the form of true "gifts" (or unbilled charges) in relation to the hospital's annual revenue is what should be considered charity care, not the overall contribution to the community.²⁹ Thus, according to the Department of Revenue, Provena's charity care was not enough to justify the exemption claimed by the hospital.³⁰ A decision by the Illinois Supreme Court, which is currently reviewing the nonprofit hospital standard for meeting the exemption, is eagerly anticipated because of the impact it will have not only on Illinois hospitals and residents, but the precedent it may set across the country.³¹

²⁵ *Id.*

²⁶ *Id.*

²⁷ Jaeger, *supra* note 20.

²⁸ Hylak-Reinholtz, *supra* note 23, at 41.

²⁹ *Id.*

³⁰ *Id.*

³¹ *Id.* at 44.

III. THE UNINSURED AND ACCESS TO CARE

Nonprofit hospitals have been severely criticized for taking actions that seem inapposite to the concept of acting as a benefit to their communities. For example, nonprofit hospitals have historically charged the uninsured a premium price for services while offering deep discounts to insurance companies, managed care plans and those with government assistance.³² This price shifting has resulted in negative press for hospitals. Additionally, much attention has been focused on the aggressive collection practices hospitals have taken against those unable to pay for health care.³³ Several federal cases have been brought against hospitals claiming unfair billing practices.³⁴ Courts have ultimately held that the federal tax code does not hold hospitals responsible for providing a certain amount of free or discounted care,³⁵ but it has still been a loss for hospitals in the court of public opinion.

In response, many hospitals have independently revised their charity care policies.³⁶ Historically, hospitals have used the Federal Poverty Level (FPL) to determine eligibility for charity care discounts, typically employing some type of sliding scale based on a patient's income against the FPL.³⁷ For those uninsured patients who may not qualify for the charity care discounts based on FPL, more hospitals are moving towards a flat-fee discount. This shift has gained support for three main reasons: (1) to accommodate an increasing number of indigent and

³² PricewaterhouseCoopers' Health Research Institute, *supra* note 7, at 16.

³³ Merza, *supra* note 3, at 217.

³⁴ Helvin, *supra* note 10, at 439-40.

³⁵ *Id.*

³⁶ PricewaterhouseCoopers' Health Research Institute, *supra* note 7, at 15.

³⁷ *Id.*

working uninsured who make too much to qualify for a full charity care benefit or government assistance; (2) recent flexibility as a result of direction from the Centers for Medicare and Medicaid Services and the Office of Inspector General allowing hospitals to offer discounts to the uninsured without jeopardizing their Medicare reimbursement; and (3) the increased scrutiny from the media and regulatory agencies.³⁸ By expanding eligibility for charity care programs and offering greater discounts to the uninsured, hospitals have expanded access to care.³⁹

Despite hospitals receiving negative attention concerning charity care, hospitals continue to play a major role in supporting the under and uninsured. The more obvious benefits are those provided in the form of free services such as poison control, literacy training, child, and maternal healthcare, special programs for the elderly and disabled, among others.⁴⁰ What may not be as obvious to the general public is the purely economic benefits hospitals offer to the community. In 2004, it is estimated that Illinois hospitals subsidized \$1.686 billion in shortfalls, which is the difference between the hospitals' costs and the reimbursement rate of government healthcare programs.⁴¹ Additionally, it was estimated that in 2004, Illinois hospitals' bad debt, or those invoices that went unpaid, totaled \$1.130 billion.⁴² This is in comparison to the total of charity care,

³⁸ *Id.*

³⁹ Helvin, *supra* note 10, at 457.

⁴⁰ Merza, *supra* note 3, at 219-20.

⁴¹ *Id.* at 219.

⁴² *Id.*

where no bill was sent to the patient, which only amounted to \$250 million.⁴³ These numbers tell the story of how hospitals struggle with their attempt to meet community needs as well as the bottom line.

IV. THE POTENTIAL FOR CRISIS AND PROPOSED SOLUTIONS

The fate of hospital tax exemption, soon to be determined by the Illinois Supreme Court in *Provena*, is significant to the discussion of access to care because of the potential negative impact a shift could have on the uninsured. Should a hospital not be able to meet a strict standardized definition of charity care to qualify for exemption, a number of changes decreasing access to care are possible. For instance, hospitals previously operating as nonprofit entities may convert to for-profit entities and change their service offerings.⁴⁴ This could include the downgrading or elimination of services vital to communities, such as trauma care, neonatal care, burn units, and community immunization programs.⁴⁵ For those hospitals in low income neighborhoods, a loss of the exemption would be devastating to the economic viability of the hospitals, causing them to close. As a result, a tremendous dislocation in healthcare delivery to those in poorer neighborhoods would be created.⁴⁶ In the end, with fewer nonprofit hospitals operating, the burden of care for the uninsured will fall to the remaining for-profit hospitals, in turn affecting their viability.⁴⁷

⁴³ *Id.*

⁴⁴ *Id.* at 223.

⁴⁵ *Id.* at 220.

⁴⁶ *Id.* at 225-26.

⁴⁷ *Id.* at 228.

Hospitals face great uncertainty in what future regulation may bring, but as an industry, there are ways hospitals may mitigate their situation. PricewaterhouseCoopers' Health Research Institute explored the issue of charity care in hospitals and completed a report that outlined what seems to be a manageable and comprehensive approach for hospitals to both increase efficiency and improve charity care.⁴⁸ The Institute's suggestions include: modify patient charges for the uninsured to the same rates paid by those with government or private insurance; educate and assist patients in utilizing charity care; minimize requirements and simplify the process; utilize skilled and highly trained individuals in patient access and patient accounting to consistently and effectively administer financial assistance; establish a mechanism to work with uninsured patients on payment plans before taking collection or legal action; distinguish clearly the internal calculation of charity care from other community benefits; create a community benefits report publicly disclosing clearly defined calculations of charity care and community benefits; and provide financial counselors at the point of entry most commonly used by the uninsured, the emergency room, identifying and assisting those patients earlier in the process.⁴⁹ It logically follows that if nonprofit hospitals, as an industry, uniformly took actions such as these, there would be less need for potentially harsh legislation and overregulation.

⁴⁸ PricewaterhouseCoopers' Health Research Institute, *supra* note 7, at 21.

⁴⁹ *Id.* at 22, 23, 26, 27, 28, 30.

V. CONCLUSION

The concept of charity care is by no means a lost cause. It is a valuable community service vital to the needs of the increasing uninsured population. The potential still remains for nonprofit hospitals to serve their communities in a charitable manner by improving access to healthcare for the under and uninsured in return for government tax incentives. In fact, it seems access to care depends on a compromise that allows nonprofit hospitals to continue providing these services. Solutions in this debate between government and hospitals can come from both sides of the table, with hospitals being more proactive in their utilization of charity care and government entities recognizing the complexity and value of being a provider of vital community healthcare.

From a legislative standpoint, it seems that it is in the best interest of lawmakers to support tax exemption for nonprofit hospitals. Overall, the services provided by hospitals do benefit their communities and uninsured population. As is the nature of an industry such as this, additional regulation seems unavoidable. Systems appear to function better when clear definitions and expectations are set forth for participants. If additional legislation only makes achieving tax exempt status more difficult, however, it will be a failure for the uninsured as the legislation will abate access to the very care meant to be subsidized. The ultimate goal of any future legislation should be to strike a balance between the objective of charity care, effectively serving the under and uninsured in communities, and the economic realities of the hospital business.

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Consumer Driven Healthcare: Does it Increase Access for the Poor, Uneducated, and Chronically Ill?

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I. INTRODUCTION

The current healthcare system needs reforming. Over forty seven million Americans are currently uninsured¹ and need reasonable access to healthcare. The current system is a “private-market employment-based system” that has high costs and inherent barriers for access to healthcare.² Consumer driven healthcare (CDHC) has recently been promoted as a way to reduce the high costs associated with the current system.³ The ideal healthcare plan would reduce costs while providing more access to healthcare. The poor, uneducated, and chronically ill arguably need help accessing the healthcare system and are the most vulnerable.⁴

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¹ Arthur Birmingham LaFrance, *Healthcare Reform in the United States: The Role of the States*, 6 SEATTLE J. SOC. JUST. 199, 211 (2008).

² John V. Jacobi, *Consumer-Directed Health Care and the Chronically Ill*, 38 U. MICH. J.L. REFORM 531, 536 (2005).

³ Linda M. Axtell-Thompson, *Consumer Directed Health Care: Ethical Limits to Choice and Responsibility*, 30 J. MED. & PHIL. 207, 208 (2005).

⁴ See Walter L. Stiehm, *Poverty Law: Access to Healthcare and Barriers to the Poor*, QUINNIPIAC HEALTH L.J. 279, 279 (2001); Wendy K. Mariner, *Can Consumer Choice Plans*

This paper will focus on the concept of CDHC and whether it will improve access to healthcare for the poor, uneducated, and chronically ill.

II. CONSUMER DRIVEN HEALTHCARE AND HEALTH SAVINGS ACCOUNTS

CDHC is a healthcare system that allows patients' greater control and responsibility over their medical services and healthcare spending in an attempt to control costs.⁵ Under the consumer driven model, the patient is viewed as a consumer in the marketplace of health services.⁶ Generally, patients have a personal health account, such as a health savings account (HSA), and an insurance plan with a high deductible.⁷ The deductible is at least \$1050 for individuals and \$2100 for families.⁸ Initially, patients pay for their medical care out of their HSAs. After the deductible amount has been met, health expenses are paid from the insurance plan⁹ and the patient pays something similar to a co-pay.¹⁰ Once an out-of-pocket maximum of \$5,000 for individuals and \$10,000 for families is met, the medical expenses are covered by the health plan.¹¹ The theory of the CDHC plan allows patients to "realize economic rewards for making good decisions and

Satisfy Patients? Problems with Theory and Practice in Health Insurance Contracts, 69 BROOK. L. REV. 485, 506-07 (2004); Niko Karvounis, *Patients Managing Chronic Diseases: Not your Average Consumer*, THE CENTURY FOUNDATION, Oct. 30, 2007, <http://www.tcf.org/list.asp?type=NC&pubid=1719>.

⁵ Axtell-Thompson, *supra* note 3, at 208.

⁶ Mariner, *supra* note 4, at 495.

⁷ COALITION FOR AFFORDABLE HEALTH COVERAGE, *Policy Solutions for the Uninsured: Health Savings Accounts*, http://www.cahc.net/p_healthsavings.html (last visited Oct. 2, 2009).

⁸ *Id.*

⁹ Jessica Greene et al., *Comprehension and Choice of a Consumer-Directed Health Plan: An Experimental Study*, 14 AM. J. MANAGED CARE 369, 369-70 (2008).

¹⁰ Mariner, *supra* note 4, at 504.

¹¹ COALITION FOR AFFORDABLE HEALTH COVERAGE, *supra* note 7.

bear the economic penalties for making bad ones.”¹² Under CDHC, HSAs have “three primary goals: (1) to promote savings for health related expenses, (2) encourage prudent healthcare spending by providing incentives to consumers, and (3) to provide consumers with the ability to select and fund their own healthcare services.”¹³

III. IMPROVING ACCESS TO HEALTHCARE THROUGH CDHC AND HSAS

In theory and design, CDHC is a healthcare system that would reduce costs and improve quality of health services overall, which in turn, provides more access to healthcare.¹⁴ Patients can use the money in their HSAs “for any health care, including preventative care, check-ups, prescriptions, dental care, eye care, and the full range of alternative medicine.”¹⁵ CDHC gives patients the freedom to spend their money as they see fit so that “the individual’s goals and preferences regarding care are factored, as much as possible.”¹⁶ This personal autonomy is important because patients can “weigh factors individually and find different tradeoffs within a mix of risks and benefits acceptable or objectionable.”¹⁷

¹² Devon M. Herrick, *Consumer Driven Health Care: The Changing Role of the Patient*, 276 NAT’L CTR. FOR POL’Y ANALYSIS 1, at 5 (2005), <http://www.nepa.org/pdfs/st276.pdf>.

¹³ Russell B. Cate, Note, *Move over Managed Care – Health Savings Accounts, Small Businesses, and Low Wage Earners: Cost, Quality, and Access*, 4 IND. HEALTH L. REV. 287, 288 (2007).

¹⁴ See Peter Ferrara, *The Obama Health Plan: Rationing, Higher Taxes, and Lower Quality Care*, THE HEARTLAND INSTITUTE 1, 34 (Aug. 6, 2009), http://www.heartland.org/custom/semod_policybot/pdf/25813.pdf.

¹⁵ *Id.* at 33.

¹⁶ Marshall B. Kapp, *Health Care in the Marketplace: Implications for Decisionally Impaired Consumers and Their Surrogates and Advocates*, 24 S. ILL. U.L.J. 1, 4 (2000).

¹⁷ *Id.* at 29.

Proponents of CDHC maintain that access to healthcare would be improved under this model because the money deposited into HSAs is tax-free and any individual can contribute to an HSA, including other family members and employers.¹⁸ This would encourage people to invest in their healthcare. Money that is deposited into HSAs can be carried over year to year without a penalty or threat of losing the money if not spent within the same year, however, the patient must pay “the required deductible at the beginning of each year.”¹⁹ This feature of CDHC allows flexibility for the patient²⁰ to decide whether or not to use their money, without financial consequences. The consumer driven system emphasizes patient autonomy and responsibility.²¹ These benefits seem to assume a generic patient since no variables are accounted for, such as level of health, education, or income. To determine the likelihood of success under CHDC, specific categories of patients should be analyzed.

IV. THE EFFECT OF CDHC AND HSAS

A. *The Poor*

The poor comprise one segment of the population in severe need of access to healthcare. They often lead life styles that do not promote good nutrition or the upkeep of adequate living conditions and habits.²² Additionally, their lack of disposable income does not grant them any advantages to or means of obtaining

¹⁸ Cate, *supra* note 13, at 295-96.

¹⁹ *Id.* at 296.

²⁰ *Id.*

²¹ Kapp, *supra* note 16, at 29.

²² Stiehm, *supra* note 4, at 279.

healthcare.²³ The poor in America generally face barriers to healthcare, including: not being able to take time off from work for healthcare related services; not being able to obtain adequate transportation for healthcare needs;²⁴ and not having the expendable income to spend on adequate healthcare or even preventative care.²⁵ Without having an opportunity to access medical care, the poor will likely suffer from health issues, and in the case of medical emergencies, they could face extreme financial difficulties.²⁶

Under the CDHC plan, the poor would be able to pick and choose what services they need, ideally reducing unnecessary healthcare, thus allowing them to save money.²⁷ They would, however, likely be conservative in their spending of necessary healthcare services as a method of saving money in their HSA overall, and accordingly, will not receive necessary services.²⁸ Consequently, the poor would not be able to afford certain services or levels of services because they would not have access to unlimited funds. Because “[v]oluntary choice and willingness and ability to pay are the hallmarks of consumer purchasing . . . [a]bility to pay constrains consumer choice.”²⁹ Thus, a patient’s access to certain services would be determined by the funds in their HSA.

²³ Cate, *supra* note 13, at 303-04.

²⁴ Stiehm, *supra* note 4, at 280.

²⁵ Leah Snyder Batchis, Comment, *Can Lawsuits Help the Uninsured Access Affordable Hospital Care? Potential Theories for Uninsured Patient Plaintiffs*, 78 TEMP. L. REV. 493, 499 (2005).

²⁶ *Id.* at 498.

²⁷ Symposium, *Healthcare Reform in America: Getting Beyond Ideology to True Reform*, 5 IND. HEALTH L. REV. 463, 477 (2008).

²⁸ *Id.* at 477-78.

²⁹ Mariner, *supra* note 4, at 493.

Once a patient exhausts all the money in their HSA, their health plan does not cover the remaining costs until they spend enough to meet the high deductible.³⁰ One problem with HSAs is that people must initially have the money to contribute to them as they pay out-of-pocket until the deductible is met. This means “[t]he gap between money in a health savings account and the high-deductible (this gap could be very high, in a range of \$2,000 to \$5,000 for families) is likely to cause a large number of families with relatively modest income to fall into the category of being ‘underinsured.’”³¹ The period in which an individual must pay the deductible is commonly referred to as the donut hole,³² because it leaves patients with high out-of-pocket costs, which the poor cannot afford. In this way, HSAs do not improve access to healthcare for the poor.

Converting the poor, who are uninsured or underinsured, into a larger group of underinsured, is a pitfall of the CDHC system,³³ and does not provide a pathway to adequate healthcare for the poor. Despite the theories that CDHC would reduce costs and spending, in 2005, people with HSAs and high deductible plans “were more than two-and-a-half times as likely to pay more than 5% of their income in out-of-pocket medical costs . . . then were people enrolled in

³⁰ James C. Robinson, *Health Savings Accounts – The Ownership Society in Health Care*, 353 N. ENG. J. MED. 1199, 1200 (2005).

³¹ Gail Shearer, Testimony Before the Joint Economic Committee, IMPACT of “Consumer-Driven” Health Care on Consumers 1, 8 (2004), <http://www.consumersunion.org/pub/0225JECTestimonyNoSummary.pdf>

³² Jessica Greene et al., *Which Consumers are Ready for Consumer-directed Health Plans?*, 29 J. CONSUMER POL’Y 247, 248 (2006).

³³ Shearer, *supra* note 31, at 2, 8.

comprehensive insurance.”³⁴ These increased out-of-pocket costs are draining on the poor because they have a limited disposable income and they are therefore unable to continually contribute to their HSAs like higher-income people.³⁵ Since the poor have a limited income, they are more likely to forego medical treatment either to save money or because they do not have the money in their HSA. In the long term, this could cause more critical and expensive health problems.³⁶ In 2005, the poor delayed or did not receive medical treatment 78% of the time compared to 44.2% for high-income people.³⁷ Under this theory, the poor would not only become underinsured, but also would not be able to afford necessary care.

The implementation of CDHC in conjunction with HSAs, will not likely increase healthcare access for the poor. HSAs do not provide a means for the poor to access healthcare easily, nor do they reduce costs for the poor.³⁸ The high deductible requirement makes the poor less likely to receive treatment and it is highly probative that their health will deteriorate as a result.³⁹ While the idea of CDHC may be significant in terms of controlling healthcare costs,⁴⁰ CDHC, in the long term, may stifle the poor more than assist them in accessing healthcare.

³⁴ Center on Budget & Policy Priorities, *A Brief Overview of the Major Flaws with Health Savings Accounts 1, 2* (2006), <http://www.cbpp.org/files/hsa-overview.pdf>.

³⁵ *Id.* at 2-3.

³⁶ *See, e.g., Id.* at 2; Cate, *supra* note 13, at 297.

³⁷ Agency for Healthcare Research and Quality, U.S. DEP’T OF HEALTH & HUM. SERVICES, *National Healthcare Disparities Report*, AHRQ Pub. No. 09-0002, 153 (2009), available at <http://ahrq.gov/qual/qdr08.htm>.

³⁸ Center on Budget & Policy Priorities, *supra* note 34, at 2.

³⁹ Cate, *supra* note 13, at 303.

⁴⁰ Axtell-Thompson, *supra* note 3, at 225.

B. The Uneducated

CDHC gives patients more responsibility and control over their healthcare and, as a result, they need to be more informed when making complex and intricate healthcare decisions.⁴¹ Patients must deal with difficult and obscure information regarding cost, coverage, benefits, and providers.⁴² Informed decisions are important so that patients are not negatively affected or harmed by their inability to make the ‘correct’ decision regarding their healthcare. Similarly, the less educated will have more difficulty with the added responsibility of CDHC. The variety of patients “will have different information needs, based on their health status, interests and abilities, and roles as simple patients, general consumers, or family decision makers.”⁴³ This makes CDHC all that more taxing on the uneducated, especially those not familiar with the medical industry.

Uneducated patients will be at a disadvantage under CDHC because their low level of literacy makes them vulnerable to making poor decisions,⁴⁴ which will negatively affect their health and their healthcare spending. CDHC places patients and consumers at the same level, but a patient has a different mind set and mental outlook than a consumer.⁴⁵ Access to healthcare under a consumer model is obstructed because “[i]llness erodes control” that a patient must possess and ultimately, “illness can cripple the patient as consumer”⁴⁶ who must be a

⁴¹ *Id.* at 214.

⁴² *Id.*

⁴³ *Id.* at 212.

⁴⁴ Kapp, *supra* note 16, at 25.

⁴⁵ Mark A. Hall & Carl E. Schneider, *Patients as Consumers: Courts, Contracts, and the New Medical Marketplace*, 106 MICH. L. REV. 643, 650 (2008).

⁴⁶ *Id.*

“seeker of information and maker of decisions.”⁴⁷ A patient that is sick or ill cannot make clear, rational, or financially beneficial decisions when they are faced with health concerns, and patients at a lower education level will have even more difficulties accessing healthcare. The immediacy and urgency of some medical issues put patients at a disadvantage because in such a situation, a patient will not be able to research all their options or find the most cost-effective plan, which affects their bargaining power.⁴⁸ CDHC detrimentally assumes that patients will foresee healthcare problems and concerns in the future, when in reality, patients are not likely to expect the type of funding necessary for their healthcare needs when they are healthy.⁴⁹ Consequently, the patient will not have the needed funds in their HSA.⁵⁰ While educational disparities exist, “painting patients with the broad brushstrokes of market logic is counter-productive because in reality we do not all have the same capacity to be effective in efforts to manage our own care.”⁵¹

C. The Chronically Ill

The chronically ill also require improved access to healthcare as they have a standard or minimum amount of medical care. The high deductible required under CDHC will operate as a barrier to healthcare for the chronically ill.⁵² The chronically ill are patients faced with the high costs of medical care on a regular

⁴⁷ *Id.* at 652.

⁴⁸ *See* Cate, *supra* note 13, at 300 (alleging that “[t]he very nature of a consumer acting as a patient places one in an inferior bargaining position because the consumer must obtain medical care in some fashion leaving little room for negotiation.”).

⁴⁹ *Id.* at 295.

⁵⁰ *Id.*

⁵¹ Karvounis, *supra* note 4, at 2.

⁵² Jacobi, *supra* note 2, at 566.

basis.⁵³ 70% of United States healthcare costs are retained by only 10% of patients, most of which suffer from a chronic illness.⁵⁴ Contrary to the chronically ill, the CDHC system benefits healthy populations because they will not have on-going or expensive treatments that they repeatedly have to pay for through deductibles.⁵⁵ Heightened access to healthcare for the chronically ill will not be realized under CDHC because the high deductible required by HSAs force the chronically ill to pay significantly greater out-of-pocket costs.⁵⁶ As a result, each year the chronically ill will be exhausting their HSAs.

The combination of HSAs and high deductibles will not decrease the costs or medical services for the chronically ill because health plans associated with high deductibles will cover any remaining costs after the deductible has been met.⁵⁷ People with chronic illnesses cannot forego necessary treatment, and under the consumer driven system, they will have an established amount of expenses each year that will operate as a surcharge or penalty simply because they are chronically ill.⁵⁸ In effect, the burden of cost will shift to these chronically ill patients⁵⁹ and become a barrier to needed healthcare.⁶⁰

⁵³ Karvounis, *supra* note 4, at 1.

⁵⁴ *Id.*

⁵⁵ Mariner, *supra* note 4, at 506.

⁵⁶ Center of Budget & Policy Priorities, *supra* note 34 at 2.

⁵⁷ Axtell-Thompson, *supra* note 3, at 211.

⁵⁸ Jacobi, *supra* note 2, at 534, 562, 566.

⁵⁹ Shearer, *supra* note 31, at 3.

⁶⁰ Axtell-Thompson, *supra* note 3, at 211.

V. CONCLUSION

Under a consumer driven model of healthcare, it is vital that the system “reflect an understanding of the wide variations and inherent limitations of decision making capability in general and, in particular, within the complex realm of health care.”⁶¹ Consumer driven systems of healthcare present numerous barriers and problems for the poor, uneducated, and chronically ill. The very character of CDHC threatens to transform the uninsured into the underinsured because of high out-of-pockets costs.⁶² Patients will refrain from getting the routine medical services or preventative care they need.⁶³ A consumer driven model is not ideal for at-risk patients because “when the consumer is part of the product, responsibility is not some independent value hidden away in an impregnable safe-space of rationality—it’s inextricably tied up with the patient as a whole: his experiences, his feelings, and yes, his education.”⁶⁴ Patients are all diverse, but under a consumer driven system, the patients that need the most help are left to suffer and are burdened with rationing their healthcare funds.⁶⁵

CDHC does not improve access to healthcare because of the combination of HSAs and high deductibles, in addition to the complexity and responsibility that adheres to the consumer model.⁶⁶ While the current healthcare system in the United States is inadequate and requires improvement, CDHC is not the

⁶¹ *Id.* at 216.

⁶² *See*, Shearer, *supra* note 31, at 8.

⁶³ Cate, *supra* note 13, at 303.

⁶⁴ Karvounis, *supra* note 4, at 2.

⁶⁵ Shearer, *supra* note 31, at 2, 8.

⁶⁶ *See* Cate, *supra* note 13, at 290, 317-18.

solution.⁶⁷ CDHC and HSAs present barriers to healthcare for the poor, uneducated and chronically ill that make them insufficient as a healthcare system. We must continue to find ways to reform and improve upon our healthcare system so costs are not only reduced, but access to healthcare is improved for all Americans.

⁶⁷ See *Id.* at 318; Center of Budget & Policy Priorities, *supra* note 34, at 1, 3; Shearer, *supra* note 31, at 8.

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***The Mental Health Parity Act: Opening the Door to
Equitable Access for the Mentally Ill***

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I. INTRODUCTION

It has long been believed that the disparities associated with healthcare stem from three prongs: cost, quality, and access. Indeed, it is often the interplay between these three prongs that affects consumers' relations with the healthcare system, and together they can combine to form great impediments in access to care.¹ Access to mental healthcare is never immune from the effects of this three pronged system, but in the past, consumers of mental health services have been faced with an additional barrier to access: discrimination by private insurer's in the coverage of mental health services.²

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¹ See RUTH L. KIRSCHTEIN, NAT'L INSTITUTES OF HEALTH, INSURANCE PARITY FOR MENTAL HEALTH: COST, ACCESS, AND QUALITY 3-4, June 2000, available at <http://www.nimh.nih.gov/about/advisory-boards-and-groups/namhc/reports/nimh-parity.pdf> (considering cost, quality, and access variables of mental health parity legislation).

² See *infra* notes 12-23 and accompanying text (discussing ways in which private insurers have discriminated against full parity for mental healthcare services). The Mental Health parity movement began in the 1990's for a variety for reasons: 1) research began to show that mental illnesses had biological as well as psychological bases, 2) during the 1970's and 1980's employers had implemented more restrictive coverage of mental illnesses, 3) increases in diagnoses due to improved diagnostic tools, and 4) growing opposition to the inequitable administration of mental healthcare benefits. Dana L. Kaplan, *Can Legislation Alone Solve America's Mental Health*

In light of the ubiquity of persons suffering from treatable mental illnesses,³ the destruction of these barriers is imperative. Statistics indicate that there are approximately forty million American adults with some variation of a mental illness and that at least five to six million of those persons have a severe mental illness.⁴ It is because of this expansive effect on the populace, and because “mental health is essential to leading a healthy life,”⁵ that maintaining equitable access to treatment for mental healthcare is an issue of extreme importance.

Nonetheless, prior to the enactment of the Mental Health Parity Acts (MHPA) of 1996 and 2008, many employers and insurer’s discriminated against mental illnesses with respect to the extent of coverage.⁶ It is for this precise reason that the MHPA was promulgated, and proponents considered its passage to be a “great step forward”⁷ in the fight to end insurer’s discrimination of mental illnesses and the services required to treat such conditions.⁸

Dilemma? Current State Legislative Scheme Cannot Achieve Mental Health Parity, 8 QUINNIPIAC HEALTH L. J. 325, 328-39 (2005) [hereinafter *Legislation Alone*].

³ See *infra* notes 4-5 and accompanying text (noting number of persons that have some form of mental illness is around forty million).

⁴ H.R. REP. NO. 110-374, pt. 1, at 25 (1997).

⁵ *Id.*

⁶ *Id.* at 25. Parity refers to equality in coverage between physical conditions and mental health conditions.

⁷ Am. Psychological Ass’n, *Landmark Victory: Mental Health Parity is Now Law*, Oct. 3, 2008, <http://www.apa.org/releases/parity-law1008.html>.

⁸ A few scholars have discussed mental health parity laws in light of the conflict between state and federal legislation, utilizing real life stories of victims of such discrimination to underscore their pleas for reformed legislation. One such example involves a family whose son required constant mental health treatment; however, the family’s health insurance did not provide equitable coverage for mental illness. Desiree Busching & Simon Kapochunas, *Timothy’s Law: Introducing New York to Mental Health Parity*, 25 HOFSTRA LAB. & EMP. L. J. 601, 601 (2008) [hereinafter *Timothy’s Law*]. As a result, the son could not receive the treatment that he needed, and in 2001 he committed suicide. *Id.* Another such example involves a family whose son had attempted suicide, “prompting his parents to admit [their son] into a psychiatric hospital.” Jeffrey M.

Part II of this Article will discuss the history of the ratification of the MHPA of 2008 including a discussion of its direct predecessor, the MHPA of 1996.⁹ Part III will then discuss the sections and provisions of the MHPA of 2008 with a focus on those that pertain directly to parity in mental health coverage.¹⁰ Part IV will provide a brief analysis of the extent to which the MHPA of 2008 will achieve the goals of its supporters, including an assessment of outstanding issues to be addressed.¹¹

II. HISTORY OF PROMULGATION

The express purpose of the MHPA of 2008 was to balance the disparity between mental illness versus physical illness benefits, and thus, to increase access “by prohibiting group health plans from imposing financial requirements...or treatment limitations...on mental health benefits that are more restrictive than those restrictions applied to medical and surgical benefits.”¹² Accordingly, the first sentence of the “purpose” of the MHPA of 2008 underscores that myriad “obstacles within our healthcare system prevent many

Barrett, *A State of Disorder: An Analysis of Mental-Health Parity In Wisconsin and a Suggestion for Future Legislation*, 2008 WIS. L. REV. 1159, 1160 (2008) [hereinafter *A State of Disorder*]. The family had to pay over \$130,000 out of pocket to cover the expenses not reimbursed by their insurance company; while at the same time the insurance company fully covered the entirety of the father’s care for his kidney disorder. *Id.* Such stories are illustrative of the impetus for both MHPA’s.

⁹ See *infra* Part II (discussing history of the MHPA of 2008 and the legislative purpose in its promulgation).

¹⁰ See *infra* Part III (highlighting the provisions of the MHPA of 2008 that specifically pertain to parity in coverage).

¹¹ See *infra* Part IV (discussing the impact of the MHPA of 2008).

¹² H.R. REP. NO. 110-374, at 13.

from getting”¹³ the necessary mental healthcare. Though other laws existed prior to the MHPA of 2008, at the time of promulgation they were considered inadequate;¹⁴ and thus, a discussion of the previous laws is necessary to set the foundation for the response of Congress in enacting the MHPA of 2008.

There had been numerous attempts by legislators to introduce mental health parity legislation prior to the MHPA of 2008,¹⁵ but the most influential of these bills was the MHPA of 1996 which served as the direct predecessor to the 2008 MHPA.¹⁶ The MHPA of 1996, in an effort to quell the fears of its opponents that imposing mandates on parity would skyrocket costs,¹⁷ opted for a weaker parity provision that only required insurer’s to maintain annual and

¹³ *Id.*

¹⁴ See *infra* note 15-16 and accompanying text (discussing history of prior laws and express purpose of enhancing the MHPA of 1996).

¹⁵ The Mental Health Parity Act of 2008 was a culmination of many previous efforts to pass legislation for mental health parity in insurance benefits. Below is a timeline of those previous recommendations:

1992: Senators Domenici and Danforth introduced the first Mental Health Parity Act: Equitable Health Care for Severe Mental Illnesses Act of 1992; but this bill did not pass into law. H.R. REP. NO. 110-374, at 13.

1993: The Health Security Act to provide for full parity was debated and introduced, but again, the bill did not push into law. *Id.* at 13-14.

1996: Senators Domenici and Wellstone introduced the MHPA of 1996 which required parity only in annual and lifetime dollar limits on health insurance benefits. *Id.* at 14. This was signed into law on September 26, 1996. *Id.*

1997: The MHPA of 1996 requirements were extended to the State Children’s Health Insurance Plan and Medicaid managed Care plans, and the Taxpayer Relief Act of 1997. *Id.* at 15.

1998: Senator Roukema made another attempt to amend the code by introducing the Mental Health and Substance Abuse Parity Amendments of 1998, but they were not passed into law. *Id.* at 15.

1999: Senators Domenici, Wellstone, and Roukema introduced, respectively, the Mental Health Equitable Treatment Act and re-introduced the Mental Health and Substance Abuse Parity Amendments. *Id.* After hearings before committees, no further action was taken on the latter. *Id.* at 16. Both bills were reintroduced in 2001 and 2002. *Id.* at 15-16.

2001 – 2007: Myriad other bills were introduced and rejected. *Id.* at 16-20.

¹⁶ *Id.* at 13.

¹⁷ See *id.* at 27-28 (discussing previous MHPA and the concerns for balancing costs with increased access).

lifetime dollar limits that were equal to those allowed for physical conditions.¹⁸ As a result of these limited parity provisions, the MHPA of 1996 did not produce “fundamental change”¹⁹ and “arbitrary” discrimination against persons seeking coverage for mental healthcare persisted.²⁰ Instead of responding to the mandate for parity, insurer’s merely imposed new limitations on mental health coverage.²¹ As a result, the status quo of discrimination remained in effect,²² foreclosing access to care for persons that were insured by such plans and unable to independently pay for mental health services.²³

The express language of the MHPA of 2008 states that its goal was “to expand the MHPA of 1996 to ensure that mental illnesses are covered under similar terms as physical illnesses...”²⁴ Moreover, at the time of the promulgation of the MHPA of 2008, twenty-eight states had “full mental health parity” laws but such laws varied greatly in language and effect.²⁵ In part because of this variance,²⁶ supporters of the MHPA of 2008 recognized that “without a

¹⁸ 29 U.S.C. § 1185a (West 1996) (current version at 29 U.S.C. § 1185a (West 2009)); H.R. REP. NO. 110-374, at 14.

¹⁹ H.R. REP. NO. 110-374, at 28.

²⁰ *Id.*

²¹ *Id.* (Insurers and employers frequently utilized loopholes such as more restricted coverage for outpatient visits than with physical conditions, reduced coverage for hospital days, and higher cost sharing requirements).

²² *Id.*

²³ *See, e.g., supra* note 8 (discussing stories of families affected by inability to pay, and insurers refusal to pay, for mental health services).

²⁴ H.R. REP. NO. 110-374, at 13.

²⁵ *Id.* at 30-31 (citing to deficits in existing state laws including that they cannot apply to self-insured plans because of ERISA preemption and that even the full state parity laws fail to cover “catastrophic care” in the situations of severe mental illness). In addition to the 28 states with full parity laws, the Report to the bill highlighted that 46 states in total had some form of mental health parity law but that “they var[ied] considerably...divided into three categories:” 1) full parity, 2) minimum standard, and 3) offering laws. *Id.* at 30.

²⁶ *Id.* at 31.

definition of covered mental health benefits, mental health parity legislation would continue to include loopholes that make parity an illusory promise.”²⁷ At the same time, public fears about costs and the stigma surrounding mental illnesses affected the public’s perception of parity laws.²⁸ Thus, the MHPA of 2008 (the 2008 version alone will hereinafter be referred to as “MHPA”) sought to address all of these issues,²⁹ and in 2008 the Employee Retirement Income Security Act (ERISA) was amended to include the provisions of the MHPA.³⁰ Set to become effective on January 1, 2009,³¹ the MHPA promised a bright future for the end of healthcare discrimination and improved access to mental health services.

III. PROVISIONS

As a result of the recognition that an effective federal health parity law would need to be predicated on “equity in financial requirements, treatment

²⁷ *Id.* at 20-21. Support for this contention was based on the idea that there was “ample evidence” to show that, in the past, employers had used narrow definitions of mental illness to “evade coverage” rather than reasonably restrict costs. *Id.* The issue of coverage was also implicated by insurers varying definitions of mental illness. Whereas historically insurers did not “delineate” coverage for specific physical conditions, doing so with respect to the extent of coverage for mental illnesses was wide practice; “such delineation was commonplace.” *Id.*

²⁸ *Id.* at 26. The Report to the Bill highlighted that in the late 1990s, the stigma surrounding mental illnesses resulted in a public that was hesitant to pay for services to treat “less severe” mental health conditions. *Id.* This was exacerbated by the public’s belief that the coverage of those services would translate into higher premiums or taxes. *Id.* The Former First Lady Carter’s testimony at the hearings concerning the passage of the MHPA of 2008 sums up the ideological underpinning of these concerns: “if insurance covered mental illnesses, it would be right to have them. This may be why the stigma has remained so pervasive. Because these illnesses are treated differently from other health conditions.” *Id.*

²⁹ See *infra* note 32 and accompanying text (noting the specific criteria on which the MHPA of 2008 was to be based).

³⁰ 29 U.S.C. § 1185a (West 2009).

³¹ *Id.*

limitations, and out of network coverage,”³² the MHPA mandates equitable coverage for treatment services.³³ This includes: in and out of network inpatient, outpatient care, and emergency care;³⁴ the number of visits or days of coverage; and “other similar limit[s] on the duration or scope of treatment.”³⁵ Additionally, the MHPA mandates equitable financial coverage including deductibles, co-payments, co-insurance, out-of-pocket expenses, and annual and lifetime limits on coverage.³⁶ These obligations encompass both mental illness and substance abuse benefits.³⁷

With respect to the definition of mental illness, the MHPA requires covered entities to adopt the “same range of mental illnesses and addiction disorders covered by the Federal Employee Health Benefit.”³⁸ It is important to note, however, that though the MHPA does mandate parity, it does so only if the entity already provides mental health coverage; the MHPA does not create an affirmative responsibility to offer mental health coverage if an entity does not

³² H.R. REP. NO. 110-374, at 24.

³³ 29 U.S.C. § 1185(a)(3) (West 2009).

³⁴ 29 U.S.C. § 1185(a)(5) (West 2009); H.R. REP. NO. 110-374, at 33-34.

³⁵ 29 U.S.C. § 1185(a)(3)(B)(iii) (West 2009); H.R. REP. NO. 110-374, at 34.

³⁶ 29 U.S.C. § 1185(a)(3)(B)(i) (West 2009); H.R. REP. NO. 110-374, at 34.

³⁷ See generally 29 U.S.C. § 1185a(a) (West 2009) (discussing general obligations under act and describing that such obligations apply for mental health and substance abuse disorders); H.R. REP. NO. 110-374, at 34.

³⁸ 29 U.S.C. § 1185a (West 2009); H.R. REP. NO. 110-374, at 34 (stating that plans must conform to the Federal Employee Health Benefit plan *with the highest average enrollment* of federal employees). Federal Employee Health Benefits are contingent upon state specific plan provisions, and even within each state, federal employee’s have panoply of plan options from which to choose. See, e.g., U.S. Office of Personnel Mgmt., *2009 Plan Information for Ill.*, Oct. 8, 2009, <http://www.opm.gov/insure/health/planinfo/2009/states/il.asp> (showing the thirty plus plan options just within the state of Illinois). Thus, this is a curiously vague standard for what was considered one of the most important provisions of the MHPA, that of which mental illnesses an employer is required to cover. H.R. REP. NO. 110-374, at 20-21.

already do so.³⁹ Lastly, the MHPA expressly provides that unlike other ERISA provisions,⁴⁰ the MHPA does not preempt more restrictive state mental health parity laws.⁴¹

IV. ANALYSIS

Though the MHPA is a large step in the right direction towards ending the serious impediment to access based on discrimination, studies performed in states in which parity laws already exist suggest that the MHPA may not result in the anticipated wider access of mental health services even if it creates an easier means through which services can be accessed.⁴² Even though studies suggest that parity does not affect premiums,⁴³ they also show that while parity may increase access for those persons already suffering from mental illness, the

³⁹ 29 U.S.C. § 1185(b) (West 2009); H.R. REP. NO. 110-374, at 24. The bill also allows for an exemption for group health plans for which implementation would result in a 2% cost increase the first year and 1% each subsequent year, and also to employers with fifty or fewer employees and those that would also experience greater than a 2% increase in cost during initiation year and 1% each subsequent year. 29 U.S.C. § 1185(c)(1); H.R. REP. NO. 110-374, at 34. The Congressional Budget Office demonstrated, however, that the estimated cost increase was at 0.4% for private insurers, and 0.2% for public insurers. H.R. REP. NO. 110-374, at 45.

⁴⁰ ERISA preemption is a peripheral but important legal issue with respect to the MHPA. ERISA governs “any benefit plan that is established or maintained by any employer engaged in commerce or in any industry affecting commerce.” 29 U.S.C. § 1003(a) (West 2006). ERISA contains a preemption clause which expressly provides that ERISA provisions supersede state laws that pertain to employee benefit plans. 29 U.S.C. § 1144(a) (West 2006); *Timothy’s Law*, *supra* note 8, at 624-25. ERISA, however, also contains what is commonly referred to as the “savings clause,” which allows states to regulate insurance provided that certain legislative criteria are met. 29 U.S.C. § 1144(b) (West 2006); *Timothy’s Law*, *supra* note 8, at 625. Thus, both the savings clause and the plain language of the MHPA create substantial enhancements to access of mental health services by allowing states to create more restrictive parity laws and still avoid preemption for those plans governed by ERISA.

⁴¹ H.R. REP. NO. 110-374, at 34-35 (“nothing in this section preempts any State law that provides consumer protections...except to the extent that such provision prevents the application of a requirement of this part”).

⁴² See *infra* notes 42-44 (discussing studies looking at effect of state parity laws).

⁴³ *Timothy’s Law*, *supra* note 8, at 610. The study, however, did show that “[none] of the insurers...identified [mental health or substance abuse] parity laws as a main consideration in a decision to self-insure.” *Id.* at 610-11.

passage of such laws does not per se increase utilization of mental health services.⁴⁴ This may be exacerbated by the MHPA's failure to provide an adequate standard by which insurers must define the breadth of mental illness coverage;⁴⁵ with the likely result of litigation as the MHPA's effects settle and the potential arises for continued abuse of statutory loopholes.

Additionally, it is self-evident that the passage of the MHPA only affects those participants of a covered entity. Thus, a myriad of other barriers continue to exist for the mentally ill with respect to access of care. Such barriers include low access for minorities⁴⁶ and the remaining stigmas that pervade our society that may contribute to the hesitancy in obtaining the requisite mental healthcare.⁴⁷ Indeed, as the MHPA only applies to private insurers and only to insurance coverage, it neglects the issue of the uninsured and a lack of access to not only compensation for coverage, but providers and facilities in and of themselves.⁴⁸ These issues of basic, physical access to services are particularly important to

⁴⁴ *Id.* at 612.

⁴⁵ See *supra* note 38 and accompanying text (discussing pervasive vagueness of the specific mental illnesses that insurer's are required to cover).

⁴⁶ See generally Matt Boucher, *Turning a Blind Eye in Legislating Mental Health Parity: The Unmet, Overlooked Needs of the Working Poor in Racial and Ethnic Minority Communities*, 19 J. CONTEMP. HEALTH L. & POL'Y 465 (2003) (criticizing myopic view of parity legislation as only within the context of private insurers). Boucher underscores one of the primary problems with legislation focused only on private insurers: 85-95% of those with treatable, severe mental illnesses are unemployed, and thus wholly unaffected by the MHPA. *Id.* at 469. As Boucher notes, racial and ethnic minorities also have disproportionate impediments to access due to lower physical access to mental healthcare facilities. *Id.* at 471, 473, 488. Boucher argues that parity legislation should coincide with an expansion of community based mental health programs as these are often the most utilized and only means of receiving mental healthcare for the working poor and minority populations. *Id.* at 489-91.

⁴⁷ *State of Disorder*, *supra* note 8, at 1162-63 (citing one effect of stigma is to preclude "the market from addressing the discrimination from mental health coverage..."). *Id.* at 1162. This is exacerbated by the stigma that "erodes confidence that mental disorders are valid, treatable health conditions." *Id.* (internal citation omitted).

⁴⁸ See *supra* notes 46-47 and accompanying text (discussing remaining gaps in access to mental health care for the uninsured).

address in light of the MHPA's proponents' indications of the high costs, both economic and social, of untreated mental illness.⁴⁹

V. CONCLUSION

The MHPA was seen as “one more step in the long civil rights struggle to ensure that all Americans have the opportunity to reach their potential.”⁵⁰ While the practical results of the MHPA have yet to be assessed, there is hope that by the time of the 2012 Government Accounting Office's mandated analysis, the MHPA's goals will have materialized.⁵¹ In fact, it is because the MHPA was “one of the most dramatic improvements in the [availability of] healthcare...for people who have mental illness”⁵² that there are such high expectations for the bill's effect. If, however, insurers continue to abuse the loopholes of the perceptively vague language of the MHPA, supporters of the MHPA may

⁴⁹ *Legislation Alone*, *supra* note 2, at 330-31 (“studies have found that individuals with untreated mental illness use non-mental health services at a high rate than individuals without mental illness. This...leads to higher overall health costs...individuals suffering from untreated mental illness have higher unemployment and disability rates than individuals not suffering from mental illness.”). *See also A State of Disorder*, *supra* note 8, at 1166 (“the annual cost of untreated mental illness in the United States is an estimated \$148 billion.”).

⁵⁰ Fred Frommer, *After 12 Years, Wellstone Mental Health Parity Act is Law*, Minn. Public Radio (Oct. 3, 2008) http://minnesota.publicradio.org/display/web/2008/10/03/parity_finalpassage (citing Representative Patrick Kennedy).

⁵¹ The MHPA requires the Labor Secretary to submit a report in 2012 and every two years following with the results of compliance audits and survey regarding compliance; and within three years the Government Accounting Office is required to submit a report analyzing the impact of the MHPA both on coverage of mental health and substance abuse services as well as the effect the MHPA has on costs to employers and insurers. *See CuraLinc Healthcare, 2008 Mental Health Parity Act* (2008) <http://www.curalinc.com/parity.htm> (describing background and requirements of the MHPA).

⁵² Doug Trapp, *Mental Health Coverage to See Boost as Long Sought Parity Law is Enacted*, AM. MED. NEWS (Oct. 27, 2008) <http://www.ama-assn.org/amednews/2008/10/27/gv111027.htm#> (citing Dr. Jeremy Lazarus, speaker of the AMA House of Delegates).

continue to see discrimination.⁵³ Moreover, implicit discrimination will continue to exist so long as physical barriers to access pervade the uninsured.⁵⁴ As the United States Supreme Court has stated, “[t]he mental health of our citizenry, no less than its physical health, is a public good of transcendent importance.”⁵⁵ Access to mental health services should embody this value.

⁵³ See *supra* notes 38, 45 and accompanying text (highlighting vague sections in the definition of covered mental illnesses).

⁵⁴ See *supra* notes 46-48 and accompanying text (discussing gaps in access for the uninsured and disadvantaged).

⁵⁵ *Jaffee v. Redmond*, 518 U.S. 1, 11 (1996).

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***Desert in the City:
The Effects of Food Deserts on Healthcare
Disparities of Low-Income Individuals***

Sonje Hawkins^{*}

I. INTRODUCTION

Food is necessary for the very existence of human beings, but food is not always a privilege that all enjoy. The lack of access to healthy foods is a silent problem in the United States that has been largely dwarfed by starvation in other areas of the world. A growing amount of research has begun to surface surrounding areas in the U.S. with little access to healthy food.¹ These areas are referred to as “food deserts,” a term that reportedly originated in Scotland in the 1990’s to describe areas with poor access to affordable and healthy diets.²

Several scholars have discussed the idea that food deserts in and of themselves represent disparities among lower-income individuals’ access to

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¹ Julie Beaulac et al., *A Systematic Review of Food Deserts, 1966-2007*, 6 PREVENTING CHRONIC DISEASE 1, 1 (July 2009), available at http://www.cdc.gov/pcd/issues/2009/jul/pdf/08_0163.pdf. [hereinafter Beaulac]

² *Id.*

nutritious food,³ but the implications of food deserts have more far-reaching effects than have been previously explored. Although “the extent to which limited access to supermarkets and other differential aspects of the food environment contribute[s] to known economic and racial health disparities remains unclear,”⁴ there are still links that can be made from lack of access to nutritious food to healthcare disparities. Further, these links can not only be made to low-income individuals, but disproportionately affected racial and ethnic groups of low-income individuals.

Part II of this article will discuss the nature of food deserts. Part III will explore the health disparities amongst low-income individuals and the disproportionate effects of diet-related diseases on this group versus the larger population. Since African-Americans are the group most disadvantaged by food deserts,⁵ this section will primarily focus on health disparities affecting African-Americans, as a representation of the larger health disparities problem. Part IV will discuss healthcare disparities generally and argue that there are several effects of food deserts on these disparities, in an analysis of “deprivation amplification.” Finally, Part V will identify proposed legislation surrounding

³See generally Beaulac, *supra* note 1; INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, THE PUBLIC HEALTH EFFECTS OF FOOD DESERTS: WORKSHOP SUMMARY 5 (The Nat’l Acad. Press 2009), available at <http://www.nap.edu/catalog/12623.html> [hereinafter Public Health Effects]; United States Department of Agriculture, *Access to Affordable and Nutritious Food: Measuring and Understanding Food Deserts and Their Consequences*, June 2009, <http://www.ers.usda.gov/Publications/AP/AP036/AP036.pdf> [hereinafter *Access to Affordable and Nutritious Food*].

⁴*Access to Affordable and Nutritious Food*, *supra* note 3, at 39.

⁵Mari Gallagher Research and Consulting Group, *Good Food: Examining the Impact of Food Deserts on Public Health in Chicago* 7, July 18, 2006, http://www.marigallagher.com/site_media/dynamic/project_files/1_ChicagoFoodDesertReport-Full_.pdf (last visited Oct. 7, 2009) [hereinafter *Good Food*].

U.S. food deserts, as well as suggest solutions to the food desert problem and its effects on healthcare disparities.

II. THE FOOD DESERT GENERALLY

A “food desert,” is a large geographic area with either no or distant mainstream grocery stores, and subsequently, no access to nutritious foods.⁶ As aforementioned, the term “food desert” was first used in Scotland to describe neighborhoods that encompassed many thousands of people or an extensive land area comprised of city blocks or square miles which did not have an adequate supply of nutritious food available.⁷ Food deserts exist both in urban and rural low-income neighborhoods.⁸ A food desert is not a complete absence of food; rather, it is an imbalance in food choice, “meaning a heavy concentration of nearby *fringe* food high in salt, fat, and sugar.”⁹ These fringe locations are sources of convenient, but often unhealthy, food that cannot support a daily healthy diet on a regular basis.¹⁰ The Mari Gallagher Research & Consulting Group, who has conducted extensive research on the food desert and its link to various diseases, posits that in order to take a first step in truly understanding the problem of food deserts, terms such as “mainstream grocer” and “fringe food

⁶National Food Desert Awareness Month, <http://www.fooddesertmonth.org>, (last visited Oct. 7, 2009); *see also* Mari Gallagher Research and Consulting Group, *Food Desert and Food Balance Indicator Sheet*, <http://fooddesertmonth.org/pdfs/Resources%20--.%20Food%20Desert%20and%20Food%20Balance%20Indicator%20Fact%20Sheet.pdf>, (2008), (last visited Oct. 7, 2009) (discussing food deserts as areas where low-income areas lack adequate access to grocery stores creating an imbalance in food choice) [hereinafter Mari Gallagher Group].

⁷Public Health Effects, *supra* note 3, at 5.

⁸*Id.*

⁹Mari Gallagher Group, *supra* note 6.

¹⁰*Id.*

venues” must be commonly defined to effectually assess the food desert situation.¹¹ A “mainstream grocer” is defined as a place where a healthy diet can be supported on a regular basis.¹² These do not only include major “full service chains” but smaller stores as well.¹³ The opposite of a mainstream grocer is a fringe food venue, where the food is not inherently bad, but “if it were the primary food source, local diets and public health would likely suffer.”¹⁴ Convenience stores and fast food restaurants are examples of fringe food venues.¹⁵

Food deserts are viewed as such because the distance to the nearest mainstream grocer can be several miles away.¹⁶ In June 2009, the U.S. Department of Agriculture (USDA) put forth a study that found approximately 23.5 million people live in low-income areas that are more than 1 mile from a supermarket or grocery store.¹⁷ The study points out that not all of these individuals are low-income, but of this 23.5 million, eleven million people, or 4.1% of the population are.¹⁸ The USDA report further purports that urban core areas with limited access to food are characterized by higher levels of racial segregation and greater income inequality.¹⁹ Moreover, the study explores this notion of distance from grocery stores creating a desert of food, and states that a

¹¹ *Id.*

¹² *Id.*

¹³ *Id.* at 2.

¹⁴ *Id.* at 1.

¹⁵ *Id.* at 2.

¹⁶ See *Access to Affordable and Nutritious Food*, *supra* note 3, at iii (discussing average distances from homes to supermarkets in low-income areas).

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.* at iv.

key concern for people who live in areas with limited access is that they rely on small grocery or convenience stores.²⁰ These stores, however, may not carry the food necessary for a healthy diet, and if they do, this food is offered at much higher prices.²¹

Chicago has been designated one of many “food desert zones” in this country, along with other cities that include Detroit, Michigan, Cleveland, Ohio, Milwaukee, Wisconsin, and Houston, Texas.²² The food deserts in Chicago, specifically, give insight into the underlying racial and ethnic disparities inherent in food deserts. The Mari Gallagher Research and Consulting Group determined that African-Americans are the most disadvantaged in relation to balanced food choices, and travel the farthest distance to any type of grocery store, about 0.81 miles on average.²³ In addition, the Group found that fast food sources are slightly closer in African-American areas, concluding that “for African-Americans, it is much easier to access fast food than other types of food.”²⁴ Chicago food deserts, for the most part, are exclusively African-American.²⁵

²⁰ *Id.*

²¹ *Id.*

²² Angela Cortez, *Food Desert Bill Would Entice New Grocery Stores With Tax Incentives*, NATURAL FOODS MERCHANDISER, September 16, 2009, <http://naturalfoodsmerchandiser.com/tabId/119/itemId/4100/Food-desert-bill-would-entice-new-grocery-stores-w.aspx> (last visited Oct. 9, 2009) [hereinafter Cortez].

²³ *Good Food*, *supra* note 5, at 17.

²⁴ *Id.* at 9, 17.

²⁵ *Id.*

III. HEALTH DISPARITIES OF LOW-INCOME INDIVIDUALS

Health disparities are defined as “the differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States.”²⁶ A convergence of race, poverty, and environment tend to lead to greater overall threats to health.²⁷ Mari Gallagher’s Research and Consulting Group has found that communities with no or distant grocery stores, or with an imbalance of healthy food options (i.e. food deserts), will likely have higher rates of premature death and chronic health conditions.²⁸ Among African-Americans specifically, the Congressional Black Caucus (CBC) found that socioeconomic factors are the leading cause of unequal healthcare among African-Americans.²⁹ In relation to food deserts, the CBC found that, as is supported in section II of this article, lower-income communities are “bombarded with inexpensive and readily available fast food, and have little, if any, affordable healthy food options.”³⁰ The result of this bombardment is a risk of heart disease that is 50% higher for poor Americans than for affluent ones.³¹ Nearly 24% of African-Americans live in poverty and 19% are uninsured.³² High blood pressure has the highest prevalence in African Americans when compared to other ethnic groups anywhere in the

²⁶ L. Mikkelsen et al., *Eliminating Health Disparities: The Role of Primary Prevention*. OAKLAND, CALIF: PREVENTION INST. 1 (2002), http://www.preventioninstitute.org/pdf/Health_Disparities.pdf (last visited Nov. 1, 2009) [hereinafter *Eliminating Health Disparities*]

²⁷ *Id.*

²⁸ *Good Food*, *supra* note 5, at 9.

²⁹ Natalie A. Thompson, *38th Annual CBC Forum Looks at Minority Health Care Disparities*, CHICAGO DEFENDER ONLINE, Oct. 1, 2008, <http://www.chicagodefender.com/article-2045-38th-annual-cbc-forum-looks-at-minority-health-care-disparities.htm>, (last visited Oct. 9, 2009).

³⁰ *Id.*

³¹ *Id.*

³² *Id.*

world.³³ In addition, 45% of African-American women have cardiovascular disease.³⁴

In terms of obesity specifically, the “prevalence of obesity” affected 16.3% of American youth in 2006, however, 28% of non-Hispanic African American females were obese, as well as 20% of Mexican-American females.³⁵ For non-Hispanic White females, the statistic was 14.5%.³⁶ Obesity can lead to other health issues, further exposing the health disparities amongst groups affected by food deserts and African-Americans specifically. Obesity has been tied to lower wages among women, which affects their family’s economic situation.³⁷ Further, there is a strong positive association between a “high glycemic load diet and the risk of coronary heart disease.”³⁸ When economic situations are affected, it becomes harder for these groups to afford the necessary treatment for their health conditions, thus further worsening these conditions.

IV. “DEPRIVATION AMPLIFICATION” AND THE LINK BETWEEN FOOD DESERTS AND HEALTHCARE DISPARITIES

As aforementioned, “greater availability of fast food restaurants and lower prices of fast food restaurant items are related to a poorer diet.”³⁹ The link between limited access to supermarkets and economic and racial health disparities

³³ *Id.*

³⁴ *Id.*

³⁵ Steven Gray, *Can America’s Urban Food Deserts Bloom?*, TIME MAG., May 26, 2009, <http://www.time.com/time/nation/article/0,8599,1900947,00.html> (last visited Oct. 9, 2009).

³⁶ *Id.*

³⁷ *Access to Affordable and Nutritious Food*, *supra* note 3, at 52.

³⁸ *Public Health Effects*, *supra* note 3, at 40.

³⁹ *Access to Affordable and Nutritious Food*, *supra* note 3, at 39.

remains unclear.⁴⁰ There is an undeniable link, however, between low-income individuals living in disadvantaged areas and limited provisional access to necessities like food, healthcare, transportation, or other services and resources.⁴¹

“Deprivation amplification” refers to “a process that could impact an individual’s health whereby, risk factors for obesity, such as being low-income, combined with limited knowledge about nutrition are intensified by exposure to a food retail environment that offers too few choices for nutritious food and too many options for less nutritious alternatives.”⁴² Factors such as “residential segregation along socioeconomic and racial lines”⁴³ have created pockets of society where lower-income individuals, and more specifically racial minorities, are adversely affected in a variety of ways because they live in food deserts. Deprivation amplification explores the notion that because of this lack of food access and other factors, such as being low-income, less education about healthy choices of food leads to health disparities.

Following from the theory of deprivation amplification, scholars have begun to make a correlation between living in a food desert and falling prey to healthcare disparities. Different populations do not experience a different set of illnesses than those affecting the general population.⁴⁴ Instead, illness rates are higher, and the overall susceptibility to disease is greater because of a broad range

⁴⁰ *Id.*

⁴¹ *Id.*

⁴² *Id.* at 39-40.

⁴³ *Id.*

⁴⁴ *Eliminating Health Disparities, supra* note 26, at 3.

of environmental conditions.⁴⁵ The California Prevention Institute states that one of the environmental factors contributing to health disparities is “inadequate neighborhood access to health-encouraging environments including affordable, nutritious food, places to play and exercise...[and] relevant health information.”⁴⁶ The Institute goes on to state that health behaviors influenced by one’s environment can lead to ill health.⁴⁷ Without access to healthy and nutritious food, an individual has a more difficult time changing his or her behavior because only unhealthy food is available, and the individual cannot travel to grocery stores with healthier food.⁴⁸ The USDA posits that consumers are capable of substituting healthier foods for energy-dense foods (i.e. foods located at fringe food venues), when these healthier foods are available and are as inexpensive as energy-dense foods.⁴⁹

Individuals lacking access to preventative information continue making poor food choices that may lead to health disparities later in their lives. Although there are disparities in treatment and care of low-income individuals and more specifically, racial and ethnic minorities,⁵⁰ it is preventative information that is lacking. While the “healthcare system continues to emphasize care that occurs after an illness occurs...[there is a de-emphasis of] preventive services that could

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ *Id.*

⁴⁸ *Id.* at 4.

⁴⁹ *Access to Affordable and Nutritious Food*, *supra* note 3, at 55.

⁵⁰ Thompson, *supra* note 29.

potentially prevent the illness or reduce the burden of disease.”⁵¹ Medical intervention often comes well after a person is sick, and the most common chronic health problems, such as heart disease, diabetes, asthma, and HIV/ AIDS, which adversely affect the occupants of food deserts, cannot be cured.⁵² Thus, prevention would be the optimal treatment solution for both chronic and acute injuries.⁵³

Significant disparities exist in the use of evidence-based preventative services for already disadvantaged populations.⁵⁴ Racial and ethnic minorities, and more broadly, individuals who are in a lower socioeconomic position, are less likely to receive “screening and treatment for cardiac risk factors.”⁵⁵ In addition, these disproportionately affected groups are also less likely to receive childhood immunizations.⁵⁶ Thus, a lack of early screening and other preventative services, leads to disparities in health for low-income individuals already living in food deserts, and unable to adequately take care of their health because of the lack of access to nutritious food.

V. PROPOSED LEGISLATION SURROUNDING FOOD DESERTS AND POSSIBLE SOLUTIONS TO THE FOOD DESERT PROBLEM

Legislation surrounding food deserts is severely lacking. One reason for this may be that the link between food deserts and healthcare has not been

⁵¹ Agency for Healthcare Research and Quality, *National Healthcare Disparities Report, 2003*, <http://www.ahrq.gov/qual/nhdr03/nhdrsum03.htm#Differential> (last visited Nov. 1, 2009) [hereinafter *National Healthcare Disparities Report*].

⁵² *Eliminating Health Disparities*, *supra* note 26, at 3.

⁵³ *Id.*

⁵⁴ *National Healthcare Disparities Report*, *supra* note 51.

⁵⁵ *Id.*

⁵⁶ *Id.*

concretized in a way that lends itself to governmental intervention. In a study conducted by the California Prevention Institute, however, researchers found that “increasing awareness of a problem among communities and individuals, followed by the formation of community collaboratives to mobilize for changes in organizational practices and policy, resulted in laws that then made possible widespread improvements in health.”⁵⁷ An example of some legislative advances regarding food deserts is the USDA’s study of food deserts, which was congressionally mandated by the 2008 Farm Bill.⁵⁸ Similarly, a recent proposed bill, the Food Desert Oasis Act of 2009, seeks to encourage grocery stores to move their business into these low-income areas by creating tax incentives.⁵⁹ These stores “would receive a rehabilitation tax credit in some cases, which would focus on redevelopment in urban centers and reducing blight.”⁶⁰ Further, “employers would receive a tax credit of \$1,500 for every employee hired from within a Food Desert Zone, and tax-exempt bonds would be used on a variety of store upgrades, from the actual purchase of a building, to equipment, and even product purchases.”⁶¹ With more incentives for stores to enter these low-income areas, these groups would have more access to healthy foods and thus lower their risk of obesity, cardiovascular diseases, and other conditions.

Besides legislation, there are alternative options that can be implemented to help combat food deserts. The California Prevention Institute stresses the

⁵⁷ *Eliminating Health Disparities*, *supra* note 26, at 5.

⁵⁸ *Public Health Effects*, *supra* note 3, at 6.

⁵⁹ Food Desert Oasis Act, H.R. 3100, 111th Cong. (1st. Sess. 2009).

⁶⁰ Cortez, *supra* note 22.

⁶¹ *Id.*

importance of primary prevention as a general solution to the healthcare disparities problem.⁶² Primary prevention means taking actions *before* conditions arise, and is distinguished from secondary prevention, which involves taking action when problems such as high blood pressure arise, and tertiary prevention, which involves intervention in response to emergencies.⁶³ The Institute found that a primary prevention approach at the community level would better combat multiple health problems, and if the approach focuses on underlying factors, such as the existence of food deserts, communities can prevent a variety of diseases.⁶⁴ In other words, the focus of the primary prevention approach is a community-focused approach, where the focus of healthcare is not treating the individual, but addressing the problems in the community as a whole, as a means of implementing a systematic analysis that works to prevent several diseases at once, rather than one disease in one individual at a time.⁶⁵

Centrally located farmers' markets are another solution that allows individuals to have easier access to fresh foods.⁶⁶ An additional solution that was implemented in 2004 in Pennsylvania, which may work in other states, was the Fresh Food Financing Initiative (FFFI), the nation's first public-private funding initiative.⁶⁷ This initiative set aside \$120 million to fund retail projects in underserved areas and provided grants of up to \$250,000 per store and \$2.5

⁶² *Eliminating Health Disparities*, *supra* note 26, at 4.

⁶³ *Id.*

⁶⁴ *Id.* at 6.

⁶⁵ See generally *Eliminating Health Disparities*, *supra* note 26, at 6-11 (explaining a multifaceted approach to prevention as well as Larry Cohen's *Spectrum of Prevention*).

⁶⁶ *Public Health Effects*, *supra* note 3, at 52.

⁶⁷ *Id.* at 58.

million per store.⁶⁸ With this funding, stores have even greater incentive to provide fresh food to low-income areas.

VI. CONCLUSION

The existence of food deserts leads to health disparities, disproportionately affecting low-income individuals and racial and ethnic minorities. Healthcare disparities refer to disparate preventative information that may help disproportionately affected groups combat disease before it can adversely affect them. The correlation between living in a food desert, and lack of preventative information, including early screening and community outreach, leads to higher risks of obesity, coronary heart disease, and other health conditions amongst individuals already adversely affected by disease and chronic conditions. With more research, the correlation between food deserts and healthcare disparities can be explored, and perhaps more legislation can be directed towards eliminating food deserts altogether.

⁶⁸ *Id.*

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***The Social Burden of Obesity:
Legal Implications of Employer and Government
Sponsored Wellness Programs***

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From the shouting matches at town hall meetings to the bipartisan accusations in Congress, Americans have blamed everyone but themselves for the huge disparities in access to healthcare and the rising costs of adequate medical treatment. The unhealthy American lifestyle is a leading factor in the high cost of medicine. If the United States has any chance for closing the gap in access to healthcare, it needs to begin holding its citizens accountable for their increasing unhealthy lifestyles, or risk drowning in crippling medical costs. This article reviews the public health and privacy ramifications of the current court decisions finding that holding individuals accountable for their lifestyle choices through wellness programs is constitutional.

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I. OBESITY IS AN EPIDEMIC WITH HIGH HEALTH AND ECONOMIC COSTS

Obesity is an epidemic, with two-thirds of the American population either obese or overweight.¹ Obesity is a known risk factor for over thirty medical conditions.² As a result, obesity leads to higher medical costs due to its direct correlation with diabetes, heart disease, hypertension, depression, high blood pressure, and certain types of cancer.³ At this rate, by 2030 over 366 million people will have diabetes⁴ and as a result, will triple the healthcare costs of their counterparts.⁵ Studies show that obesity-related diseases, all of which are to a large degree preventable, are the costliest conditions in terms of employee absenteeism, disability, and decreased productivity.⁶ Additionally, obese people have been found to spend 36% more on health services over their lifetime than normal weight individuals.⁷ These studies are evidence that obesity is not only physically unhealthy, but is crippling the financial health of our already troubled economy. Obesity costs the healthcare system \$70 billion annually or 7% of the total healthcare costs in the United States.⁸ The government finances roughly half the total annual medical costs attributable to obesity, with the average tax payer spending \$175 per year to cover obesity-related medical expenses of Medicare

¹Helen Johnson Alford & James W. Lampkin II, *The Supersizing of America: Obesity's Potential Implications for the Insurance Industry*, 56 FDCC Q. 465, 466 (2006).

² Anne Mayberry, *Health Issues: It's Not the Money*, 45 MGMT. Q. 16-17 (2004).

³ *Id.*

⁴ *Id.* at 17.

⁵ Lucinda Jesson, *Weighing the Wellness Programs: The Legal Implications of Imposing Personal Responsibility Obligations*, 15 VA. J. SOC. POL'Y & L. 217, 223 (2008).

⁶ *Id.* at 222.

⁷ Alford & Lampkin, *supra* note 1, at 477.

⁸ *Id.* at 479.

and Medicaid recipients.⁹ Employers are off-setting \$12 billion of those costs each year through group insurance plans for their employees,¹⁰ with an increasing number of employers creating wellness programs or turning to self-insurance to avoid the substantial premiums for high-risk employees.¹¹ Employers may leave their workers uninsured by deciding to stop providing insurance plans all together, as studies show that obese workers are less productive, miss more days of work, and have the highest disability filings, thus costing the company more money to employ than normal-weight workers.¹²

II. TARGETING UNHEALTHY LIFESTYLES THROUGH WELLNESS PROGRAMS.

A. Government-Sponsored Programs

With healthcare expenses expected to rise from 16% to 21% of the country's Gross Domestic Product (GDP) by 2015,¹³ both the public and private sectors are implementing wellness programs to lower their excessive costs.¹⁴ In a reaction to the debilitating costs of covering obesity-related illnesses, which make up 80% of the portion of GDP spent on healthcare,¹⁵ several state governments

⁹ Jay Bhattacharya & Neeraj Sood, *Rand Health Working Papers, Health Insurance and the Obesity Externality*, NAT'L BUREAU OF ECON. RESEARCH 6 (2006), http://www.rand.org/pubs/working_papers/2006/RAND_WR340.pdf.

¹⁰ Erin E. Patrick, *Lose Weight or Lose Out: The Legality of State Medicaid Programs that Make Overweight Beneficiaries' Receipt of Funds Contingent Upon Healthy Lifestyle Choices*, 58 EMORY L. J. 249, 251 (2008).

¹¹ Laura J. Schacht, *The Health Care Crisis: Improving Access for Employees Covered by Self-Insured Health Plans Under ERISA and the Americans with Disabilities Act*, 45 WASH. U. J. URB. & CONTEMP. L. 303, 303 (1994).

¹² Alford & Lampkin, *supra* note 1, at 477.

¹³ Jesson, *supra* note 5, at 221.

¹⁴ *Id.* at 224.

¹⁵ *Id.* at 222.

are introducing wellness programs that lower costs by targeting unhealthy behavior.¹⁶ South Carolina's program makes the patient responsible for any cost exceeding those allotted to the individual.¹⁷ West Virginia started the only penalty-based wellness program in the United States for Medicaid and Medicare beneficiaries.¹⁸ To qualify for coverage, Medicare participants must sign an agreement requiring them to adhere to health improvement programs as directed by their doctor.¹⁹ Failure to comply will not eliminate coverage, but reduce it to the basic benefit package, which has greatly restricted benefits as compared to the enhanced package received upon compliance.²⁰

B. Employer-Sponsored Programs

Employment is the only source of insurance coverage for 62.2% of the under-sixty-five population, as employers are the purchasers of most private insurance.²¹ Thus, employees who lose their jobs or are dropped from coverage have few other options, especially if they do not have the money to afford insurance on their own, and do not qualify for Medicare or Medicaid.²² Employers who provide their employees with insurance are struggling to contain costs resulting from covering obese employees subject to higher premiums.²³ As a result, many are following the government's lead and implementing wellness

¹⁶ *Id.* at 223.

¹⁷ *Id.* at 225-26.

¹⁸ Patrick, *supra* note 10, at 249.

¹⁹ *Id.*

²⁰ *Id.*

²¹ Ann Hendrix & Josh Buck, *Employer-Sponsored Wellness Programs: Should Your Employer Be the Boss of More Than Your Work?* 38 SW. L. REV. 465, 466 (2009).

²² *Id.* at 468.

²³ Alford & Lampkin, *supra* note 1, at 479.

programs.²⁴ In 2006, 28% of employers had some sort of wellness program in place.²⁵ A typical wellness program includes worksite fitness, subsidized gym memberships, healthy vending machines, and financial incentives for employees enrolled in diet programs.²⁶ These programs are designed to reduce costs by incentivizing healthy lifestyle choices by limiting the benefits of employees who do not conform to company-determined standards.²⁷

III. WELLNESS PROGRAMS ARE BOTH BENEFICIAL AND DETRIMENTAL

A. Economic Benefits

Wellness programs, regardless of their source, have both detrimental and beneficial effects. A study found that healthy weight decisions are made in the absence of government intervention when individuals faced the full costs of their decisions about eating and exercise, increasing social welfare.²⁸ Even moderate levels of cost sharing dramatically reduced the social harm of obesity because weight loss resulted in lower insurance premiums, and overall healthcare costs.²⁹ These savings are crucial at a time when the government is already struggling to cover medical expenses, and millions of Americans remain uninsured.³⁰ Furthermore, weight loss, in general, provides the economic benefit of improving productivity, increasing income, and decreasing the probability of missed work days due to

²⁴ Hendrix & Buck, *supra* note 21, at 467.

²⁵ *Id.*

²⁶ Patrick, *supra* note 10, at 251.

²⁷ Jesson, *supra* note 5, at 233.

²⁸ Bhattacharya & Sood, *supra* note 9, at 25-26.

²⁹ *Id.*

³⁰ Schacht, *supra* note 11, at 303.

illness.³¹ A study showed that normal-weight workers had higher overall salaries due to fewer missed work days and less money subtracted from paychecks to pay the higher insurance premium charges.³²

B. Detrimental Effects on Access to Healthcare

Despite the benefits, wellness programs can also result in disparities in access to healthcare.³³ Obese people make an average \$1.42 per hour less than their normal-weight counterparts, but only \$0.25 less per hour if they are insured outside of the company.³⁴ Additionally, these programs, which take away the cost-sharing mechanism, provide an incentive to profit from discrimination by hiring only thin workers.³⁵ Some companies have reduced their costs by eliminating their employee group insurance if several employees were obese, or severely restricted the amount paid for certain illnesses, such as high blood pressure and cholesterol, both highly correlated with obesity.³⁶

Unfortunately, as the cases below illustrate, obese employees will have little legal recourse if they are eliminated from an employer's insurance plan. According to *Alexander v. Choate*, a plan only fails to provide meaningful access if access to a public service is inadequate for a "disabled" individual.³⁷ Moreover, courts have consistently refused to recognize obesity as a disability under the

³¹Hendrix & Buck, *supra* note 21, at 477.

³²Jay Bhattacharya & M. Kate Bundorf, *The Incidence of the Healthcare Costs of Obesity*, 28 J. HEALTH ECON. 649, 650 (2009), available at <http://elsevier.com/locate/econbase>.

³³Alford & Lampkin, *supra* note 1, at 479.

³⁴Bhattacharya & Bundorf, *supra* note 32, at 653.

³⁵*Id.* at 649.

³⁶Schacht, *supra* note 11, at 303.

³⁷Patrick, *supra* note 10, at 263.

Americans with Disabilities Act.³⁸ Courts have also recognized the validity of employer insurance policies that refuse to cover any procedures or drugs used in the treatment of obesity or obesity-related diseases, like high blood pressure or degenerative joint disease³⁹ because obesity is not an illness as defined under these plans.⁴⁰ The Texas Court of Appeals in *Bobbitt v. Electronic Data Systems* held that because obesity was not an illness, in that it was not impairment of vital functions, the defendant had no duty to reimburse a gastric bypass surgery under their plan.⁴¹ The *Bobbitt* holding is significant because it permits insurance companies to deny policy holders reimbursement for obesity treatments, and in essence, prohibits an effective, and for some people, the only, way of starting a healthier lifestyle.⁴²

IV. WELLNESS PROGRAMS ARE CONSTITUTIONAL

A. The Obese is Not a Suspect Class, Nor is There a Fundamental Right to Healthcare

Wellness programs, however, have sparked a debate beyond their potential benefits or detriments. There is concern over whether they are constitutional in light of the inherent disparities in access to medically necessary care that result.⁴³ Because of the stigma of contempt attached to obesity, it has become one of the

³⁸Alford & Lampkin, *supra* note 1, at 490.

³⁹*Cain v. Fortis Ins. Co.*, 694 N.W.2d 709, 714-15 (S.D. 2005).

⁴⁰Alford & Lampkin, *supra* note 1, at 481.

⁴¹*Bobbitt v. Elec. Data Sys. Corp.*, 652 S.W.2d 620, 621, 622-23 (Tex. App. 1983).

⁴²Alford & Lampkin, *supra* note 1, at 482.

⁴³Patrick, *supra* note 10, at 276.

last socially acceptable forms of discrimination.⁴⁴ Obesity can result from any combination of factors, such as excessive eating, lack of exercise, genetic predisposition, socioeconomic status,⁴⁵ and cultural norms.⁴⁶ Because obesity has been found to be related to poverty and ethnicity,⁴⁷ it can be argued that a strict scrutiny standard should be applied to government wellness programs that charge obese individuals higher premiums for failing to meet pre-determined health standards.⁴⁸ Courts, however, refuse to recognize obese people as a suspect class or discrete and insular minority, specifically limiting it to race⁴⁹ and disability, respectfully.⁵⁰ Currently, there is no explicit or implicit constitutional right to healthcare, like voting rights or interstate travel, meaning that the resulting disparities in access are not unconstitutional.⁵¹ Historically, the Supreme Court has been very conservative in defining fundamental rights, limiting them to marriage, procreation, and childbearing.⁵² Other federal and state courts also agree that treatments for obesity are cosmetic and not medically necessary, even

⁴⁴Katherine Mayer, *An Unjust War: The Case Against the Government's War on Obesity*, 92 GEO. L. J. 999, 1013-14 (2004).

⁴⁵Jennifer S. Haas et al., *The Association of Race, Socioeconomic Status, and health Insurance Status with the prevalence of Overweight Among Children and Adolescents*, 93 AM. J. PUB. HEALTH, 2105, 2105, 2109 (2003).

⁴⁶Mayberry, *supra* note 2, at 19.

⁴⁷Haas, *supra* note 45, at 2109.

⁴⁸Hendrix & Buck, *supra* note 21, at 476.

⁴⁹Patrick, *supra* note 10, at 277.

⁵⁰Schacht, *supra* note 11, at 344.

⁵¹Patrick, *supra* note 10, at 262.

⁵²Hendrix & Buck, *supra* note 21, at 488.

with a doctor's prescription,⁵³ making it unlikely that access to treatments for obesity violates a Constitutionally-guaranteed right.

B. Wellness Programs do not conflict with the Equal Protection Clause

Wellness programs have been challenged as unconstitutional under the Fourteenth Amendment Equal Protection Clause, which prohibits the states from denying a person equal protection under state law.⁵⁴ A state wellness program is constitutional if it does not require that all similarly situated persons be treated differently.⁵⁵ If there is a disparate impact on a class of persons, the plaintiff has to show that the insurance law is not rationally related to a legitimate governmental interest.⁵⁶ The programs have no disparate impact as long as every participant is denied coverage for obesity-related treatments.⁵⁷ Moreover, state-sponsored wellness programs are likely to meet the "legitimate interest" standard because a healthy population is in the public interest, due to the astronomical costs of healthcare and the proven benefits of healthier, and thus more productive, work force.⁵⁸ There is a legitimate interest in reducing spending in order to increase the availability of funds available for others and an increase in the quality of care provided.⁵⁹ A recent study found that if insurance premiums are not risk rated for obesity, such that everyone pays different amounts based on weight, the

⁵³*Thrasher v. Corp. Sys. Inc.*, No. Civ.A.2:01-CV-295-C, 2002 WL 31572682, at *1-2 (N.D.Tex. Feb. 7, 2002).

⁵⁴Patrick, *supra* note 10, at 276-77.

⁵⁵*Id.*

⁵⁶*Id.* at 277.

⁵⁷*Cain v. Fortis Ins. Co.*, 694 N.W.2d 709, 714 (S.D. 2005).

⁵⁸Hendrix & Buck, *supra* note 21, at 471, 484-85.

⁵⁹*Id.* at 478.

initiative for all plan participants to lead a healthy lifestyle decreases, reducing the overall social welfare.⁶⁰

C. Wellness Programs Do Not Violate Privacy Rights

Although there is no constitutional right of access to healthcare, especially for a condition courts have yet to recognize as an illness, there is a long-standing tradition of privacy protection.⁶¹ The New York Supreme Court held in *Whalen v. Roe* that there was a right to privacy prohibiting disclosure of personal matters and to make important decisions.⁶² The Court, however, recognized limits to that right if there is a more pressing public concern, such that the disclosure is not unwarranted.⁶³ The Court further stated that a request for personal information, like requesting weight and blood pressure information from doctors of obese employees in wellness plans, is sufficiently warranted if it protects the health of many.⁶⁴

Moreover, for a court to recognize a right to privacy violation there must be an unreasonable and serious intrusion of information not already in the public domain.⁶⁵ In *Rodrigues v. Scotts*, the United States District Court of Massachusetts held that testing for off-duty conduct, like smoking, was not an unreasonable intrusion because the employee smoked around others and

⁶⁰Bhattacharya & Sood, *supra* note 9, at 3, 14.

⁶¹Hendrix & Buck, *supra* note 21, at 477.

⁶²Jesson, *supra* note 5, at 278-79.

⁶³*Id.* at 280.

⁶⁴*Id.*

⁶⁵*Rodrigues v. E.G. Sys. Inc.*, No. 07-10104-GAO, 2009 U.S. Dist. WL 2245653, at *2 (D.Mass. July 23, 2009).

purchased cigarettes in public.⁶⁶ Obesity may face a similar fate because people consume food in public, and those that join gyms exercise in the public eye. Further, obesity is a condition that is recognizable by the naked eye, further decreasing the chances of judicial protection.

Furthermore, employer-mandated wellness programs regulating off-duty conduct are likely to be upheld under the Constitution, provided the conduct could be shown to be job-related.⁶⁷ While food consumed or amount of exercise seem unrelated to job performance, according to studies, normal weight workers are less likely to claim disability, are more productive, and on average, take fewer sick days.⁶⁸ This operates on the logic that a healthier workforce would reduce healthcare costs, which in turn would benefit the financial health and stability of the company.⁶⁹

State courts have also recognized the lack of a reasonable expectation of privacy in the workplace.⁷⁰ In California, to win on an invasion of privacy claim against a private employer, the employee must show that he had a legally protected privacy interest, a reasonable expectation of privacy under the circumstance, and that the conduct was constituted a serious invasion of privacy.⁷¹ An employer, however, need only negate one of the three elements, or alternatively show the request for private information is justified under the

⁶⁶ *Id.*

⁶⁷ Hendrix & Buck, *supra* note 21, at 489.

⁶⁸ Jesson, *supra* note 5, at 224.

⁶⁹ Hendrix & Buck, *supra* note 21, at 489.

⁷⁰ *Id.* at 491.

⁷¹ *Id.* at 490.

relatively low threshold of the substantial furtherance of one or more countervailing interests.⁷² While most states only recognize privacy that reaches private conduct in government action and only for serious violations, California is one of the few states to have a constitutional provision regarding privacy that reaches private conduct, with most only recognizing the right in government action, and only for serious violations.⁷³ Additionally, even if then state law reaches private actions, states like New York and Colorado provide for exceptions of business necessity in their Constitutions,⁷⁴ or, like in Michigan, have no employment privacy provision for off-duty conduct at all.⁷⁵ Under Minnesota's state Constitution, an employer can restrict an employee's use of lawfully consumable products if it's reasonable related to employment activities or responsibilities.⁷⁶

V. CONCLUSION

The contract for West Virginia's wellness program requires the participant sign an agreement stating "I understand that is it my responsibility to do what is necessary to stay healthy."⁷⁷ Courts seem to be echoing this sentiment as they continue to hold wellness programs constitutional, refusing to define obesity as a disability, or extend constitutional protection of a right to privacy in the

⁷² *Id.*

⁷³ *Id.* at 489-90.

⁷⁴ *Id.* at 493-94.

⁷⁵ *Id.* at 492.

⁷⁶ *Id.* at 493.

⁷⁷ Patrick, *supra* note 10, at 283.

employment setting. Furthermore, the despondent state of the economy and an alarming incidence of obesity in the population provide both the government and employers with legitimate issues of public concern that outweigh the right to penalize for unhealthy off-duty conduct. It is likely that this trend will become the standard for litigation on obesity-related insurance coverage. Because almost half of the nation is covered by an employers' health insurance plan, if employers eliminate their plans to lower costs incurred from covering obese employees, or institute wellness programs that many obese and overweight employees cannot follow, many people will be left uninsured, resulting in disparities in health care coverage. With obesity at epidemic proportions, a new population of uninsured or underinsured is highly likely to develop. While a national devotion to safeguarding individual liberties exists, there is also something inherently democratic about programs that demand personal accountability. As a nation we demand personal accountability from our representatives and our business leaders. With obesity reaching epidemic proportions, it could be time to hold ourselves to the same standards.

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***Health Disparities at Historical Black Colleges
and Universities: HIV Epidemic Among
Young African Americans***

*Tamara L. Rogers-Gant**

I. INTRODUCTION

According to the Center for Disease Control and Prevention (CDC), acquired immunodeficiency syndrome (AIDS) is the leading cause of death among African Americans between the ages of twenty-five and forty-four.¹ Although African Americans comprise approximately 12% of the United States' population, African Americans comprise 45% of all new Human immunodeficiency virus (HIV) cases.² These statistics show that HIV and AIDS are affecting African Americans in alarmingly disproportionate numbers. Specialists argue that a lack of knowledge perpetuates the crisis.³ Since many infected African Americans are not aware of their infection, they continue

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¹ The Henry Kaiser Family Foundation, HIV/AIDS Policy Fact Sheet: Black Americans and HIV/AIDS, Sept. 2009, <http://www.kff.org/hivaids/upload/6089-07.pdf>.

² *Id.*

³ Martinique C.G. Free, *Utilizing Student Organizations at Historical Black Colleges and Universities in the Rural South to Facilitate HIV/AIDS Education*, at 1 (2006), http://etd.library.pitt.edu/ETD/available/etd-08022006-134212/unrestricted/FreeMa_etdpitt2005.pdf.

behavior that puts others at risk, which affects the rate at which the virus is spread.⁴ Additionally, HIV/AIDS among students at Historically Black Colleges and Universities (HBCUs) is a growing public health concern. The lack of basic HIV/AIDS knowledge, underestimating risky behaviors, and the lack of discussions relating to sexuality are some factors contributing to the spread of HIV/AIDS within the HBCU population.⁵

This article will discuss how African American college students in particular are at an increased risk for HIV.⁶ This HIV epidemic among African American college students is especially prevalent on the campuses of Historical Black Colleges and Universities (HBCUs).⁷ Moreover, this article will discuss how HBCUs must change the HIV discourse by encouraging dialog among students regarding HIV and AIDS and educate students about sexual risk taking.⁸ HIV/AIDS among students at HBCUs in the rural South is a growing public health concern. However, since HBCUs are poorly funded, grants from the U. S. Department of Health and Human Services may help to fund HIV prevention efforts at minority institutions of higher education.

Furthermore, this article will analyze how federal agencies have been working toward improving public health conditions within minority communities,

⁴ *Id.* at 48.

⁵ *Id.* at 1.

⁶ Su-I Hou, *HIV-related behavior among black students attending Historical Black College and Universities versus white students attending a traditionally white institution*, 21 AIDS CARE 1050, 1050 (2009).

⁷ *Id.* at 1051.

⁸ Bruce H. Wade, *The Disabling Nature of the HIV/AIDS Discourse Among HBCU Students: How Postcolonial Racial Identities and Gender Expectations Influence HIV Prevention Attitudes and Sexual Risk-taking*, 4 WAGADU 125, 138 (2007), available at <http://wagadu.org/Volume%204/Vol4pdfs/Chapter%209.pdf>.

and how government funding for prevention interventions are insufficient to meet the need of high risk groups.⁹ Moreover, this article will discuss how a “unified effort” needs to be integrated into an “already fragile health care system” to address this overwhelming health disparity in minority communities.¹⁰ It will also discuss how federal agencies are working toward eliminating this health disparity.¹¹ For instance, in the Fiscal Year (FY) of 2010, the U.S. Federal Government will invest more than \$19.4 billion in domestic HIV/AIDS treatment, prevention, and research.¹²

Finally, this article will discuss how proposed efforts should be developed to address this epidemic, such as developing and implementing HIV prevention programs that provide services for members of racial/ethnic minority communities at a high risk for HIV infection. Legislators should be encouraged to support these efforts by acknowledging that these disparities are placing a burden on African American communities, and that these proposed, intergovernmental approaches are necessary to combat the spread of HIV/AIDS.

⁹ See The Henry J. Kaiser Family Foundation, *Putting it Together: Small \$ for HIV Prevention*, http://www.kff.org/pullingittogether/080309_altman.cfm (last visited Sept. 21, 2009).

¹⁰ Deana McRae, *Overcoming the Epidemics: Racial Disparities in HIV and STDs*, <http://www.healthystates.csg.org/NR/rdonlyres/71BDA0D3-69DC-82C0-6E283A4CDA6A/0/OvercomingtheEpidemic.pdf>, (last visited Sept.21, 2009).

¹¹ *Id.*

¹² The Henry Kaiser Family Foundation, *HIV/AIDS Policy Fact Sheet: U.S. Federal Funding for HIV/AIDS: The President’s FY 2010 Budget Request, May 2009*, <http://www.kff.org/hivaids/upload/7029-05.pdf> [hereinafter “*U.S. Federal Funding for HIV/AIDS*”].

II. HIV/ AIDS AMONG AFRICAN AMERICANS

New cases of HIV infections, AIDS cases, and HIV-related deaths are the highest among African Americans than any other racial ethnic group in the U.S.¹³ With approximately 1.1 million people living with HIV/AIDS in the U.S., African Americans account for more than 500,000 of the HIV/AIDS cases.¹⁴ African Americans have an incidence rate that is seven times higher than the incidence rate among whites.¹⁵ Furthermore, African Americans have the highest rates of HIV cases and HIV- related deaths.¹⁶ While new cases of HIV infections, AIDS cases, and HIV-related deaths are the highest among young African American adults, and a significant amount of young African America adults attend HBCUs. Therefore, it is imperative “to study their patterns of risk and protective behaviors to develop effective HIV prevention strategies to be set in place at these HBCUs.”¹⁷

III. HIV/AIDS AMONG HISTORICAL BLACK COLLEGES AND UNIVERSITIES

HIV/AIDS among students at HBCUs is a growing public health concern.¹⁸ Patterns of HIV-related behaviors are different among African American students attending HBCUs compared to white students who attend

¹³ Henry Kaiser Family Foundation, *supra* note 1.

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ Hou, *supra* note 6, at 1051.

¹⁸ *Id.* at 1050.

predominately white institutions.¹⁹ HBCU students are recognized as practicing risky behaviors, such as vaginal intercourse.²⁰ As a result, an increased risk for HIV infection is particularly high among African American college students.²¹

Due to “distrust of research establishment, fear of stigma and of contracting disease from taking the vaccine,” African American students at HBCUs are unwilling to participate in preventive vaccine clinical trials.²² Moreover, many African American students distance themselves from HIV/AIDS programs and prevention methods because they view people infected with HIV as stigmatized.²³ Although much of society has the misconception that HIV affects only those who are “flawed” or “impaired”, many African American students are poised to become future leaders in communities. Thus, the increasing prevalence HIV/AIDS at HBCUs will have significant health, financial, and social ramifications for African American communities.

IV. EFFORTS TO FIGHT HIV/AIDS ON HBCU CAMPUSES

In order to address the disproportionate rate of HIV/AIDS affecting African American students at HBCUs, partnerships with universities, community-based organizations (CBOs), AIDS service providers, and secondary schools need

¹⁹ *Id.* at 1053.

²⁰ *Id.* at 1053.

²¹ *Id.* at 1050.

²² Rodney J. Carter, *Willingness to Participate: HIV/AIDS Preventive vaccine knowledge, beliefs and attitudes among students attending Historically Black Colleges and Universities HBCUs*, http://apha.confex.com/apha/132am/techprogram/paper_92269.htm (last visited Sept. 21, 2009).

²³ *Id.*

to be implemented.²⁴ By developing campus-based programming, collaboration with community-based resources, faculty research and student involvement, HBCUs can make important contributions to the deadly epidemic of HIV/AIDS affecting students.²⁵

Since 1996, the HIV/AIDS Orientation and Professional Education (HOPE) program, funded by the CDC, has developed prevention programming at HBCUs to reduce the rate of HIV infections among African American students.²⁶ Between 1996 and 2000, the HOPE program has awarded nine HBCUs with one-year grants “to enhance curricular and co-curricular programs with HIV/AIDS information.”²⁷

In addition to the HOPE program, African American students have created the *Ledge Magazine*, which is a HIV/AIDS awareness magazine that was implemented as “a tool to mobilize black college students in the fight against the epidemic.”²⁸ *Ledge Magazine* was envisioned and published by Howard University alumnus Christopher D. Catcher, and the articles discuss a range of different issues such as issues such as what scares students the most about unprotected sex and dating on campus.²⁹

²⁴ National Library of Medicine: National HIV Prevention Conference, *Images of Hope: HIV Prevention Strategies Implemented at Nine HBCUs*, July 30, 2003, <http://gateway.nlm.nih.gov/MeetingAbstracts/ma?f=102261813.html>.

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Ledge Magazine*, *Ledge Magazine Confronts AIDS on HBCU Campuses*, Nov. 19, 2004, <http://www.msuspokesman.com/home/index.cfm?event=displayArticlePrinterFriendly&uS...>

²⁹ *Id.*

V. THE ROLE OF HBCUS IN THE EPIDEMIC

In order to develop appropriate HIV/AIDS strategies, a better understanding of the behavior patterns and beliefs of African American students is needed.³⁰ HBCUs need to develop a strategy “to combat the idea of HIV/AIDS as a disabling and stigmatized condition and to better educate students about how gender role attitudes influence sexual risk taking.”³¹ It is also important for HBCUs to develop programs that are campus specific.³² These HBCUs must encourage students to take part in the planning, implementation, and assessment of such projects.³³

Furthermore, HBCUs should encourage dialogs and discussions among their students regarding the HIV/AIDS epidemic and give them an opportunity to have their voices heard concerning this issue.³⁴ It is important to study the pattern of risk and protective measures used by the students at these HBCUs in order to develop effective HIV prevention strategies.³⁵ For instance, it may be helpful to use student organization leaders at these campuses to lead HIV/AIDS intervention discussions to address the issues of sexuality and the stigma of HIV/AIDS to better educate the student body on this topic.³⁶

³⁰ Hou, *supra* note 6, at 1056.

³¹ Wade, *supra* note 8, at 138.

³² *Id.*

³³ *Id.*

³⁴ *Id.* at 139.

³⁵ Hou, *supra* note 6, at 1051.

³⁶ Free, *supra* note 3, at 2.

In addition, it is imperative for HBCUs to abandon the belief that risk reduction programs promote sexual activity.³⁷ It is important for the students to learn that the most effective ways to protect themselves include knowing their HIV status and consistently using safe sex practices when engaging in any sexual activity.³⁸ It is also important for students to learn not to pre-judge or misjudge an entire group as being at-risk for HIV/AIDs.³⁹

VI. ECONOMICS AFFECTING THE DISPARITY

At this time, HBCUs are experiencing great financial difficulties for several reasons.⁴⁰ First, Obama's educational budget did not include the \$85 million that HBCUs have received annually for the past two years.⁴¹ The two-year old program provided direct funds to federally recognized HBCUs, and the expiration of these funds result in a \$73 million cut.⁴² Secondly, the stock market fluctuations and "decreasing donor dollars," is affecting everything "from student admission and financial aid to basis operating cost and the school's overall assets."⁴³

These factors have had a major affect on HBCU budgets, which ultimately may lead to health disparities at these black institutions. For instance, health care

³⁷ Wade, *supra* note 8, at 138.

³⁸ *Id.*

³⁹ *Id.*

⁴⁰ Black America News, *Obama's Education Budget Cuts \$85 Mil from HBCUs*, May 11, 2009, http://blackamericaweb.com?q=print/news/the_state_of_black_america_news/9229

⁴¹ *Id.*

⁴² *Id.*

⁴³ TaRessa Stovall, *The Defenders Online: Economic Crisis Hits Historically Black Colleges Hard*, Dec. 10, 2008, <http://www.thedefendersonline.com/2008/12/10/economic-crisis-hits-historically-black-col...>

concerns, in particular the epidemic of HIV/AIDS, is not going to be a greater priority over providing financial aid and operation costs at the schools. Therefore, the health disparities at these African American institutions may be overlooked, which may ultimately lead to even more serious problems for these schools.

Further, the HIV/AIDS epidemic has placed a great economic burden on the US Government.⁴⁴ The U.S. Government budgeted \$12.6 billion for people living with HIV/AIDS in the 2006 FY.⁴⁵ However, almost 18 million new cases occur each year, resulting in an annual cost of \$11.4 billion a year.⁴⁶ At this alarming rate, the U.S. Government may not be able to financially support these efforts in the future, which will ultimately lead to a greater health disparity. In particular, it may seem almost impossible for the U.S. Government to designate specific funds to HBCUs, unless approved by the legislature.

VII. THE U.S. GOVERNMENT IS CURRENTLY ADDRESSING THESE DISPARITIES

As health disparities persist, federal agencies have been working toward improving public health conditions within minority communities. For example, the CDC remains committed to reducing the devastating impact of HIV/AIDS through working to ensure effective resources by creating prevention programs, research and evaluation efforts, surveillance activities, and policy development.⁴⁷

⁴⁴ McRae, *supra* note 10, at 2.

⁴⁵ *Id.*

⁴⁶ *Id.*

⁴⁷ Department of Health and Human Services, Centers for Disease Control and Prevention, *CDC's Procurement and Grant Offering*, July 29, 2009, <http://www.cdc.gov/about/business/funding.htm>.

Nearly 85% of the CDC's budget is awarded through grants and contracts to help promote healthy living and prevent disease, injury, and disability.⁴⁸ These grants also assist other health-related and research organizations that encourage healthy living and prevention methods.⁴⁹ The CDC awards approximately \$7 billion each year, in over 14,000 separate grant and contract actions, including simplified acquisitions.⁵⁰

Moreover, Barack Obama plans to team up with community leaders from churches and other community organizations in order to promote HIV testing in minority communities.⁵¹ In addition, Obama is a co-sponsor of the Early Treatment of HIV Act, which provides Medicaid coverage to low-income, HIV-Positive Americans.⁵² He also supports the JUSTICE Act, which was designed to prevent transmission of HIV within the American prison institutions.⁵³ Furthermore, Obama has pledged that during his first year of presidency, he will implement a national HIV/AIDS strategy, to reduce HIV infections and increase access of care for those who are suffering from HIV-related health disparities.⁵⁴

VIII. HOW CAN LEGISLATORS ADDRESS THE EPIDEMIC?

Although efforts are being made to address the overall epidemic of HIV/AIDS in America, legislators should acknowledge that HIV rates amongst

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ Barack Obama.com, *Barack Obama: Fighting HIV/AIDS Worldwide*, <http://barackobama.com/pdf/issues/FactSheetAIDS.pdf> (last visited Sept. 21, 2009).

⁵² *Id.*

⁵³ *Id.*

⁵⁴ *Id.*

young African Americans adults, including the significant amount of students that attend HBCUs, have remained disproportionately high and demand increased efforts from federal, state, local agencies.⁵⁵ State officials should acknowledge these disparities in order to react and empower these communities to address the epidemic. “An “intergovernmental approach” is necessary to combat the spread of HIV/AIDS in the African American community.”⁵⁶ To reduce the spread of HIV, state policymakers can take the following steps: 1) implement a call to action, in which state officials are urged to put minority health as a priority on their agenda, and 2) create a task force to work in a partnership with federal agencies to improve health services and prevention programs within their states.⁵⁷

IX. PROPOSED EFFORTS TO ADDRESS THE HBCU EPIDEMIC

Since HBCUs are poorly funded, possible grants from the government may help fund HIV prevention efforts to address this issue at HBCUs. For example, the CDC has published a Funding Opportunity Announcement (FOA) for HIV Prevention Projects for CBOs.⁵⁸ As a result, in the 2010 FY approximately \$43 million will be available to fund 145 awards to CBOs. The awards will be given to help CBOs develop and implement HIV Prevention

⁵⁵ McRae, *supra* note 10, at 1.

⁵⁶ *Id.*

⁵⁷ *Id.*

⁵⁸ Department of Health and Human Services, Centers for Disease Control and Prevention, *Funding Opportunity Announcement (FOA) PS10-1003: HIV Prevention Projects for Community-Based Organizations (CBOs)*, <http://www.cdc.gov/hiv/topics/funding/PS10-1003/> (last visited Sept. 21, 2009).

Programs and HIV prevention services for members of racial/ethnic minority communities, which are at a high risk for HIV infection.⁵⁹

Efforts such as the FOA will directly address the health disparities of the HIV/AIDS epidemic at HBCUs. By awarding such grants, HBCUs will be able to combat the misconceptions of HIV/AIDS by disabling the stigmatized condition and better educating students about possible sexual risks.⁶⁰ By implementing programs and activities with funding from government initiatives, such as the FOA, HBCUs will be able to change the HIV/AIDS discourse by encouraging dialogs among students. Since the lack of basic HIV/AIDS knowledge, risky behaviors, and lack of discussions relating to sexuality are some factors that contribute to the spread of HIV/AIDS,⁶¹ the funded programs by the FOA will be able to help HBCUs to abandon the outmoded belief that risk reduction programs promote sexual activity by educating students.⁶² Additionally, HBCUs will be able to teach sexually active students ways to effectively protect themselves by knowing their HIV status.⁶³

X. CONCLUSION

The epidemic of HIV in the U.S. is neither inevitable nor acceptable. It is possible to end this epidemic, but such an achievement will require that we dramatically expand access to HIV prevention programs, which most HBCUs

⁵⁹ *Id.*

⁶⁰ Wade, *supra* note 8, at 138.

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

have not been able to financially implement at their institutions. These possible grants will be able to assist these African American institutions with providing resources, and by helping them to integrate new HIV prevention approaches on their campuses. However, while financial support from the government is important, it is equally important for administrators, faculty, and students at HBCUs to recognize the seriousness of the HIV/AIDS epidemic in order to help cure this unrecognized health disparity. If this health disparity at HBCUs continues to be overlooked, this may ultimately lead to even more serious problems, which financial efforts from our government may not be able to solve.