Providing Care for the Uninsured Without the Federal Case

Estimated at close to 50 million strong, the fate of America’s uninsured has caused quite a stir of late. As the media anxiously reports on the U.S. Supreme Court’s acquiescence to assess the constitutionality of certain tenets at the heart of healthcare reform, the nation sits anxiously on the sidelines, awaiting the outcome. Indeed, a suggested, unprecedented televised hearing on the insurance mandate could potentially attract even more viewers than the record-breaking 111 million football fans who watched the Green Bay Packers beat the Pittsburgh Steelers in Superbowl XLV on Feb. 6, 2011.

The uninsured conundrum

At the core of the debate lies an enormous price tag. The sheer volume in dollars it takes to provide medical treatment to the uninsured is astounding, and its ramifications affect many fundamental aspects of our healthcare structure. In 2008, uncompensated medical care in the United States approached an estimated $57 billion, of which nearly $43 billion was paid by federal, state and local governments from funds earmarked for this very purpose. Although the federal government typically foots close to half of this annual bill, its contribution equals only 2 percent of federal healthcare spending yearly. The great bulk of responsibility for America’s uninsured falls to our nation’s hospitals, who shoulder approximately 60 percent of uncompensated medical care, due largely to a regulatory structure mandating that emergency departments at hospitals participating in Medicare or Medicaid must treat just about anyone who arrives in need of medical care, regardless of citizenship, legal status or ability to pay.

To add to the friction, most Americans have a stronger grasp on the rules of professional cricket than they do the leading constitutional challenge to President Obama’s 2010 Patient Protection and Affordable Care Act. While the general public’s confusion is in many ways understandable when it comes to the current healthcare debacle, with its myriad regulations and precedent setting legal ramifications, perhaps there exists a viable solution that does not rest primarily upon the doctrine of justiciability. The answer may be as simple as the fact that the federal government is attempting to penalize the wrong parties in our current healthcare equation. Instead of forcing the uninsured to obtain coverage, those in power might consider requiring all 5,800 hospitals across the nation to do one simple thing: Provide basic emergency medical care for the nation’s uninsured, free of charge.

Spend money to make money

In fairness to the hospitals, of course, the federal government should also make one small concession. The federal government spends an enormous amount of money each year as it oversees the nation’s healthcare system, a trend that shows no signs of slowing even as America’s financial crisis widens. Since its inception, healthcare reform has added approximately thirty-two provisions and an estimated $350 million in expenses relating to healthcare fraud and abuse. While eliminating such further taxation on the system is a laudable goal in the long run, the question must be asked as to whether this is the best time for our government to be waging such a war with the already fragile healthcare industry.

Currently, the federal government has several tools at its disposal with which it can police healthcare providers. Two particularly powerful entities include the Medicare self-referral prohibitions (more commonly known as the Stark laws) and the federal anti-kickback statutes (not to mention additional state regulations, such as the Physician Ownership and Referral Act in California). These overlapping and sometimes contrary healthcare tenets are all built upon a foundation of finite statutory prohibitions that allow an abundance of exceptions to the general rules. Such exceptions are often referred to as safe harbors, as they define certain areas where the federal government generally will not intervene. Given the enormous net these regulatory provisions provide, inadvertent technical violations are in many instances

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unceremoniously met with swift and draconian punishment. This is true even if the transgression itself inflicts no particular burden on the system and the violation a *bona fide* mistake.

In addition to monitoring fraud, our healthcare system keeps a watchful eye on ways to eliminate waste. One recent example involving Medicare Recovery Audit Contractors collected over $1 billion in its first demonstration project, and as a result the Medicaid Integrity Contractors have since extended these efforts to recover and prevent additional inappropriate federal healthcare payments. However, as successful as these programs may have been in recovering money from providers, the Office of the Inspector General has recently criticized CMS for what the OIG considers substandard oversight in relation to these integrity contractors, citing an abundance of inaccurate workload data and an overall lack of uniformity. Absent an appropriate way to monitor those who police the providers, it is difficult to objectively assess the success of RACs and MICs.

Although it seems that public opinion favors strict regulatory oversight when it comes to our nation’s health care system, the fact remains that the technical machinations existing within the regulatory infrastructure may have reached a point where the system is in desperate need of an overhaul that could rival the epic changes brought about by the Affordable Care Act in 2010.

**Back to the hospitals and free care**

Even as the federal government ramps up its efforts to increase healthcare’s sustainability, or perhaps as a result of these efforts, our nation’s current healthcare system lacks both balance and focus. While hospital emergency departments continue to be inundated with uninsured patients, those same patients now find themselves wondering if they will soon be required to obtain health insurance, leaving both patient and provider to struggle under the weight of uncertainty. Rather than spend valuable time and energy on creating a perfect storm for our tenuous system, perhaps it is time for a compromise.

Without detracting from the herculean efforts of the OIG and other federal and state officials in their collective attempt to save healthcare, Congress should consider loosening the often-rigid standards that can on occasion form a noose around the necks of participants on both sides of the argument. This would afford healthcare providers an opportunity to conduct operations like a business, but one that maintains at its very core a commitment to never compromise on patient care. Once relieved of such an immense burden, hospitals that elect to operate in this relaxed environment and are identified to the public as such should soon have the resources necessary to provide basic emergency medical care to those who cannot afford insurance, or in the alternative, pay into such a system proportionately. If properly structured, such an agreement would effectively ease the strain on patient, provider, and “police,” while at the same time it may provide for an opportunity to direct the collective energies of all three sectors in building a new system based on unity rather than discord. No matter how the Supreme Court ultimately rules on this high profile issue, until all those involved can agree to work toward a collective solution, the basic principles at the heart of the health care reform may be doomed to undermine one another, and ultimately cause the downfall of reform itself.