

A Dose of Reality: Assessing the Federal Trade Commission/Department of Justice Report in an Uninsured, Underserved, and Vulnerable Population Context

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Abstract Despite the size of their report, the Federal Trade Commission and Department of Justice pay virtually no attention to tens of millions of uninsured and underinsured persons. By focusing on an increasingly rarified group of health care customers—healthy, affluent, and highly insured—the report takes on an untethered quality, with only the slightest tip of the hat to its own limitations. Furthermore, the report overstates the extent of legal constraints on the market, in particular, the degree to which the market is free to select its customers and tailor its goods and services to the best risks. By miscasting the legal context of the American health care system, the report ultimately undermines much of its potential value.

A Report Untethered from Reality

Size can be deceiving. Although the Federal Trade Commission/Department of Justice report, *Improving Health Care: A Dose of Competition* (FTC/DOJ 2004), on the role of competition in health care industry covers an enormous amount of ground, its basic flaw is the failure to recognize the limitations of its own construct. As a result, the report takes on a brittle and artificial quality; instead of focusing on the possible, the document conveys a sense of untetheredness from today's health care reality for a considerable portion of the U.S. population. The report pays scant attention to tens of millions of people: the nearly 46 million persons who are completely without coverage (DeNavas-Walt, Proctor, and Lee 2005); members of working-age families, who have a one-

in-three chance of being without coverage over a two-year period (Families USA 2004); the 52 million Medicaid beneficiaries (Kaiser Family Foundation 2005a); millions of individuals isolated from the social mainstream by residence in impoverished rural and urban communities and barriers related to language, poverty, lack of citizenship, and cultural apartness (Rosenbaum, Shin, and Darnell 2004); and persons living in anything less than the most affluent of circumstances, whose serious, chronic, and costly physical and mental health conditions make them unattractive customers in a highly competitive market.

Improving Health Care gears its analysis to a world inhabited by educated, healthy, and financially comfortable health care consumers whose personal circumstances not only make them desirable customers but also equip them to navigate increasingly complex health insurance products and health care choices. (Even this rarefied group is now beginning to raise serious alarms about the dark side of consumer-driven health plans, as underscored in a 2005 *Washington Post* article profiling the travails of a prominent health policy figure in Washington, DC [Gearon 2005]). Indeed, *Improving Health Care* essentially assumes a world in which all health care consumers—like consumers of other goods and services sold in the market—are created equal, and for whom sellers of health care services will compete with equal gusto, if only they can be whipped into competitive shape.

By focusing on solutions tailored to the characteristics of a rarefied population, *Improving Health Care* dons blinders that in turn make the study a strange and bewildering read, bordering on the outright disturbing. Its slight tip of the hat to its own limitations is contained in the following brief passage and admonition: “Competition also may worsen the problems of the uninsured . . . by decreasing the ability of providers to cross-subsidize some products and services. Competition will not transfer resources to those who do not have them. Proposals to address these matters should be carefully evaluated to ensure that the consequences of any reform are pro-competitive” (FTC/DOJ 2004: chap. 5, 28). This bare acknowledgment of the downside of its recommendations appears in passing in chapter 6 of the study, rather than as a prominent caveat to its own recommendations.

In short, the central dilemma with *Improving Health Care* (as well as the set of theoretical constructs on which it rests) is not that it does a weak job of placing its recommendations in context but, rather, that the agencies ignore context entirely. In their analysis, major segments of the American population—whose life circumstances simply are out of sync with the

conceptual framework in vogue in Washington, DC, circa 2006—simply cease to exist. This seeming breakdown in the relationship between people and the formulation of a public policy framework by government is not confined to this particular study, of course. In recent years, the nation's capital has witnessed the growth of a chasm of epic proportions between what people need and what policy makers espouse. Congressional leaders respond to federal deficits by proposing to slash expenditures for child care, health care, food aid, foster care, child support, and other services for the poor while preserving over \$70 billion in planned tax breaks (Parrott and Shapiro 2005). Official efforts to publish evidence-based reports on subjects such as health disparities and health care inequity are suppressed in favor of whitewashes so embarrassing that, when the censored draft (inevitably) is leaked, the agency director must be permitted to post the draft report, along with a letter that attempts to explain the incident (Clancy 2004). Scientists and physicians opposed to the relaxation of governmental controls over childhood lead poisoning are removed from official government advisory committees. In public hearings, the Medicaid program, which insures more than 50 million persons at a per-capita cost significantly lower than the commercial coverage (Kaiser Family Foundation 2005a), is dismissed as a hotbed of financial abuse and state scams (Barton 2004, 2005). A legislative proposal to permit states to disinsure Medicaid beneficiaries is titled "Health Opportunity Accounts."¹

In the case of *Improving Health Care*, federal agencies charged with enforcing laws related to market competition have simply decided to sidestep consideration of the obvious issues that arise when one attempts to apply market theory to a health system lacking the means for allocating health care resources on the basis of need rather than wealth and power. The report might have addressed this potential deficiency by couching its recommendations in a larger context of coverage reforms and interventions aimed at lessening nonmarket barriers, but this would have been an admission of analytic limitation that neither agency could be permitted to make. As a result, the analysis is fundamentally undermined in two ways: first, by its failure to address the more complex dynamics of health care access that act as structural barriers to a more competitive environment; and, second, by its failure to articulate for policy makers and powerful health interests the essential precondition on which competition depends, namely, inclusion of the entire population in a health care-

1. S. 1833, 109th Cong., 1st Sess. Medicaid Health Opportunity Account Act of 2005.

financing scheme, coupled with certain regulatory interventions designed to compensate for market failure. The agencies had an ideal opportunity to convey these two basic points but did not do so, and as a result they considerably diminish the value of their report.

Drilling Down on What the Report Failed to Consider

Two aspects of the report's omissions merit closer attention because of their impact on the overall goal of competition in health care access. The first is the legal framework for health care access. The second is those dimensions of the access problem that extend beyond the purely economic and necessitate consideration of sociodemographic and personal characteristics associated with reduced health care access.

The Legal Context for Health Care Access

There is no legal right to health care in the United States (Rosenblatt, Law, and Rosenbaum 1997). U.S. expenditures and opinion polls underscore the stock that Americans place in health care. Indeed, the Kaiser Family Foundation (2004) reports that in national public opinion polls conducted since 1992, health care has never ranked lower than fourth as a priority issue for voters.

Many nations identify health care as a constitutional matter. In their survey of world constitutions, Eleanor Kinney and Brian Alexander Clark (2004) found that more than two-thirds of all constitutions contain provisions addressing health or health care and, furthermore, that, in almost all constitutions, health care is expressed in universal terms rather than being limited to certain populations. Faced with the need to balance societal needs against market conduct, other nations with first-world industrial economies and democratic governmental arrangements have opted for a national public policy response in which society's available financial resources are allocated across the population by various allocation approaches, either alone or in combination with one another (Jost 2003). We commonly think of these nations as having national health insurance systems, although their programs embody a wide range of strategies related to the organization and financing of health care. Whatever the strategy, the point is that, ultimately, government is accountable for system design, execution, and performance.

What is particularly important about the lack of a legal right to health

care in the context of health care access is that, correspondingly, health care providers have no legal duty to furnish care. The protests of marketeers to the contrary, the U.S. health care industry remains remarkably free, under common-law and statutory principles, to choose its customers and tailor products to attractive market segments. This fundamental freedom is curbed in only the most modest respects. For example, the Emergency Treatment and Women in Labor Act (EMTALA),² an outgrowth of earlier laws such as the Hospital Survey and Construction Act of 1946 (Hill Burton),³ requires the provision of certain emergency-related services on the part of Medicare-participating hospitals. After years of litigation and protest over this relatively narrowly drawn but privately enforceable legal obligation, the U.S. Department of Health and Human Services in 2003 promulgated regulations that further narrow the EMTALA obligation with respect to screening and stabilization services as well as the duty of hospitals to maintain on-call specialists (Rosenblatt, Rosenbaum, and Frankford 2004).

Beyond EMTALA, federal laws impose virtually no duty of care on health care providers. Furthermore, there is very little in the way of legal prohibition against discrimination among patients. For example, other than Hill Burton's community service requirement, no federal law prohibits discrimination on the basis of health insurance status.⁴ As a result, the health care industry remains unfettered in its freedom to select lucrative payers and reject those, such as Medicaid beneficiaries, whose sponsorship is unprofitable.

Even where discrimination on the basis of race is concerned, U.S. law is remarkably free of constraints. Thus, industry practices that may have a discriminatory impact—such as practice location, participation in public insurance, affiliation with community-based providers, or acceptance of referral patients—go unchallenged, and the federal government collects virtually no data regarding the racial and ethnic disparities that may result from such market freedoms (Rosenbaum and Teitelbaum 2003). It is these unintentional but systemic practices, which carry implications for racial and ethnic minority populations, that tend to raise concern among experts in health disparities (Institute of Medicine [IOM] 2002).

Title VI of the 1964 Civil Rights Act prohibits both intentional and de facto discrimination by federally assisted entities on the basis of race or

2. 42 U.S.C. 1395dd.

3. 42 U.S.C. §291 et. seq.

4. 42 C.F.R. 124.603(e).

national origin (which also includes language).⁵ From Medicare's inception, however, an unwritten agreement between the Johnson administration and the Senate insulated participating physicians from the application of Title VI, on the theory that the program's original indemnity model placed it outside the meaning of federal assistance in the case of physician services (Smith 1999). Despite the transformation of Medicare's physician payment structure away from indemnification and toward direct payment, this exemption remains in full force today, honored by the Department of Health and Human Services (HHS) Office for Civil Rights (2003) almost entirely without comment. Furthermore, regulations implementing Title VI have not been modernized since their original promulgation forty years ago and thereby fail to address their applicability to modern delivery systems participating in multiple-sponsor arrangements (Rosenbaum and Teitelbaum 2003). Even the very limited accountability for the racial implications of seemingly neutral practices has eroded further in recent years, as a result of a decision by the United States Supreme Court declaring the law's de facto discrimination prohibition to be essentially no longer privately enforceable.⁶ Finally, even when such practices were subject to challenge, "business necessity" was an affirmative defense that could defeat even a meritorious claim (Rosenbaum and Teitelbaum 2003).

Persons with disabilities do not fare much better in the health care marketplace, at least where the law is concerned. One of the more remarkable laws in the context of civil rights and health care access is the Americans with Disabilities Act of 1990 (ADA). In a dramatic departure from precedent, and with virtually no legislative history, the ADA classifies health care as a public accommodation for purposes of its prohibition against discrimination against qualified persons with disabilities, thereby bringing wholly private health care systems within the scope of its standards (Teitelbaum and Rosenbaum 2003). The potentially far-reaching implications of this statutory classification of health care as a public accommodation became evident in a 1998 decision by the United States Supreme Court, regarding a dentist's arbitrary refusal to treat a patient with HIV.⁷

But even the ADA operates under severe constraints in the context of health care finance. Where employee health benefits are concerned, a systematic narrowing of the definition of "qualified person with a disability" by the United States Supreme Court means that the ADA can no longer

5. *Lau v. Nichols* 414 U.S. 563 (1974).

6. *Alexander v. Sandoval* 532 U.S. 275 (2001).

7. *Bragdon v. Abbott* 524 U.S. 624.

be invoked as protection against employee health benefit plans that discriminate against various types of health conditions (National Council on Disability 2004). Furthermore, even outside the employee health benefit context, the courts have eviscerated the meaning of the ADA when applied to health insurance. Leading judicial opinions have interpreted the ADA as wholly irrelevant with respect to coverage content, leaving companies free to engage in benefit design practices that have the effect of rendering policies almost meaningless for persons with disabilities. Even where an insurer stipulates in court documents that it lacks any actuarial basis for its coverage restrictions, blatantly intentional coverage design is deemed beyond the purview of the law. Thus, for example, in *Doe v. Mutual of Omaha*,⁸ a federal appeals court found absolutely no legal violation under the ADA as a result of a \$25,000 HIV/AIDS cap imposed on plan enrollees by an insurer, despite the insurer's admission that it "has not shown and cannot show that its AIDS Caps are or ever have been consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification, or state law."⁹

The king of all market deregulation laws may be the Employee Retirement Income Security Act (ERISA).¹⁰ ERISA preemption doctrine is legendary, sweeping away even modest state law constraints on insurance design in the self-insured employer-sponsored market. The fact that self-insured ERISA health benefit plans operate free of design constraints other than the limited standards found in ERISA itself (such as portability and continuation coverage) inevitably has a chilling effect on states' ability or willingness to regulate the insured group market (Jacobson 1999; Rosenblatt, Rosenbaum, and Frankford 2001, 2004). The discretion of employer plans is so absolute that they can maintain coverage benefit standards that leave employees only with inappropriate treatment options; indeed, when administrators write inappropriate treatment guidelines directly into the plan documents, the limits are considered nonappealable constraints on benefit design itself. Thus, in *Jones v. Kodak Medical Assistance Plan*,¹¹ the court of appeals held that, by incorporating unpublished alcoholism treatment coverage criteria directly into its plan documents, Kodak completely insulated itself from a medical necessity appeal and, furthermore, that the company committed no violation of ERISA in not making its limitations public to plan participants and beneficiaries. The court's opinion

8. 179 F. 3d. 557 (1999), *reh. den. en banc* (1999), *cert. den.* 528 U.S. 1106 (2000).

9. *Doe v. Mutual of Omaha* 179 F.3d 561.

10. 29 U.S.C. § 1001 et. seq.

11. 169 F.3d 1287 (1999).

regarding the merits of the patient's appeal was perhaps best captured in this passing comment about the Kodak plan: "Plan is entirely self-funded, which means that Eastman Kodak employees do not contribute toward the premiums. Rather, payment for covered medical care comes out of company revenues."¹² The fact that employees give up compensation in exchange for coverage went totally unnoticed by the court in its reflection on corporate largesse and discretion.

This brief review of the legal framework governing health care in the United States suggests that, far from burdening the market, U.S. law can be characterized in precisely the opposite way, as extraordinarily generous to a trillion-dollar-plus industry, which is left free to pick its markets and its customers to design its products, virtually unconstrained by obligations related to equitable access. The types of constraints on market conduct that the nation has come to expect in the context of housing, for example—an equally private enterprise—simply are not in evidence where health care is concerned. There is no health care equivalent to federal fair-housing legislation. Financial conduct that redlines the sick and disabled is dismissed as nonchallengeable decisions regarding benefit design; and benefit design standards at both the federal and state levels are minimal to nonexistent. When state insurance coverage laws are held up to close scrutiny, even laws related to basic services such as childhood immunizations are shown to be riddled with limitations and caveats. A recent study of childhood immunization insurance mandates found that in no state are insurers obligated to cover all Centers for Disease Control and Prevention–recommended vaccines for children (Rosenbaum et al. 2003).

What this legal framework means in the context of the FTC/DOJ report is fairly self-evident. If this level of market freedom is the hallmark of a regulated health system, what would be the implications of further deregulation? How much more market power can the population stand, particularly persons whose poverty, health needs, or dependence on public insurance makes them unattractive customers? What more do the agencies want? Indeed, the current legal environment already tolerates a ready arsenal of tactics to limit access; these tactics range from discriminatory design of coverage offerings to selective marketing, selective location of practices and services, refusal to participate in public insurance or other programs subsidizing health care for the uninsured, and selective contracting with health care providers to limit participation by those serving complex and difficult cases that might attract the wrong customers. No

12. 169 F.3d 1289.

federal laws bar such conduct. How much more unconstrained can we get? And, if the limited constraints that do exist were removed, how many more “drags on the system” might be thrown overboard in the name of competition?

What the FTC/DOJ Report Omitted from Its Health Care Access Discussion

Just as the report fails to come clean about the legal environment for health care access, it also tends to downplay the magnitude of the health care access problem. This underreporting and downplaying occurs in two ways: first, by mischaracterizing the magnitude of the uninsured problem; and, second, by failing to explore those access barriers that transcend insurance coverage.

How the Report Mischaracterizes the Uninsured Problem. The analysis attempts to frame the problem of lack of insurance coverage as one that, while worth noting in a few passages, does not carry any real significance in the context of policy implications. The uninsured are portrayed as “fluid” (“A substantial majority of those currently uninsured will not be uninsured a year from now” [FTC/DOJ 2004: chap. 5, 24]). The portrait that emerges from the four and a half pages in toto devoted to the discussion of insurance is that of relatively affluent and healthy individuals who experience short periods without coverage and who simply have made a discretionary decision not to purchase it. Even a cursory review of the evidence shows just the opposite: two-thirds of the uninsured are low income, and one-third lives in poverty; more than a third report needing health care but not getting it; and over three-quarters of the uninsured at any given time will have been uninsured for the previous twelve months (Kaiser Family Foundation 2005b).

The lack of health insurance is far grimmer and entrenched than the FTC and DOJ would have readers believe, and with good reason: by their own admission, competition would exacerbate the health care access problem for uninsured persons. One need only juxtapose *Improving Health Care* against thorough reports on the uninsured to grasp the magnitude of the understatement. In this regard, perhaps the most important work is a multiphase project conducted by the Institute of Medicine, which over a several-year period examined the problem of health insurance and its consequences in great depth. The IOM concluded that the problem is “large, growing and persistent” and noted its significant association with

the receipt of health care, health status, sickness, and death (IOM 2004). The IOM's work portrayed a problem with societal implications reaching well beyond its immediate impact on individuals without coverage and extending to families and entire communities. One would think that this ecological approach would have held great interest for the DOJ and FTC, since so many of their recommendations go to geographic markets, yet the agencies appeared to make no use of these findings as they crafted their recommendations.

One of the most unsettling aspects of the FTC/DOJ report is its failure to consider the impact of the insurance problem on specific subpopulations. Without examining subpopulation experiences, the report leaves itself in no position to assess the import of its recommendations on particular subgroups such as low-income persons and members of racial and ethnic minority groups. Thus, for example, more than one-third of the poor and 30 percent of the near poor (family incomes at or below 200 percent of the federal poverty level) were uninsured in 2003. Together these two population subgroups amount to 88 million persons (Kaiser Commission on Medicaid and the Uninsured 2004). Similarly, the report mentions the large number of "young immortals" without coverage but at the same time fails to note that persons aged thirty-five and over made up nearly 40 percent of the uninsured population, a smaller proportion to be sure than younger Americans, but of potentially far greater concern to the health care system. Twenty-nine percent of children, and 40 percent of non-elderly adults, in fair to poor health status, are uninsured (*ibid.*).

Improving Health Care makes no mention of the racial and ethnic characteristics of the uninsured, despite the fact that minority groups are disproportionately represented. Lack of health insurance was a fact of life in 2003 for more than one in five African Americans and over one in three Hispanic Americans, compared with fewer than one in eight white persons. Together, racial and ethnic minority groups comprised the majority of uninsured persons that year (*ibid.*).

Nor does the report address evidence of disparities in health status by source of insurance coverage, although this would seem critical to fashioning competition recommendations that ensure at least some semblance of cross-payer parity in a competitive system. For example, Medicaid beneficiaries are four times more likely than those with employer coverage and over twice as likely as the uninsured to report being in fair to poor health (*ibid.*).

These data, taken together, suggest that certain distinct and highly vulner-

able subpopulations could bear the brunt of adverse access consequences that might be expected from greater competition, and yet the dimensions of the problem go undiscussed. Nor does the report discuss interventions that might be used to mitigate access barriers facing underserved populations, such as investment in health centers and other publicly supported primary-care entry points into the health system (IOM 2000; Rosenbaum, Shin, and Darnell 2004; Strunk and Cunningham 2004). Of course, once the establishment of primary-care entry points such as health centers is identified as a possible option for remedying the maldistribution of health care resources, it becomes necessary to address the evidence showing that, despite the quality of their care, health centers face serious problems securing adequate specialty care for their patients (Gusmano, Fairbrother, and Park 2002). Addressing this problem may necessitate market intervention through regulations aimed at ensuring minimum affiliation relationships between the health care safety net and specialty and inpatient providers, but such a recommendation would be an admission of need for at least modest regulatory remedies to overcome market failure.

Conclusion

Examining the FTC/DOJ report through the lens of health care access, one gets the distinct sense of operating in a parallel universe. One universe is inhabited by well-insured affluent persons, whose coverage derives through large and powerful group purchasers whose health care-purchasing efficiencies could be greatly improved. The other universe is inhabited by tens of millions of uninsured, underinsured, and medically vulnerable persons, who are at risk for a host of health care access barriers and adverse health outcomes.

In the first universe, the central problem is too much spending for too little value, and the remedies are deregulation and the use of competitive purchasing tools that will slowly but surely cause prices to fall while improving quality for affluent and educated consumers. In the second universe, the central problem is millions of people who barely have a hold on the health care system. The implications for the inhabitants of the second universe of the remedies from the first universe are never considered; indeed, this second universe is simply not considered. In their defense, perhaps, neither the FTC nor the DOJ is charged with the duty to develop policies that promote equitable access to health care. But when the government issues a report of this magnitude, should the public not expect that major federal agencies would feel at least a small obligation

to draw policy makers' attention to the implications of their proposals for the medically underserved and vulnerable?

To have produced a report that attempts to straddle and reconcile both universes, the FTC and DOJ would have had to deal forthrightly with the problem of access. Probably for reasons linked to fundamental ideology and outlook, as well as the ferocious control over information flow that now dominates the nation's capital, the report fails to do this. As Jost and colleagues point out in this issue, straddling the two worlds would have necessitated addressing the lack of legal and societal protections where health care access is concerned. By attempting to ignore the world of the uninsured and underserved, the FTC and DOJ ironically end up doing more damage to their own cause than if they had dealt with the limits of competition in a straightforward manner and had, without flinching, outlined the conditions that might make true competition possible in the United States.

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