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FOREWORD:

FEDERAL-STATE CONFLICTS IN HEALTH CARE

Joan H. Krause*

Debates over federalism – the proper distribution of power between the federal and state governments – are an inherent part of our legal and political history.¹ As Alexander Hamilton warned more than two hundred years ago, “a disposition in the State governments to encroach upon the rights of the Union is quite as probable as a disposition in the Union to encroach upon the rights of the State governments.”² The tension inherent in a bifurcated scheme of government, where national sovereignty supplements but does not supplant local authority, has given rise to many vexatious legal challenges. In recent years, such challenges have implicated a variety of legal topics, including national security,³ election law,⁴ and

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⁴ See, e.g., Bradley W. Joondeph, Bush v. Gore, Federalism, and the Distrust of Politics, 62 OHIO ST. L.J. 1781 (2001) (arguing that the Supreme Court’s decision in Bush v. Gore was consistent with the Court’s approach in other federalism challenges).
environmental law, as well as the broader question of the judiciary’s role in resolving these disputes.

Few areas of law implicate the federalism debate as much as health care. Concerns over the proper allocation of federal and state authority permeate virtually all areas of health care, from the confines of the individual doctor-patient relationship to the expansive boundaries of the public health system. Almost by definition, the modern health care system requires federal and state authorities to coexist. Medicaid, for example, is a joint federal-state program that provides health care to the financially and medically needy. While Medicare is federally funded, the program provides care to the elderly and disabled through a vast network of private physicians and institutions that are licensed by their respective states. Similarly, a state’s ability to regulate employee health care benefits is limited by the federal Employee Retirement Income Security Act of 1974 (ERISA), which has greatly complicated regulation of the managed care organizations from which many employers purchase health insurance. With the advent of technological advances, even those

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6 See, e.g., Chemerinsky, supra note 1, 7-9 (discussing the Supreme Court’s approach to federalism); Steven G. Culbiris, Federalism and the Rehnquist Court: a Normative Defense, 574 Annals Am. Acad. Pol. & Soc. Sci. 24, 26 (2001) (characterizing “Constitutional federalism” as “a major theme of the constitutional text”); Philip P. Frickey & Steven S. Smith, Judicial Review, the Congressional Process, and the Federalism Cases: An Interdisciplinary Critique, 111 Yale L.J. 1707 (2002) (arguing that the Supreme Court’s recent approach to federalism “has flunked political science”).


9 See, e.g., 42 U.S.C. § 1396 et seq. (federal Medicaid provisions); Dayna Bowen Matthew, The “New Federalism” Approach to Medicaid: Empirical Evidence That Ceding Inherently Federal Authority to the States Harms Public Health, 90 Ky. L.J. 973, 977-78 (2001-2002) (arguing that the ‘predictable effect of increasing states’ control over Medicaid will be decreased access to healthcare for the poor, young and disabled . . . and thus inevitably disproportionate harm to the public health of those states’ Medicaid populations”).

10 See, e.g., 42 U.S.C. § 1395 (defining “physician” for purposes of the Medicare program to include “a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the State in which he performs such function or action”).


practices that traditionally have been left to the states, such as regulating the entities that sell prescription drugs to state residents, have taken on a national character.\(^{13}\) In light of the tremendous overlap of responsibility, it is not surprising that federal and state health care authorities find themselves in conflict. Indeed, the wonder may be that they do not do so more often.

The articles in this Symposium address various facets of the potential for federal-state conflicts in health care. Professor Stephen Utz begins the debate with a cogent assessment of the failure of health care federalism, arguing that the term “has indeed become a code word for a deliberate absence of coordination of state-run programs, which political ideology regards as the antidote to big government.”\(^{14}\) Utz faults our traditional focus on “micro” issues in health law (particularly bioethics), blaming it for our failure to engage in a serious debate of broader societal issues. Because of this narrow view, Utz argues, important health care policy decisions have been shaped by private decisionmakers, whose focus is on their own financial health rather than broader health policy.\(^{15}\)

Utz explores several of our purported health care goals: cost containment, universal coverage, portability of coverage, health care benefit packages, medical research, rationing of scarce resources, and the integration of health with other policy areas. As Utz demonstrates, however, many of these goals are inherently incompatible – and given our present federalist approach, the simultaneous pursuit of them has resulted in a disorganized, decentralized health care system that fails to achieve our aims. While Utz concludes that a federalist approach may offer advantages on particular health care issues of local preferences, he argues that fairness may preclude local variations on other issues, and calls for an informed public debate.\(^{16}\)

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\(^{13}\) See, e.g., Sara E. Zeman, Regulation of Online Pharmacies: A Case for Cooperative Federalism, 10 ANNALS HEALTH L. 105 (2001) (discussing federalism issues arising from the proliferation of online pharmacies).


\(^{15}\) Id. at 165.

\(^{16}\) See id. at 180.
Professor Barry Furrow turns the focus to a specific area where federal and state coordination is crucial: the task of reducing medical errors. Since the publication of the Institute of Medicine’s (IOM) report, *To Err is Human*, the reduction of medical errors has become a priority for both the government and the medical profession. Furrow takes as his starting point the IOM’s conclusion that the vast majority of medical errors, particularly in the hospital context, are caused by *system* failures rather than *individual* wrongdoing. Despite the importance of tracking information about medical mistakes, however, we have yet to implement a coordinated federal/state reporting system. Furrow reviews the current approaches to medical error, ultimately rejecting, as counterproductive, the tort system’s focus on individual providers. Furrow prefers an approach grounded in the systemic nature of medical care, which recognizes that medical errors arise from a combination of individual, system, and team-based deficiencies – deficiencies that are illustrated, tragically, in several of the medical malpractice cases he discusses.

Furrow argues that only *mandatory* reporting of medical errors can force medical institutions to take responsibility for their actions and facilitate the operational changes that will promote error reduction. Voluntary systems, in Furrow’s view, offer few incentives for change: “[b]lame connotes moral responsibility, and we want our health care institutions to be held accountable for their errors. Stripping away blame may neutralize responsibility.” Consequently, Furrow rejects as ineffective recent efforts to encourage error reporting, such as the Joint Commission on the Accreditation of Healthcare Organization (JCAHO) “Sentinel Event Policy” and the Centers for Medicare and Medicaid Services (CMS) requirement that hospitals develop quality assessment and performance improvement pro-

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18 Committee on Quality of Health Care in America, Institute of Medicine, *To Err is Human: Building a Safer Health System* (Linda T. Krohn et al. eds. 2000) (hereinafter, *To Err is Human*).

19 Furrow, supra note 17, at 182; *To Err is Human, supra* note 18, at 66 (arguing that in the medical context, “most human errors are induced by system failures”).

20 Furrow, supra note 17, at 183.

21 Id. at 187.

22 See id. at 187-94.

23 Id. at 204.

24 Id. at 187.
grams. Instead, Furrow prefers the approach taken in Pennsylvania’s Medical Care Availability and Reduction of Error Act, which mandates reporting of errors and near misses both to a state agency and to the patients who may have been affected, and imposes significant penalties on individuals and facilities for failure to comply. By adding “teeth” to the reporting requirements, coupled with broad immunity from discovery, Furrow argues that the Pennsylvania legislation best aligns the incentives of medical providers and patients in reducing medical errors.

Professors Bryan A. Liang and Steven D. Small continue the discussion of the systems-based nature of medical error, focusing their inquiry on the disadvantages of the current litigation model for communicating relevant error information. Liang and Small argue that the litigation process stifles communication by silencing the party with the most information about what happened – health care providers – due to fear of potential malpractice liability. Similar to Furrow, Liang and Small review the research that has contributed to our understanding of the systems-based nature of medical error, noting that the most dangerous errors are “latent failures . . . entwined with the design, organization, and structure of complex systems” such as health care. Unlike Furrow, however, the authors reject the “shame and blame” approach to medical mistakes, arguing instead that a voluntary, cooperative, non-punitive approach is most likely to foster the type of open communication that will promote error reduction.

Liang and Small focus their inquiry on the types of information that providers are able to generate about medical errors. While such information is crucial to reducing systems errors, it also is highly prized in the malpractice context. Liang and Small argue that if error information can be accessed for litigation purposes, health care providers will be significantly less likely to compile such reports – thus preventing necessary conversations about patient safety from taking place. Under the Federal Rules of Civil Procedure and current state law, such error information is likely to be discoverable in a

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25 Furrow, supra note 17 at 207-212.
26 See 49 P.S. § 1303.301 (2002).
28 Id. at 222-223.
29 Id. at 225.
lawsuit.\textsuperscript{30} The most significant exception to discovery is the immunity offered under many state statutes for peer review and quality assurance committee proceedings (the “PR/QA privilege”).\textsuperscript{31} Because the exception is construed narrowly, however, and is not available in every jurisdiction – including, most notably, in the federal courts – Liang and Small conclude that the current PR/QA privilege is not sufficient to safeguard relevant information about medical errors.

The lack of privilege is exacerbated in the context of mediation, which Liang and Small argue must be a crucial component of the process of sharing safety information with patients.\textsuperscript{32} By using a neutral mediator to assist the parties in a medical dispute, the mediation process may be able to achieve more creative and mutually acceptable solutions than traditional litigation. In order to effectively facilitate this interaction, the parties must maintain a certain level of trust, which in turn requires their communications to remain confidential. Similar to the PR/QA privilege, however, there is a wide disparity among jurisdictions regarding the extent to which mediation communications are protected from disclosure – leading to significant venue and choice of law disputes.\textsuperscript{33} To address these impediments to open discussion regarding medical error and patient safety, the authors propose a new federal statute, the “Promotion of Health Care Quality and Patient Partnership Act.”\textsuperscript{34} Only through a federal statute, argue Liang and Small, can inconsistencies regarding evidentiary privileges be eradicated, and the important goal of patient protection attained.

Next, Professor Alison Barnes examines another area in which the federal and state approaches may conflict: the process of structuring an elderly patient’s assets so as to enable the patient to become eligible for Medicaid long term care coverage.\textsuperscript{35} As Barnes notes, access to long term care in this country is dependent primarily on the patient’s ability to pay. Long term care insurance has not been a popular product, in part because the premiums are so high that it appeals only to a relatively affluent population. On the other

\textsuperscript{30} Id. at 228.
\textsuperscript{31} Id. at 229.
\textsuperscript{32} Liang & Small, supra note 27, at 242.
\textsuperscript{33} Id. at 247.
\textsuperscript{34} Id. at 252-263.
end of the spectrum, Medicaid long term care benefits are available to those who are financially “needy” enough to meet the program’s definitions. For those in the middle, however – those not rich enough to pay for long term care, but not poor enough to qualify for Medicaid – there has been little recognition of any need for financial assistance. As Barnes notes, “[a] persistent theme is that many elders can and should provide for their own long term care costs out of their life savings, and if that is not possible, the right model to meet these needs is a poverty program.” Thus, a debate has arisen about the propriety of structuring patients’ assets to enable them to qualify for Medicaid.

Barnes argues that the federally established (and state interpreted) Medicaid asset and income rules, by definition, are designed “to apply to people who have not been poor.” These complicated rules permit the patient to retain certain limited assets (such as a homestead), permit non-institutionalized spouses to retain additional assets and to receive their own income, and permit the creation of certain irrevocable trusts that functionally reduce the grantor’s income. As a result, according to Barnes, “Medicaid long term care has become a program for middle class elders of at least modest means.” Because the states interpret the federal provisions differently, however, access to Medicaid long term care differs significantly in different regions of the country. Barnes recognizes the need to balance the state’s legitimate concern for allocating scarce public funding with the psychological impact of forcing the elderly to become virtually destitute in order to access long term care. While providing guidance on the types of asset planning that are permissible under Medicaid, Barnes raises troubling questions about whether the current program reaches the population it was designed to protect – and whether modifications are needed to recognize the middle class’ legitimate need for assistance with long term care costs.

Professor Mark Strasser addresses another timely federal-state conflict: the recognition of marriages in which one partner is a transsexual by virtue of having undergone a surgical sex-change. These issues arise because many states – as well as the federal De-

36 Id. at 265-266.
37 Id. at 267.
38 Id. at 268.
fense of Marriage Act (DOMA) – define marriage as a union of two individuals of the “opposite sex.” As Strasser explains, however, states have taken drastically different approaches to determining an individual’s “sex,” which in turn affects whom that individual will be permitted to marry. In states that look to the individual’s post-surgical sex, a transsexual will be permitted to marry a member of the opposite “apparent sex” – thus, a male-to-female transsexual could marry a man. In states that look to an individual’s “chromosomal sex,” however, the individual will forever be considered a member of the sex determined at birth. In such states, “a post-operative male-to-female transsexual can marry a woman but not a man” – an anomalous result in states that refuse to recognize “same sex” unions.

These definitional differences are amplified when considered in the context of federalism. As Strasser explains, because DOMA does not clearly define “sex,” it remains for the various meanings to be given force via litigation – a crucial issue in disputes over entitlement to federal benefits. Moreover, while DOMA makes clear that states are not required to recognize same sex unions created in other states, the law fails to identify which state’s definitions will be used to determine whether the partners are of the “same” or “opposite” sexes. Without this crucial guidance, the new federal law has only further complicated the existing differences among the states – a significant problem in an increasingly mobile society. As Strasser concludes, the idea that “a post-operative transsexual who travels across state lines may well not have his or her marriage recognized, even though it is recognized in the domicile . . . is simply intolerable.”

The Symposium concludes with an amicus curiae brief submitted by the American College of Legal Medicine (ACLM) in the

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41 See Strasser, supra note 39, at 309 (discussing M.T. v. J.T., 355 A.2d 204 (N.J. App. 1976) (permitting marriage between a man and a post-operative male-to-female transsexual)).

42 See id. at 303 (discussing Littleton v. Prange, 9 S.W.2d 223 (Tex. App. 1999) (holding that sex is determined at birth)).

43 Id. at 303.

44 Id. at 321.

45 Id. at 325.

46 Id. at 328.
pending Oregon v. Ashcroft litigation. In 1994, Oregon voters adopted the Oregon Death with Dignity Act, which permits physicians to prescribe lethal doses of medication to terminally ill patients under certain limited circumstances. In 2001, Attorney General John Ashcroft directed the Drug Enforcement Administration to take action against physicians who participate in these activities by revoking their authority to prescribe controlled substances under the Controlled Substances Act (CSA), on the ground that physician-assisted suicide is not a “legitimate medical purpose” under the Act. The ACLM, which is comprised primarily of physician-attorneys, opposed Attorney General Ashcroft’s action and submitted a brief on behalf of the state of Oregon.

In the Brief, which was drafted by Miles Zaremski and Professor Maxwell Mehlman, the ACLM argues that the CSA does not give the Attorney General the unilateral authority to determine the legitimacy of a particular drug use; rather, that determination must be based on a scientific evaluation by the Department of Health and Human Services. In considering such scientific information, moreover, the ACLM argues that the law must recognize the existence of significant variations in medicine, and the fact that experts may differ in their opinions as to the acceptability of individual medical practices. The ACLM argues that the only exception that should be made to this requirement of deference to expert medical judgment under the CSA arises when a state has explicitly defined the limits of accepted medical use within its borders – as the state of Oregon has done by enacting the Death With Dignity Act. Thus, the ACLM concludes that the Attorney General’s action not only conflicts with the CSA’s requirement that determinations of medical legitimacy have a scientific basis, but also interferes with the state of

49 Dispensing of Controlled Substances To Assist Suicide, 66 Fed. Reg. 56,608 (Nov. 9, 2001) (arguing that such activity is not a “legitimate medical purpose” under 21 C.F.R. § 1306.04, and may subject physicians to possible suspension of their controlled substances registration under 21 U.S.C. § 824(a)(4)).
50 ACLM Brief, supra note 47, at 333-334.
51 Id. at 334-339.
Oregon’s right to define the scope of medical conduct for its residents.

The articles in this Symposium illustrate the complex relationship between federalism and health care, and the need to reconsider many health care disputes in light of federalism concerns. While it is clear that some health care issues — such as the federally-funded Medicare program, or the federal laws governing controlled substances — are national in nature, it is equally clear that there is a good reason to recognize the continuing role of the states in protecting the health of their residents. Where state interpretations differ, however, so too will individuals’ health care entitlements. If we cannot make peace with the variations that exist across the country, perhaps it is indeed time to rethink our approach to federalism in health care.

52 Id. at 338-339. Not surprisingly, there is strong opposition to a number of these arguments. For example, in an amicus brief supporting Attorney General Ashcroft, the United States Catholic Conference argued that it is “self-evident” that “assisting suicide is not a legitimate medical purpose.” Brief Amici Curiae of the United States Catholic Conference et al. In Support of Attorney General Ashcroft, 18 ISSUES IN L. & MED. 153, 154 (2002). The authors argued that the distinction between managing pain and assisting suicide is well-recognized in federal law, and that the CSA “gives no recognition to individual state laws that may seek unilaterally to redefine this medical and ethical consensus.” Id. at 158-59.