



2001

The Proposed Patients' Bill of Rights: The Case of the Missing Equal Protection Clause

Dean M. Hashimoto

Follow this and additional works at: <https://digitalcommons.law.yale.edu/yjhple>

 Part of the [Health Law and Policy Commons](#), and the [Legal Ethics and Professional Responsibility Commons](#)

Recommended Citation

Dean M. Hashimoto, *The Proposed Patients' Bill of Rights: The Case of the Missing Equal Protection Clause*, 1 YALE J. HEALTH POL'Y L. & ETHICS (2001).

Available at: <https://digitalcommons.law.yale.edu/yjhple/vol1/iss1/4>

This Article is brought to you for free and open access by Yale Law School Legal Scholarship Repository. It has been accepted for inclusion in Yale Journal of Health Policy, Law, and Ethics by an authorized editor of Yale Law School Legal Scholarship Repository. For more information, please contact julian.aiken@yale.edu.

The Proposed Patients' Bill of Rights: The Case of the Missing Equal Protection Clause

Dean M. Hashimoto, M.D., J.D., M.P.H.*

Following the footsteps of most other states, Massachusetts opened its Office of Patient Protection in January 2001. Established under what the media hailed as a "landmark" patients' bill of rights, the Massachusetts legislature created a state agency empowered to review medical decisions made by health maintenance organizations (HMOs) that are challenged by patients.¹ However, after opening its doors, the agency now faces an immediate and major problem—the lack of any patient complaints. On January 27, 2001, the *Boston Globe* reported the agency's activity as follows: "[I]n their first three weeks, the medical crusaders in this little office have been more like those proverbial Maytag repairmen—twiddling their thumbs in boredom. The office, established under a landmark patients' bill of rights as a referee between HMOs and clients, has yet to hear a single beef."²

While the problem may be due to a lack of knowledge about the availability of the appeals process, the immediate result of this Massachusetts reform mirrors the longer-term experience of other states. Health policy researchers at Georgetown University analyzed the limited reliance of patients on the right to appeal HMO decisions and found that patients rarely exercise their newly found due process rights to appeal treatment denials. For example, in the first five years of Florida's external review process (from 1993 to 1998), only 403 cases arose in a population of 4.4 million state residents enrolled in managed care plans.³ Despite the relatively small impact of this health care reform effort by various states, it appears that Congress will soon pass similar "landmark" federal legislation.

In the past year, the presidential candidates and the U.S. Congress

* Dean M. Hashimoto is an Associate Professor of Law at Boston College. Professor Hashimoto serves also as the Chief of Occupational and Environmental Medicine for the Partners HealthCare System at the Massachusetts General Hospital and the Brigham and Women's Hospital.

† The author thanks Dr. John Crongeyer for providing excellent editing support and Erica Valenti for her able research assistance. He dedicates this article to Professor Jay Katz, who inspired a generation of Yale law students to study the interface of law and medicine.

have introduced proposals that would place a patients' bill of rights at center stage in the current debate over health care reform. Our political leaders call for increased accountability of managed care organizations (MCOs). They advocate guarantees for certain patient rights (including a broader choice of physicians), establish procedures reviewing denials of treatments by MCOs, and entitle patients to sue their health plans for damages in state courts if a MCO's denial of care causes harm.⁴ This congressional plan for national reform is patterned after what a majority of states have already adopted. In the 2000 presidential election campaign, Republican and Democratic candidates alike recognized the great importance of health care reform and expressed specific support for the patients' bill of rights.⁵ As a result, it appears quite likely that Congress will make the patients' bill of rights one of the most highly publicized health care reforms of recent times.

This Article consists of six parts. Part I describes the important role of managed care plans in health care delivery and considers why the public perceives a compelling need for regulating MCOs through a patients' bill of rights. Part II outlines the major reforms contemplated by Congress that may be included in the patients' bill of rights. The proposed reforms provide: (1) protection only for those enrolled in private managed care plans that are self-insured or employer-sponsored; (2) appeals of disagreements between MCOs and patients over treatment decisions; and (3) access to specialists and emergency rooms. Part III illustrates how these proposed reforms place a heavy emphasis on regulating MCOs by assigning due process rights to patients of privately funded health plans.

The essay then offers a vision of a patients' bill of rights that bases its reform on principles of both equality and due process. Empirical research demonstrates that although managed care systems appear to provide roughly adequate health care for the general public, they may not be providing equal treatment for the poor and elderly. Furthermore, empirical research also indicates that race accounts for the largest disparities in treatments. Part IV describes how the patients' bill of rights could safeguard the rights of more patients by extending protections to publicly financed managed care programs such as Medicaid. Part V suggests that certain due process protections, such as the right to appeal treatment decisions, will have only a limited impact on patient care. If reformers of managed care desire to achieve a broader and more equitable result, they should seek reforms that encourage health care providers to offer patients treatment approaches more consistent with national standards of medical care. Part VI discusses the impact that the principle of equality would have on improving access by minorities to appropriate

health care. This type of reform would emphasize the importance of encouraging MCOs to integrate their care with local and state agencies in order to promote public health.

I. THE IMPORTANT ROLE OF MANAGED CARE IN HEALTH CARE DELIVERY

In response to escalating costs associated with the traditional fee-for-service approach, employers and insurers have turned to MCOs as a financial solution. Managed care systems represent an increasingly dominant approach to health care delivery. The two major types of MCOs are HMOs and preferred provider organizations (PPOs). HMO health plans place at least some of their providers at risk for medical expenses and rely on designated providers as gatekeepers. PPOs, on the other hand, contract with independent providers for services at a discount. Because employers and insurers pay HMOs and PPOs fixed rates based on the health characteristics and size of an employee group, HMOs and PPOs have a direct financial incentive to minimize costs.⁶ HMOs enrolled over eighty-one million Americans by 1999, and the number enrolled in various forms of PPOs now reportedly rivals those in HMOs.⁷ More than 70% of Americans who receive health insurance through their employers are enrolled in MCOs.⁸

MCOs rely on two primary mechanisms to minimize costs: (1) managing the quality of care delivered; and (2) limiting patient visits to specified provider groups.⁹ First, MCOs may manage the quality of care delivered by arranging for primary care physicians to serve as the gatekeepers and to coordinate access to hospitals and specialists. MCOs may also encourage reasonable utilization of medical services through the education of providers, utilization reviews, and treatment/referral guidelines. Second, MCOs can contract with panels of providers and limit patient visits to these panels. This arrangement allows MCOs to contract at financial discounts by guaranteeing provider groups exclusive rights to certain volumes of patients. If a provider group is not willing to provide care at sufficient discounts, the MCOs may contract with other provider groups.

Overall, managed care systems appear to improve the control of medical costs. Total expenditures have decreased, while enrollment in managed care plans has increased.¹⁰ Rising medical costs in the late 1980s spurred the development of the managed care industry. In the early 1990s, costs stabilized and then rose again before reaching a plateau in the mid-1990s. Medical costs were expected to rise 5-7% in 1999.¹¹

Although managed care slowed increases in medical costs during the 1990s, the public distrusts managed care systems. This distrust stems from

concern that MCOs place undue pressure on doctors to reduce costs. Former Vice President Al Gore, during his presidential campaign in 2000, said, “[t]here’s an emergency in America all right, and it’s the lack of a strong, enforceable patients’ bill of rights.” Promising to give doctors power to make all medical decisions—rather than leaving them up to cost-conscious HMOs—Gore said the insurance company has no “right to play God.”

The Gore campaign also unveiled a health care advertisement deriding health insurance managers as “some bean-counter[s] behind a computer terminal who should not be able to deny patients certain treatment because it costs the HMO too much.”¹² Gore’s political speech reflects the public’s general wariness of the financial motivations of MCOs.

Notably, however, Gore’s attack does not contain specific references to any objective proof that the quality of care provided by MCOs is less than that associated with fee-for-service insurance coverage. Health care service researchers who have compared objective quality measurements of managed care plans with fee-for-service arrangements have reached conclusions that do not raise substantial concerns about the quality of overall care provided. Experts who have reviewed the medical literature have concluded that the quality of managed care plans is roughly equivalent to fee-for-service insurance plans.¹³ The studies focusing on health outcomes have not found a significant difference in the general population between fee-for-service plans and managed care arrangements.¹⁴ Surveys of private health plans, however, clearly show that comprehensive managed care plans offer better coverage for medical services, such as vision and dental care, than fee-for-service arrangements.¹⁵ The proposed reforms for managed care do not appear to be in response to specific and objective evidence regarding quality of care, but instead seem to respond to the public’s more general concern about the financial incentives of MCOs to reduce costs. As a result, reformers in Congress do not focus on specific ways to improve medical treatment, advocating due process protections of patient choices instead.

II. THE PROPOSED PATIENTS’ BILL OF RIGHTS

Congress appears to be moving in the direction of adopting a patients’ bill of rights that is designed to protect middle-class participants in managed care systems.¹⁶ Republicans and Democrats plan to regulate some or nearly all private managed care plans. The proposed patient protections focus on procedural measures that emphasize individual initiative. The patients’ bill of rights requires particular resource allocations that reflect middle-class values.

A. Coverage

The two political parties disagree as to the proportion of mainstream members of managed care plans that will be protected by the patients' bill of rights. Republicans would limit certain resource allocation protections to the forty-eight million Americans who get their coverage from self-insured plans. Democrats favor further extensions of these protections to employer-sponsored plans that apply to an additional seventy-five million Americans. Both parties have proposed extending the internal and external review procedures to all self-insured and fully insured employer-sponsored plans.¹⁷

B. Procedural Fairness

Both presidential candidates emphasized their concern about leaving it up to managed care administrators to deny medical diagnostic tests and treatments, rather than leaving these decisions in the hands of doctors.¹⁸ The public worries that financial pressure on MCOs creates too strong an incentive to reduce the amount of diagnostic testing and treatments even if medically necessary. The Republican and Democratic versions of the patients' bill of rights give patients the right to an external review of a health plan's benefit decision by independent medical reviewers.¹⁹ Additionally, the Democrats would like to give physicians, not health plans, the authority to determine when medical testing and treatments are necessary and forbid MCOs from giving physicians financial incentives to withhold care.²⁰

The greatest controversy, however, arises from the Democratic position in favor of allowing patients to sue if an injury results from a denial of care.²¹ Currently, patients do not have this legal right to sue because courts have interpreted the Employee Retirement Income Security Act of 1974 (ERISA)²² as barring such suits against MCOs in state court because of federal preemption.²³ Congressional Republicans oppose removing this preemption and would rely mainly on external appeals to medical reviewers.

Both Republican and Democratic proposals provide various consumer protection provisions.²⁴ These protections include a ban on "gag clauses" in physician contracts that forbid physicians from making disclosures to patients. The consumer protection provisions also require MCOs to disclose specific types of health plan information.

C. Access to Health Care

Congressional proposals require that patients have access to certain providers and services. The proposals require MCOs to provide coverage for patients' visits to emergency rooms if a prudent layperson would consider the visit to be an emergency.²⁵ The proposals would also give patients direct access to gynecologists and pediatricians without the necessity of a referral from a primary care physician, and provide continuity of care for patients previously treated by certain specialists who have left the network.²⁶

D. Summary

The patients' bill of rights represents a congressional effort to extend certain procedural and substantive rights to members of mainstream managed care plans. Congress appears ready to provide health care reform to members of self-insured and, perhaps, all privately insured programs. The procedural protections emphasize individual initiative to pursue internal and external medical review procedures. The proposed reform gives members of private managed care plans broader access to emergency rooms and specialists.

III. THE FOCUS ON DUE PROCESS RIGHTS

The name for this legislative reform—the “patients’ bill of rights”—analogously refers to the U.S. Constitution’s Bill of Rights. This terminology highlights the perceived importance of this proposed reform. This reform establishes procedural protections of patients’ choices of treatment within managed care systems. The proposed rights for patients bear a striking similarity to rights guaranteed by the Due Process Clause of the U.S. Constitution. Just as the Due Process Clause guarantees criminals a right to a fair trial and to appeal jury verdicts, the proposed patients’ bill of rights gives patients the right to external reviews of medical decisions and to sue HMOs. Similarly, just as police must read criminal suspects their *Miranda* rights while under custody, the patients’ bill of rights would require health plans to disclose certain information about coverage and ban gag clauses in physicians’ contracts.

Moreover, the proposed reform’s emphasis on protecting particular kinds of patients’ choices bears some similarity to a different aspect of the Due Process Clause that involves “substantive” due process rights. The Supreme Court in *Roe v. Wade*²⁷ established that the Due Process Clause guaranteed a woman’s right of access to a particular medical procedure, an

abortion, that cannot be interfered with by the government or even by her spouse. Similarly, Congress now contemplates establishing a patient's right to access specialists and emergency rooms without approval by his or her primary care physician.

Abortion rights and the proposed patients' rights share yet another similarity. Those who are financially unable to afford to exercise these rights cannot benefit from the existing rules. In *Harris v. McRae*,²⁸ the Supreme Court held that the government is not required to provide financial support to the indigent who seek abortions under Medicaid even if medically necessary. Similarly, the proposed patients' bill of rights would not extend its protections to the indigent who receive their medical care through Medicaid managed care plans. The government remains committed in both cases to enforcing the due process guarantees for the majority who can afford to exercise their rights in the private realm. On the other hand, the government does guarantee a right of equal access by the poor who constitute a minority in the community. Thus, the real challenge is to make this "equal" access truly meaningful.

While proponents of the patients' bill of rights rely on due process as the main framework for reforming managed care, they neglect an important perspective within the U.S. Constitution—our society's commitment to equality. The current proposal for reforming managed care systems consists of a bill of rights that lacks an equal protection clause. This Article considers how the current proposal could be revised if reformers of managed care instead relied on a principle of equality that would protect minorities including racial/ethnic groups, the poor, and the elderly.

Researchers in health care services have identified substantial disparities in health care delivery involving racial/ethnic minorities, the poor, and the elderly. Dr. Jack Geiger, an expert in this field, stated in an editorial in *The New England Journal of Medicine* that "race was the overriding determinant of disparities in care" and that "[t]hese issues are all the more urgent because of the risk that managed competition and capitated payment systems may increase the likelihood of discriminatory judgments, not least in the urban teaching hospitals that are essential resources for inner-city populations."²⁹

IV. EXPANDING THE APPLICATION OF THE PATIENTS' BILL OF RIGHTS

The emphasis by the patients' bill of rights on individual choice, due process protections, and limiting its jurisdiction to private health plans will result in an important regulation that largely benefits the employed middle class. This essay critiques the proposed reform and then advocates

the addition of a complementary perspective based on equality of choices, equal protection, and responsiveness to socioeconomic diversity. The patients' bill of rights should promote health care delivery that is inclusive in its application, not just its conception. Reformers should extend the reform's application to Medicaid managed care plans.

Both Republicans and Democrats propose to extend the patients' bill of rights to privately insured health care plans, thus covering only those that are self-insured and possibly those that are employer-sponsored.³⁰ This proposed reform will not extend to Medicaid managed care plans, which have become the dominant delivery model for low-income beneficiaries. Medicaid managed care plans include more than seventeen million beneficiaries—more than half of the Medicaid-eligible population.³¹

The federal government encouraged the development of Medicaid managed care programs by establishing a waiver process in 1993 that allowed states to enroll Medicaid recipients in managed care programs.³² Medicaid enrollments in managed care programs have skyrocketed since the initiation of the waiver process. States have substantially increased their reliance on Medicaid managed care systems in the absence of strong empirical evidence that they result in any substantial improvements in care.³³ On the other hand, state Medicaid programs estimate that the rates of savings range from 5-34%.³⁴ Thus, the current benefits of managed care may lie in their financial benefits, not their direct health effects.

It is unfair to guarantee special legal protections to members of private managed care plans while failing to provide these same guarantees to members of publicly financed managed care programs including Medicaid. The U.S. Supreme Court recently described in *Pegram v. Herdrich* how HMOs must engage in rationing medical care to reduce medical costs.³⁵ The Court noted that this "rationing necessarily raises some risks while reducing others (ruptured appendixes are more likely; unnecessary appendectomies are less so)."³⁶ The Court also indicated that this decision-making involves "judgments of social value, such as optimum treatment levels and health care expenditure."³⁷ The patients' bill of rights is premised on the belief that health care has a high social value that warrants special protections to encourage these optimum treatment levels and expenditures. By not making the patients' bill of rights applicable to Medicaid, we are further segregating the health care system of the lower socioeconomic class and increasing differences in the quality of health care provided.

The poor and the elderly may have a greater need to be protected by a system that safeguards patients' rights. Dr. John Ware and other Boston area physicians analyzed differences in health outcomes of chronically ill

adults treated in HMOs and fee-for-service systems over a four-year period, and they published their results in the *Journal of the American Medical Association* in 1996.³⁸ After conducting this observational study of 2,235 patients, they found that the average patient's physical and mental health outcomes did not differ between managed care and fee-for-service systems.³⁹ The elderly and poor in HMOs, however, were nearly twice and more than twice, respectively, as likely to decline in health compared to other patients in fee-for-service systems.⁴⁰

While the application of the patients' bill of rights to Medicaid would increase expenses, it is not an impractical concept. Many of the proposed reforms are similar to rights that have been established for publicly funded managed care plans associated with Medicare. Under Medicare regulations, patient protections include the right to external reviews, prohibitions of certain financial incentives for physicians, and standards establishing consumers' rights to access specialists and other services.⁴¹ Moreover, some states have similar protections for their Medicaid managed care plans. States may establish these patient protections through their contracts with MCOs.⁴² Reformers should examine these state contracts and choose those patient protections that have proven effective for uniform application across states.

V. PROMOTING EQUALITY THROUGH INFORMED CONSENT

The proposed patients' bill of rights establishes appellate review for patient challenges to denials of treatment by MCOs. While the procedural due process protections—including internal and external review procedures—are important in individual cases, they will only benefit a small percentage of managed care enrollees. Among those patients who are denied a treatment request, few seek external reviews. While the procedural rights of review are important patient protections, reform that is based on the principle of equality should have more expansive effects. In particular, the reforms currently proposed will not broadly impact the daily decisions and the important conversations that occur between physicians and patients. Empirical studies have pointed out that physicians, not MCOs, may be offering less care, even if medically necessary, to patients in managed care plans compared to those in fee-for-service arrangements. The advice and recommendations offered by physicians to patients ultimately impacts care to a greater extent than MCO policies or treatment denials.

Researchers at Harvard Medical School recently published a study regarding the preeminent importance of doctor-patient communications on health care in *The New England Journal of Medicine*.⁴³ They compared the

use of coronary angiography after acute heart attacks among Medicare beneficiaries in managed care plans and fee-for-service arrangements. They analyzed data from more than 50,000 beneficiaries and evaluated patient care based on guidelines proposed by the American College of Cardiology and the American Heart Association. Among those patients for whom angiography is useful and effective, 46% of fee-for-service beneficiaries underwent angiography compared to 37% of managed care beneficiaries. Thus, in situations where angiography is believed to be medically useful, physicians order it less often for those enrolled in managed care programs than for those in fee-for-service arrangements.

The study offered two other important conclusions. In both managed care and fee-for-service arrangements, the level of angiography use was much higher among patients initially admitted to a hospital with angiography facilities than among those admitted to a hospital without such facilities. Thus, the physical infrastructure of health care delivery may have a decisive impact on what is offered to patients. The most striking conclusion, however, is that physicians in both groups ordered angiography for less than half of those patients for whom it would have been medically useful.

Physicians have a greater impact on patient choices than MCOs. MCOs deny physician recommendations in just 3% of cases overall and in only 1% of cases involving hospitalization and surgical requests.⁴⁴ In cases where angiography is believed to be medically useful, physicians ordered it in less than half of the cases, whether or not their patients were in managed care or fee-for-service plans. If we are serious about protecting the choices of patients, we must focus reform on finding ways to profoundly influence physician-patient relationships and what physicians are recommending to their patients.

Dr. Jay Katz described in his book, *The Silent World of Doctor and Patient*,⁴⁵ the need in an age of medical science and sophisticated technology for more honest and complete conversations between physicians and patients. Although his book was published more than fifteen years ago, its message remains important in today's managed care settings. To achieve effective physician-patient relationships, we need to go beyond the banning of gag clauses in physician contracts or simply requiring MCOs to add more fine print in managed care contracts with patients. Managed care plans may provide an important infrastructure for educating physicians, identifying health priorities, and monitoring data to ensure that adequate treatments are more universally provided.

In addition, MCOs should make their treatment guidelines more accessible to patients through their physicians. For example, when a

patient suffers from a heart attack, a physician should discuss the evaluation and treatment options (including obtaining an angiogram) with the patient and his or her family. The physician should also disclose if the managed care plan's guidelines differ from national recommended guidelines, and should discuss the availability of angiography facilities. In short, to make the patients' bill of rights truly effective, reformers should move in the direction of enhancing physician-patient relationships in ways such as these.

VI. PROMOTING PUBLIC HEALTH THROUGH MANAGED CARE

The proposed patients' bill of rights does not address disparities in health care treatments and outcomes of racial/ethnic minorities. Physicians tend to pursue less aggressive therapies for African-American patients compared to white patients. Researchers affiliated with the Health Care Financing Administration (HCFA) analyzed Medicare administrative data from 1993 to study the relationship between race and the utilization of health care services.⁴⁶ These data demonstrated that physicians performed certain procedures—including mammography, coronary angioplasty, coronary artery bypass surgery, and hip repair surgery—less frequently on African-American patients. Many other research studies have confirmed some of these findings and have also shown that black patients receive fewer nephrology referrals, less frequent surgeries for lung cancer, and have generally poorer health outcomes.⁴⁷ Because managed care places increased economic pressures on physician judgments, there may be an increased likelihood of discriminatory results in treatments and health outcomes.

The results of one recently published study offered surprising and controversial results. The study included 147 Veterans Administration (VA) hospitals for six common medical diagnoses (pneumonia, angina, congestive heart failure, chronic obstructive pulmonary disease, diabetes, and chronic renal failure).⁴⁸ Prior studies of VA hospitals have indicated that there are racial differences in the treatment of specific diseases.⁴⁹ The more recent study found that African-American patients had lower mortality rates than whites for each of the six diagnoses.

Critics of this study pointed out that it is difficult to know if the empirical results are "real." It may be that the differences in outcomes between African-American and white patients were due to differences in the severity of their illnesses and other co-morbidities at the time of admission.⁵⁰ Even the authors of the VA study conclude that the outcomes may be attributable to the nature of the VA system as an equal-access health care system.⁵¹ The VA system has few financial barriers and may

therefore offer better access to care for African-American patients.

Obviously, further research needs to be done to better understand racial differences in treatments and outcomes. Researchers should study managed care systems where the financial pressures may be more pressing than fee-for-service systems. For example, researchers should conduct more empirical research on the effects of deductibles and co-payments, the quality of translational services, the presence of minority physicians, and the geographic proximity of health care delivery to minority groups.

The current debate over the proposed patients' bill of rights is an example of what Professor Mary Ann Glendon calls "rights talk."⁵² It tends to lead to discussions that ignore our responsibilities and "regularly promotes the short-run over the long-term, crisis intervention over preventive measures, and particular interests over the common good." Managed care plans should increase their collaboration with local and state agencies to improve access to health care programs by racial/ethnic minorities and the indigent. Public health programs include immunizations, injury prevention, diabetes detection and treatment, cancer screening, heart disease risk management, and protection from environmental hazards. Racial/ethnic minorities and the indigent are among the chief beneficiaries of public health programs because of the higher disease incidences, reduced access, and poorer health outcomes in their populations. Managed care plans may provide an important structure for collecting data, identifying priorities, supporting outreach programs, and promoting incentives to improve the success of public health activities.⁵³

Reformers should base their reforms on programs that have promoted public health through health care financing systems. An example of a successful Medicaid program is early periodic screening, diagnosis, and treatment (EPSDT) for children under twenty-one years of age. This program entitles children to vision, dental, hearing, and screening services. Studies have demonstrated that EPSDT programs can improve children's health, although their implementation has been limited to less than 40% of poor children.⁵⁴

EPILOGUE: THE CASE OF THE MISSING EQUAL PROTECTION CLAUSE

It is ironic that Congress has analogized the proposed reform in health care to the Bill of Rights in the U.S. Constitution and yet appears to create a patients' bill of rights that is missing an equal protection clause. After all, the most renowned civil rights case is *Brown v. Board of Education*.⁵⁵ Declaring that "education is perhaps the most important function of state and local governments," the U.S. Supreme Court held that the segregation

of public elementary schools based on race violated the equal protection of laws guaranteed by the Fourteenth Amendment. In its opinion, the Court rationalized its holding based, in part, on empirical studies of children taught in segregated schools that purportedly showed that their educational and mental development was retarded because of segregation.⁵⁶

The Court also issued a companion case, *Bolling v. Sharpe*,⁵⁷ on the same day as *Brown*. In *Bolling* the Court considered whether racial segregation in the District of Columbia public schools violated the Bill of Rights. Because these schools received federal funding, the Court could not, as it had in *Brown*, rely on the Fourteenth Amendment's equal protection clause that applies to state action. The Court had to interpret the Fifth Amendment that restricts federal action. Unlike the Fourteenth Amendment that contains both equal protection and due process clauses, the Fifth Amendment only has a due process clause. In *Bolling*, the Court thus considered the case of a missing equal protection clause. The Court nevertheless declared that "it would be unthinkable that the same Constitution would impose a lesser duty on the Federal Government,"⁵⁸ and required, therefore, that the District of Columbia public schools must be desegregated just as in *Brown*. The Court believed that segregation in public education should no longer be tolerated. Equality, in that context, was too important a principle to ignore.

Today, few would contend that the *Brown* or *Bowling* cases were incorrectly decided. Yet, we have learned that desegregating public school systems did not lead to true equality in education. Our ongoing struggle to provide adequate education and health care remain parallel and require our full commitment to promoting adequate quality in both public and private domains. We are confronted today with congressional proposals that would create a patients' bill of rights without an equal protection clause. If we proceed along our current pathway in health care reform, Congress will pass a patients' bill of rights establishing due process protections for middle-class citizens who are provided health insurance through their employers. Congress is not likely to entitle the poor who must rely on Medicaid programs to the same due process rights. The citizen belonging to a private managed care plan will be entitled by federal law to appeal denials of treatment, to have direct access to certain specialists, as well as other important rights. However, the Medicaid patient affiliated with the identical managed care organization may be denied the same treatment and may not be entitled to appeal the denial or have equal access to the desired providers. Based on available empirical research, the poor and the elderly suffer worse physical health outcomes in managed

care systems compared to fee-for-service plans, while this finding has not been found to be true for the middle class.⁵⁹ The largest disparities in health care delivery have been associated with race. By ignoring this empirical information, the proposed patients' bill of rights will re-enforce the segregation of health care between the "haves" and "have nots."

The Massachusetts Office of Patient Protections has yet to consider even a single patient complaint. If this trend continues, it will mirror the experiences in thirty-seven other states with similar offices where patients come in at a trickle.⁶⁰ The proposed patients' bill of rights should be more than a much ballyhooed gesture to support the middle-class who are enrolled in privately insured managed care plans. Instead, it should be a true bill of rights with due process and equal protection guarantees that ensure rights to decent medical care by all—including racial/ethnic minorities, the poor, and the elderly.

References

1. Raja Mishra, *Shortage of Cases for HMO Agency*, BOSTON GLOBE, Jan. 27, 2001, at A1.
2. *Id.*
3. *Id.* at A12. For additional state implementation information, see STEPHANIE LEWIS & KAREN POLLITZ, CONSUMER PROTECTION IN PRIVATE INSURANCE: STATE IMPLEMENTATION AND ENFORCEMENT EXPERIENCE, A REPORT FOR THE OFFICE OF THE ASSISTANT SECRETARY FOR PLANNING AND EVALUATION (U.S. Dep't of Health and Human Serv., No. HHS 100-97-0005, 2000).
4. Tiffany F. Theodos, *The Patients' Bill of Rights: Women's Rights Under Managed Care and ERISA Preemption*, 26 AM. J.L. & MED. 89, 89-90 (2000).
5. Anne E. Kornblut, *Bush, Gore Debate Education, Health*, BOSTON GLOBE, Sept. 1; 2000, at A26.
6. Dean M. Hashimoto, *The Future Role of Managed Care and Capitation in Workers' Compensation*, 22 AM. J.L. & MED. 233, 235 (1996).
7. Peter D. Fox, *An Overview of Managed Care*, in ESSENTIALS OF MANAGED HEALTH CARE 3 (Peter R. Kongstvedt ed., 2001).
8. Alycia C. Regan, *Regulating the Business of Medicine: Models for Integrating Ethics and Managed Care*, 30 COLUM. J.L. & SOC. PROBS. 635, 637 (1997).
9. See Note, *The Impact of Medicaid Managed Care on the Uninsured*, 110 HARV. L. REV. 751, 754 (1997).
10. See Edward Guadagnoli et al., *Appropriateness of Coronary Angiography After Myocardial Infarction Among Medicare Beneficiaries: Managed Care Versus Fee for Service*, 343 NEW ENG. J. MED. 1460, 1460 (2000).
11. Gail Marcus & John C. Thomson, *Sales and Marketing in Managed Health Care Plans: The Process of Distribution*, in ESSENTIALS OF MANAGED HEALTH CARE, *supra* note 7, at 540.
12. Kornblut, *supra* note 5.
13. See Richard I. Smith et al., *Examining Common Assertions About Managed Care*, in ESSENTIALS OF MANAGED HEALTH CARE, *supra* note 7, at 73-74; Robert H. Miller & Harold S. Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, HEALTH AFF., Sept.-Oct. 1997, at 7; Robert H. Miller & Harold S. Luft, *Managed Care Plan Performance Since 1980: A Literature Analysis*, 271 JAMA 1512 (1994).
14. See John E. Ware et al., *Differences in 4-Year Health Outcomes for Elderly and Poor, Chronically Ill Patients Treated in HMO and Fee-for-Service Systems*, 276 JAMA 1039, 1045 (1996).
15. See Gregory Acs et al., *Self Insured Employer Health Plans: Prevalence, Profile, Provisions, and Premiums*, HEALTH AFF., Summer 1996, at 266.
16. President Bush announced in his State of the Union Address that he continues to support the passage of a patients' bill of rights. The latest senate bill, S. 283, 107th Cong. (2001), is sponsored by senators John McCain and Edward Kennedy.
17. David Nather, *Plan Regulation: Managed Care Reform Returns to Congress with Revival of Democratic, GOP Proposals*, BNA's Health Care Daily Report, FED. NEWS, Jan. 25, 1999, at 3.
18. See *id.* at 1.
19. *Id.* at 2.

20. *Id.*
21. Theodos, *supra* note 4, at 90.
22. Employee Retirement Income Security Act, Pub. L. No. 93-406, 88 Stat. 829 (1974) (codified as amended in scattered sections of 26 U.S.C. & 29 U.S.C.).
23. Theodos, *supra* note 4, at 90.
24. See Nather, *supra* note 17, at 3.
25. *Id.* at 2.
26. *Id.* at 3.
27. 410 U.S. 113 (1973).
28. 448 U.S. 297 (1980).
29. H. Jack Geiger, *Race and Health Care – An American Dilemma?*, 335 NEW ENG. J. MED. 815, 816 (1996).
30. The U.S. Department of Health and Human Services issued regulations on January 19, 2001—two days before President Bush assumed office—that would provide modified protections for Medicaid patients in managed care programs. See Medicaid Program: Medicaid Managed Care, 66 Fed. Reg. 6228 (Jan. 19, 2001). Shortly after assuming his office, President Bush put the regulations on hold. Insurers, governors, and Medicaid directors have already begun to lobby to change the regulations by cutting back on patient protections.
31. Robert E. Hurley & Stephen A. Somers, *Medicaid Managed Care*, in ESSENTIALS OF MANAGED HEALTH CARE, *supra* note 7, at 684.
32. See Note, *supra* note 9, at 755.
33. Hurley & Somers, *supra* note 31, at 696.
34. See Note, *supra* note 9, at 756.
35. 530 U.S. 211, 221 (2000).
36. *Id.*
37. *Id.*
38. See Ware et al., *supra* note 14, at 1043-44. The study was unable to find differences in Medicaid patients in HMOs compared to fee-for-service plans, but the researchers concluded that the relatively small sample of Medicaid patients in the study did not allow it to rule out differences among Medicaid patients favoring either system. *Id.* at 1044.
39. See *id.* at 1046.
40. *Id.*
41. See Carlos Zarabozo & Jean D. LeMasurier, *Medicare and Managed Care*, in ESSENTIALS OF MANAGED HEALTH CARE, *supra* note 7, at 673.
42. Hurley & Somers, *supra* note 31, at 691.
43. See Guadagnoli et al., *supra* note 10, at 1461.
44. See Stefan C. Weiss, *Defining a “Patients’ Bill of Rights” for the Next Century*, 9 JAMA 856 (1999); C. Arnst et al., *Are HMOs Crying Wolf?*, BUS. WKLY., Aug. 3, 1998, at 83.
45. JAY KATZ, *THE SILENT WORLD OF DOCTOR AND PATIENT* (1984).
46. See Marian E. Gornick et al., *Effects of Race and Income on Mortality and Use of Services Among Medicare Beneficiaries*, 335 NEW ENG. J. MED. 791 (1996). This study is extensively discussed in Barbara Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135, 139-41 (1998).
47. Ashish K. Jha et al., *Racial Differences in Mortality Among Men Hospitalized in the Veterans Affairs Health Care System*, 285 JAMA 297 (2001).
48. *Id.*
49. *Id.*

50. See David H. Mark, *Race and the Limits of Administrative Data*, 285 JAMA 337, 337 (2001).

51. Jha, *supra* note 47.

52. MARY ANN GLENDON, RIGHTS TALK: THE IMPOVERISHMENT OF POLITICAL DISCOURSE, at xi (1991).

53. See Jeffrey P. Koplan & Jeffrey R. Harris, *Not-So-Strange Bedfellows: Public Health and Managed Care*, 90 AM. J. PUB. HEALTH 1824, 1824-26 (2000).

54. See Colleen A. Foley, *The Doctor Will See You Now: Medicaid Managed Care and Indigent Children*, 21 SETON HALL LEGIS. J. 93, 105 (1997).

55. 347 U.S. 483 (1954).

56. *Id.* at 494 n.11.

57. 347 U.S. 497 (1954).

58. *Id.* at 500.

59. See Ware et al., *supra* note 14.

60. See Mishra, *supra* note 1.

