Health Care for the Poor

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Summary. In 1989, Congress considered federal Medicaid legislation expanding eligibility for pregnant women and children, while the Health Care Financing Administration and the states began implementing expansions mandated under the Medicare Catastrophic Coverage Act of 1988 (MCCA). Congress also considered repealing important Medicare benefit expansions and limits on out-of-pocket expenses under MCCA. Although a few administrative developments and cases favored applicants for Hill-Burton coverage, the trend of the past few years to deny such coverage continued almost unabated. Several states passed or implemented legislative initiatives to protect the medically uninsured, while courts expanded protection for indigent patients under the federal antidumping statute.

I. Medicaid

A. Federal Legislative and Administrative Law Developments

1. Statutory Changes

In 1989, Congress took a breather after completing marathon changes in the Medicaid program as part of the Medicare Catastrophic Coverage Act of 1988 (MCCA). This year, rather than undertaking sweeping changes, Congress is considering legislation dealing with a few discrete Medicaid issues. Possible amendments include expansions of Medicaid coverage for pregnant women and infants; phased-in mandatory coverage of children up to 100 percent of poverty; mandatory hospice care; clarification of the MCCA spousal impoverishment provisions; expansion of the Medicare premium buy-in; and statutory codification of rules requiring reimbursement sufficient to assure adequate provider participation.

2. Federal Administrative Changes

During 1989, the Health Care Financing Administration (HCFA) proposed a number of important regulatory changes, but finalized few. Early in the year, HCFA proposed Medicaid eligibility rules that will conform federal regulations with recent (and not so recent) statutory amendments. By and large, these proposed policies were already in effect in the states, since they reflect statutory mandates found in omnibus legislation passed by Congress between 1981 and 1988. Among other things, HCFA has proposed mandatory Medicaid coverage for all
poor children under age six (under age seven as of October 1, 1989); mandatory pregnancy-related and postpartum services through the 60-day period beginning on the day pregnancy ends; mandatory Medicaid coverage for disabled widows between the ages of 60 and 64 who lose SSI eligibility and Medicaid because they become entitled to and receive social security disability benefits; and a mandatory requirement that Medicaid applicants and recipients provide information to assist the state in pursuing any third party who may be liable to pay for medical assistance.

Late in the year, HCFA issued another, massive set of eligibility proposals to implement recent (and not so recent) statutory changes. These proposals include a number of important interpretations of eligibility rules regarding, among other things, categorical eligibility, deeming, and the medically needy program.

As has been its practice for a number of years, many more policy changes were accomplished in HCFA's State Medicaid Manual issuances than in its regulatory promulgations. Important manual provisions implemented parts of MCCA and included sections on eligibility for Qualified Medicare Beneficiaries; coverage of poor pregnant women, infants, and children; income and resource eligibility rules for certain institutionalized individuals and certain individuals under home- and community-based waivers who have community spouses. In another transmittal, HCFA finally acquiesced to the numerous federal circuit court of appeal and district court opinions that limit income deeming in the Medicaid program to deeming from spouse to spouse and from parent to child.

**B. State Legislative and Administrative Developments**

States were busy in 1989 implementing mandatory and optional Medicaid expansions authorized by the MCCA and Congress's prior Omnibus Budget Reconciliation Acts. By the end of the year, 41 states had raised income eligibility for infants and pregnant women to at least the federal poverty level, and had extended coverage to 185 percent of the federal poverty level--the maximum allowed by the Omnibus Budget Reconciliation Act of 1987.

Indications are, however, that implementation may be a long way from actually providing benefits for eligible individuals. For instance, states are required to use Medicaid dollars to pay cost-sharing for Qualified Medicare Beneficiaries (QMBs). Not all states have implemented the provisions; others have questionable restrictions on coverage. In Michigan, legal services clients enjoined the state to implement the QMB program. In Ohio, clients filed suit to require the state to extend coverage to persons whose resources do not exceed 200 percent of the SSI resource limit; the state has limited eligibility to persons whose resources do not exceed its lower, section 209(b) resource limits.

With the expansion of eligibility for children and pregnant women, some states turned their attention to helping these groups actually obtain a Medicaid card. Following studies showing that applicants for Medicaid often fail to establish eligibility because of complications during the application process, a number of states took steps to shorten and simplify their Medicaid applications. Other states engaged in successful pilot projects, such as providing on-site Medicaid eligibility determinations at prenatal clinics for pregnant women. In Alabama, a
law was enacted providing that pregnant women who have been suspended from Medicaid because of fraud, abuse, or other deliberate misuse of the program may be reinstated if it is determined that continued coverage would be in the best interests of the unborn child. /16

Reacting to budgetary constraints, other states initiated Medicaid cutbacks. New York established the Medical Assistance Utilization Threshold System (MUTS) to limit the number of physician or clinic visits, laboratory tests, dentist visits, and prescriptions that a Medicaid recipient will be allowed to have each year. /17 One legal services program has challenged the legislation based on noncompliance with state administrative procedures. /18 Meanwhile, Oregon passed controversial legislation that would expand Medicaid eligibility to provide capitated, managed care to any resident with income below the federal poverty level. To offset costs, the state would pick and choose which benefits would be offered. This "rationing" system would rank services from the most to the least important, considering comparable benefits and costs. When funding does not cover all services on the list, the least important would be cut. Oregon Senator Robert Packwood has introduced special legislation in Congress to waive mandatory federal Medicaid laws and allow Oregon to ration services to the poor.

C. Litigation Developments

Federal courts continued to grapple with the responsibility of state Medicaid agencies to make independent disability determinations in 1989. The Eighth Circuit decided that a state Medicaid agency in a "1634 state" may adopt SSA's determination of disability for SSI purposes. /19 Section 1634 states have entered into agreements under which HHS's determination of SSI eligibility also serves as the determination of Medicaid eligibility; about half of the states have entered into such agreements. Similarly, in Oregon--a non-1634 state--a district court decided that, if SSA makes a "final determination" of SSI eligibility before the individual applies for Medicaid or within the Medicaid time limits (60 days), the state should adopt SSA's decision. /20 However, "final determination" was defined broadly to include only a decision that is no longer appealable due to the expiration of time limitations or a decision that fully exhausted administrative appeals.

Low Medicaid provider participation continued to plague most states. The American Medical Association Center for Health Policy Research reported that Medicaid provider participation decreased between 1984 and 1988. /21 In some states, these low levels reached crisis proportions, resulting in litigation brought by persons who could not find a provider in their community. On June 1, 1989, the California Department of Health Services entered into a partial settlement of a statewide class action regarding access of Medi-Cal recipients to maternity and dental care. /22 The state raised reimbursement rates to maternity care providers, implemented a number of changes to expedite the processing of physicians' claims for reimbursement for maternity care, and implemented outreach programs to providers and recipients. The dental portion of the case continues.

Also in California, the state appellate court ordered the Department of Health Services to comply with federal Medicaid regulations that require a ten-day notice to recipients and the opportunity for a hearing before termination, suspension, or reduction of coverage. The court also held that the opportunity for a hearing under the federal regulations includes the right to
continued Medicaid payments pending a hearing decision when the recipient requests a hearing before the end of the notice period. /23

During 1989, state Medicaid programs responded to the AIDS crisis. The state of Louisiana passed a law requiring the Medicaid agency to expedite eligibility for people with AIDS in 1988. Implementation was to occur in 1989. If preliminary review indicates a preponderance of evidence for presumptive Medicaid eligibility, coverage should begin immediately and continue until the Medicaid application is either denied or approved. /24

The Eighth Circuit affirmed a lower court decision in Weaver v. Reagen /25 that requires the Missouri Medicaid program to cover the life-prolonging drug AZT. The case also has important implications for general Medicaid amount, duration, and scope issues. The court found that states must provide Medicaid coverage for AZT to HIV-infected individuals who are eligible for Medicaid and whose physicians have prescribed AZT for their treatment, without regard to whether Food and Drug Administration (FDA) criteria for AZT treatment are met. (Missouri’s coverage regulations were virtually identical to the FDA’s approval statement for the drug.) The state argued that its reliance on the FDA’s approval statement was a reasonable exercise of its discretion to place limitations on covered services based on medical necessity and utilization controls. The court disagreed and found that the fact that the FDA has not approved a drug for a particular use does not necessarily bear on uses of the drug that are established within the medical community as medically appropriate. The court noted that the federal Medicaid statute and regulatory scheme create a presumption in favor of the medical judgment of the attending physician to determine the medical necessity of a particular treatment.

Courts also responded to challenges to state medically needy programs. In cases of note during the year, Illinois was ordered to allow Medicaid applicants to spend down both income and resources, /26 and California was prohibited from placing a one-month limit on old bills for medically needy spend down applicants. /27

II. Medicare

A. Legislative and Administrative Developments

At the time of this writing, major legislation affecting the Medicare program is making its way through Congress. Both houses, responding to complaints from elderly constituents upset about paying income tax surcharges to finance increased benefits under MCCA, have voted to repeal significant benefits and limits on out-of-pocket expenses granted by the Act. /28 Expanded skilled nursing facility benefits, prescription drug coverage, and the $1,370 cap on out-of-pocket expenses for Part B services appear to be doomed, although less costly benefits may survive. /29 Both the House and Senate bills repeal the income tax surcharge; however, the Senate version retains a flat premium to be paid by all beneficiaries. /30

Meanwhile, House and Senate committees responsible for FY 1990 appropriations have passed bills aimed at reducing the Medicare budget by between $2.8 and $3 billion. /31 Cost-
reducing measures include a new national fee scale, or resource-based relative value scale (RVS), designed to standardize reimbursement for physician and supplier services nationally. /32 Other provisions would prohibit physicians from balance-billing Medicaid patients and reduce fees for certain services and medical equipment items. Yet others would tighten enforcement of Medicare secondary payor provisions. /33 By contrast, certain providers and health delivery systems may receive a financial boost. Rural hospitals would receive increases in prospective payment system (PPS) rates, while Medicare HMOs would be reimbursed at 100 percent per capita instead of 95 percent. /34

HCFA published two sets of proposed regulations protecting beneficiary rights this year. The first set, published in January, establishes criteria for national coverage determinations. /35 In June, another proposed rule implemented the hospital discharge planning requirements of the Omnibus Budget Reconciliation Act of 1986 (OBRA-86). The regulations, which are awaiting approval by the new HCFA administrator, require hospitals to screen and provide discharge planning evaluations for "at-risk" Medicare patients. /36

HCFA also published major updates of portions of the Medicare Intermediary and Carriers Manuals in response to previous litigation and administrative developments. Pursuant to a decision expanding home health coverage for Medicare beneficiaries in Duggan v. Bowen, /37 HCFA revised sections of the Intermediary Manual to clarify criteria for coverage of these services. /38 HCFA likewise finalized carrier hearing procedures requiring expanded use of "on-the-record" Part B hearings, even when claimants have requested in-person hearings. /39

B. Litigation Developments

Decisions in several cases this year expanded Medicare beneficiary rights. Under a settlement in Sarrassat v. Sullivan, HCFA agreed to require skilled nursing facilities to give written notices of noncoverage to Medicare beneficiaries upon admission or upon a change in level of care and to require skilled nursing facilities to submit claims to Medicare at the beneficiary’s request. The agreement also prohibits nursing homes from billing beneficiaries before a Medicare determination is made. /40

A decision in Martinez v. Bowen opened the door to expanded rights for home health beneficiaries. The Tenth Circuit dismissed an HHS appeal of a 1987 district court remedial order granting pretermination hearings to home health beneficiaries, thus obligating HCFA to begin complying with the 1987 order. /41 Beneficiaries enrolled in HMOs received relief from bureaucratic delays at the reconsideration stage of appeal in a settlement in Levy v. Sullivan. /42 HCFA, which reviews all reconsideration requests made by Medicare enrollees, had allowed a backlog of appeals to accumulate over a two-year period. Under the settlement, HCFA agreed to assure that reconsiderations would be performed within 30 days of the request, to permit claimants ALJ review if they did not receive reconsideration decisions within 60 days, and to process the backlog of pending cases under these same timeliness standards. /43 Finally, in a victory for rehabilitation hospital patients, a federal district court ruled that denials of admissions, services, and Medicare coverage generally based on arbitrary rules of thumb violated Medicare law and that rehabilitation hospitals must base such determinations upon individualized assessments of the need for care. /44
C. Part B Appeals

The Part B appeals process has become further entangled with additional steps and delays. In Isaacs v. Bowen, the Second Circuit upheld HCFA’s practice of requiring a carrier hearing, even if the amount in controversy exceeds $500. In February, HCFA issued new carrier hearing guidelines mandating the use of “on-the-record” hearing decisions, even where beneficiaries have requested in-person hearings. Finally, Medicare claimants have filed a challenge to Office of Hearings and Appeals (OHA) practices at the ALJ hearing level. Challenged practices include excessive delays by the Part B Development Center in processing requests for hearing, designating a single ALJ in each region to hear Medicare cases, and violations of Administrative Procedure Act provisions forbidding administrative agency staff who perform investigative functions from participating in the final decision.

III. Hill-Burton

A. Uncompensated Care

One of the most important Hill-Burton developments this year came with an HHS Program Policy Notice setting forth a "clarification" of the Hill-Burton Act to require eligibility for aliens to receive uncompensated services. According to this notice, aliens' eligibility must be determined according to the same criteria used for American citizens. However, HHS stated that, in order to establish eligibility, aliens must have resided in the U.S. for at least three months. Further, eligibility is based on all income received, regardless of whether such income was received in U.S. or foreign currency. This requirement may create some difficulties for applicants seeking to provide adequate documentation for prompt eligibility determinations. However, it is important to note that hospitals remain obligated to act reasonably in requiring income documentation.

In its annual adoption of the revised poverty income guidelines, HHS again left facilities the option of employing the guidelines' definition of the term "family" or adopting their own definition. HHS recommended that a facility's definition of family be available in writing.

The affirmative Hill-Burton collection defense remained one of the most important tools available to litigants to enforce their entitlements under Hill-Burton. In Creditor's Protective Association, Inc. v. Flack, an Oregon appellate court held that hospitals must accept the Hill-Burton collection defense even after the 20-year uncompensated care obligation has expired. The court held that the patient was entitled to assert Hill-Burton eligibility as an affirmative defense to a hospital collection action when (1) the patient was eligible for uncompensated care at the time the services were rendered; (2) the patient made a proper request before the hospital had exhausted its Hill-Burton obligation; and (3) the hospital denied coverage after the patient had provided proof of income for the period relevant to the eligibility determination.
Despite these positive developments in securing eligibility, funds available for indigent care were threatened by several cases and HHS policy changes. One of the most serious setbacks was HHS's attempt to extinguish the two-day rule. Under the two-day rule, facilities were required to make eligibility determinations within two working days of the request for uncompensated services. Failure to do so resulted in noncredit for the care provided. Unfortunately, in Douglas Count Hospital v. Bowen, a federal district court invalidated the penalty of noncredit for violating the two-day rule as beyond the authority of the statute. In response to this decision, HHS issued a "Change in Assessment Policy" to extinguish the rule. HHS's decision to extinguish the two-day rule is being challenged in Mazon v. Flagstaff Health Management Corp. In this case, plaintiffs allege that the change, as well as its retroactive application, unconstitutionally violates their due process rights, and that HHS violated the Administrative Procedure Act by failing to proceed by appropriate rulemaking in making the change.

In another setback that will cost millions of dollars in uncompensated care, the Eighth Circuit held in Lile v. University of Iowa Hospitals and Clinics that hospitals may receive credit toward their uncompensated care obligations from reimbursement received under a state indigent care program. The court deferred to the Assistant Surgeon General's revised interpretation that credit should only be denied for governmental reimbursement when it is federal reimbursement, rather than state or local reimbursement.

Uncompensated care funds were also lost in a federal bankruptcy court decision, In re St. Mary Hospital, in which the court found that the Hill-Burton Act does not prevent a hospital that had previously received Hill-Burton funds from subsequently closing its operations and depriving the community of free medical services contemplated by the Act.

**B. Community Service**

Now that many facilities' 20-year obligations under Hill-Burton to provide uncompensated services are coming to a close, the community service obligations that last indefinitely are becoming the most important aspects of Hill-Burton law. These community service obligations require facilities to provide emergency service, which includes a liberal definition of women in labor; prohibit upfront deposits when persons have the ability to meet reasonable payment plans; prohibit denial of care based on the fact that a patient is not under the care of a physician with staff privileges; and require unconditional participation in Medicaid and Medicare, and participation in other third-party payor programs where third-party payment meets actual costs. Unfortunately, there is no case law on how to determine whether the third-party payor's rates meet "actual costs." This question is currently being litigated in National Rural Health Association v. Bowen, in which rural hospitals are arguing that they are not required to participate in Medicare because the Medicare reimbursement rates do not meet actual costs. This issue is also the subject of an administrative complaint in California charging that, where the state indigent program bases its rates on Medicaid rates, and where Medicaid rates are based on actual costs, participation in the state indigent program should also be mandatory.
As noted above, the community service obligations are also important because they prohibit denial of emergency care. Unfortunately, a Michigan appellate court adopted a restrictive interpretation of emergency care by holding that Hill-Burton does not require facilities to accept emergency patients who are transferred from another hospital. /64

IV. Medical Care for the Uninsured Poor

A. Legislative and Administrative Law Developments

A number of states have enacted legislation establishing broad new programs to insure significant portions of their medically uninsured. Maine has passed legislation establishing the Maine Health Program, which will provide Medicaid-level services for all minors with income up to 125 percent of poverty and adults with income up to 95 percent of poverty. /65 The Maine Department of Health Services, in conjunction with the University of Southern Maine, has started Maine Care, a state-subsidized, managed care demonstration program for small employers and self-employed people. /66

Oregon has adopted a law that would expand Medicaid eligibility to include all state residents with income below the poverty level. The expansion is paired with a controversial priority-setting process for rationing health care in the Medicaid program, and would require a federal waiver or federal statutory change to be fully implemented. /67 Hawaii, the only state to require most employers to provide health insurance, /68 has passed legislation establishing the framework for a state program to insure the remaining uninsured population. /69 Virginia's legislature has created an indigent care trust fund that will draw on both state and hospital contributions, with funds to be distributed to hospitals providing specified levels of indigent care. /70 Virginia also has passed legislation funding its State/Local Hospitalization Program for indigents, requiring counties to participate in the program, and standardizing eligibility requirements. /71 In the wake of significant hospital deregulation, Washington has passed legislation requiring hospitals and their medical staff to show maintenance of effort in their admissions of uninsured and high-cost patients; the legislation also contains "antidumping" emergency care provisions and a requirement that hospitals adopt charity care policies that presume that people with incomes at or below poverty are eligible for full charity care. /72

States also have moved to implement programs previously established by statute. In Massachusetts, Health Security Act /73 implementation includes final regulations for new state-funded programs to insure working disabled adults, disabled children, and working former Medicaid recipients. Under a sliding scale established by regulation, beneficiaries with incomes at or below 200 percent of the federal poverty income guidelines are not liable for premiums. /74 Phase-in programs, the first step toward covering the general uninsured population, also have begun in six states.

California has passed legislation implementing Proposition 99, a voter initiative passed in 1988. /75 The initiative, which levied an additional 25-cent-per-pack cigarette tax, will raise hundreds of millions of dollars for indigent health care, health education, physician services, research, and environmental programs; the funds must be used to supplement, not supplant,
existing services. Pursuant to statutes previously passed, /76 Wisconsin and Washington have instituted pilot programs subsidizing insurance for low-income uninsured people.

A number of states have adopted regulations governing hospitals' provision of uncompensated care. Massachusetts has promulgated new regulations defining eligibility for hospital inpatient and outpatient free care that is reimbursed by the state's Uncompensated Care Pool. Under the new regulations, anyone with income at or below 200 percent of the federal poverty income guidelines must be given free care if treated; hospital bills will be capped, based on a sliding scale, for people between 200 percent and 400 percent of poverty. /77 Louisiana has adopted regulations governing provision of free care at the state's charity hospitals. Under the regulations, persons with income at or below the federal poverty level will be eligible for free care; between 100 percent and 200 percent of poverty, there will be a sliding scale. /78 In New Jersey, new regulations require hospitals to post notice of the availability of free care under the state's uncompensated care trust program. Anyone who meets an asset test and who has income at or below 150 percent of poverty is eligible for free care; between 150 percent and 250 percent of poverty, there is a sliding scale. /79

Finally, states have continued to establish study commissions as a first step toward providing health coverage for the uninsured. This year, Minnesota, Iowa, and California passed legislation establishing groups to study the uninsured, /80 and Vermont passed legislation continuing and funding its previously established study commission. /81 In several states, including North Carolina, Texas, Virginia, Pennsylvania, Wisconsin, Washington, and Vermont, study commissions, legislative committees, public officials, and other groups announced comprehensive proposals to provide coverage for the uninsured.

Technical work undertaken for study commissions has become part of the national discussion. In both Vermont and Massachusetts, studies growing out of the work of special commissions on the uninsured focused attention on affordability of health care and insurance. Both studies examined the cost of necessities and concluded that, for all family sizes, people at or below 200 percent of poverty have no disposable income available for health care or insurance. Depending on family type, family size, and child care status, many families up to 250 percent or even 300 percent of poverty may not have disposable income available for health care costs. /82 These two studies have influenced the discussion, in their respective states and beyond, about the level of contribution to health care costs that realistically can be expected in programs designed to address the needs of the uninsured.

B. National Proposals, Hearings, and Reports

In 1989, comprehensive health coverage received increased national attention, not only from low-income clients and their representatives, but also from Congress, business leaders, providers, and academics. The Pepper Commission (United States Bipartisan Commission on Comprehensive Health Care) convened national hearings. In both the acute and the long-term care arenas, the Commission is looking at three approaches: (1) expanding or improving existing public programs such as Medicare and Medicaid; (2) improving the availability of private insurance; and (3) establishing a comprehensive "social insurance" plan in place of the current private insurance system. /83 The House Energy and Commerce Committee's Health
and Environment Subcommittee also held hearings on provision of adequate health care to the uninsured.

Several proposals for comprehensive national health coverage were introduced and widely discussed. Senator Edward Kennedy (D-Mass.) and Representative Henry Waxman (D-Cal.) introduced a new version of their Basic Benefits for All Americans Act. The bill would require employers to provide health coverage for workers and would expand Medicaid to cover other uninsured people. Congressman Ronald Dellums (D-Cal.) reintroduced his bill to establish a national health service.

The New England Journal of Medicine (NEJM) published two different proposals for universal health coverage. One, by Physicians for a National Health Program, urged a system based on a single public payor, in place of the current private insurance system, and a series of measures to regulate costs. The other, by Dr. Alain Enthoven of Stanford University and Richard Kronick, would require employers to provide insurance for most workers; other people would obtain insurance through government sponsors that contracted with competing plans. This program would include significant fiscal incentives for consumers to choose cost-effective plans. NEJM also published an article linking uninsured status to infant death and poor health outcomes, as well as editorials arguing for universal health coverage.

The National Leadership Commission on Health Care also released a proposal for universal coverage, based on a "play-or-pay" provision (a requirement that employers who do not provide coverage pay a tax) and a residual public program. The Health Security Partnership, a group of leading health care experts, offered a proposal for universal coverage based on state and territorial administration within federal guidelines; the proposal includes a systemic approach to cost containment and relies on prospective budgeting within each major element of the plan.

C. Litigation

The California Court of Appeals held that indigent mental health services were the subject of a distinct statutory scheme that limited counties' financial liability, and accordingly were not part of counties' more general, and financially unlimited, obligation to provide necessary health care for their indigent residents. In another case, the court also held that a general statute directing counties to "relieve and support" their indigent residents and to provide aid "humanely" required the provision of nonemergency dental services needed to remedy substantial pain or infection.

In an en banc decision, the Supreme Court of Arizona held that both the state and counties have a statutory duty to provide the full continuum of community mental health care to all chronically mentally ill individuals who would reasonably benefit. And, in a civil rights suit alleging that the state made counties use stringent verification and documentation requirements that impeded indigent access to care, the Arizona Court of Appeals upheld plaintiffs' right to try several counts on the merits.
V. Emergency Room Law

At the time of this writing, Congress was considering amendments to clarify and strengthen the antidumping statute. A bill approved by the House Ways and Means Committee would require hospitals to post notices informing patients of their rights under the statute and to maintain records of every transfer to and from the emergency room. The bill would also impose statutory physician obligations upon on-call and attending physicians and would provide "whistleblower" protections for physicians who refuse to transfer an unstable patient. Finally, the bill would also impose a stricter standard of liability on hospitals and would strengthen enforcement provisions.

Two cases brought by indigent patients under the COBRA statute have upheld the rights of individual patients to sue for damages. In Maziarka v. St. Elizabeth Hospital, the court held that the plaintiff had standing because the antidumping statute expressly provides that anyone harmed by a violation of the statute may obtain damages and equitable relief. In Bryant v. Riddle Memorial Hospital, the court held that Congress had intended to create a private cause of action for plaintiffs alleging harm caused by violations of the statute.

Two other cases addressed the issue of damages available to dumping victims under the statute. In Reid v. Indianapolis Osteopathic Medical Hospital, Inc., the court held that the antidumping statute provision limiting damages to the amount available under state personal injury law incorporated the state's law capping damages for medical malpractice. By contrast, the court in Wilson v. Atlancare Medical Center stated in dicta that the state's law requiring that medical malpractice claims be submitted to a tribunal may also apply to claims brought under the federal statute.

Finally, an HHS administrative law judge fined a Texas physician $20,000 for ordering the transfer of an uninsured woman in active labor. This is the first fine imposed on a physician under the antidumping law.

footnotes

1. For further discussion of these changes, see National Health Law Program, Health Advocate: Special Issue (Fall 1988); National Health Law Program, Health Care for the Poor in 1988, 22 Clearinghouse Rev. 981 (Jan. 1989).
10. Id.
17. N.Y. Dep't of Social Servs. Regulations 500 et seq.
24. La. Act 674 (July 15, 1988) (if final determination of ineligibility is made, the law provides that the individual must reimburse payments made by the agency).
27. Hunt v. Kizer, No. 2-89-836 EJG (E.D. Cal. Aug. 28, 1988) (Clearinghouse No. 44,761). See also California Dep't of Health Servs. v. HHS, 853 F.2d 634 (9th Cir. 1988) (Clearinghouse No. 43,284).
29. The Senate version would retain unlimited hospitalization; up to 38 days of full-time home health care; coverage for IV and immunosuppressive drugs, starting in 1991; mammograms and respite care.
30. This premium was $4.00 in 1989 and is scheduled to increase to $4.90 in 1990 and to $10.20 by 1993. Beneficiaries would pay this premium in addition to the regular Part B premium.
34. On October 13, 1989, the Senate voted to eliminate a number of provisions from the reconciliation bill including RVS and Medicare secondary payor provisions. They may be voted upon separately.
43. Id.
52. 42 C.F.R. Sec. 124.508(a).
53. The rule was adopted pursuant to Corum v. Beth Israel Medical Center, 373 F. Supp. 550 (S.D.N.Y. 1974), which held that failure to give "prompt notice" would result in noncredit.
60. 42 C.F.R. Secs. 124.601-607.
68. Hawaii Prepaid Health Care Act, Laws of 1974, Chapter 210. This is permitted by an exception to the federal ERISA law's preemption, 29 U.S.C. Sec. 1144(b)(5).
76. 1987 Wis. Laws ch. 27; 1987 Wash. Laws, 1st Extraordinary Sess., ch. 5.
77. 117 Mass. Regs. Code Secs. 2.00 et seq.
78. La. Admin. Code Tit. 48, Sec. 9010.
96. Id.
97. 42 U.S.C. Sec. 1395dd.