12TH ANNUAL REVIEW OF POVERTY LAW

- Child Support
- Consumer
- Economic Development
- Education
- Employment
- Families
- Health
- Housing
- Immigration
- Medically Dependent
- Mental Health
- Migrants
- Seniors
- Veterans
- Welfare
- Youth

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Summary. During 1991, important Medicaid provisions of OBRA-90 were implemented, several of which improved coverage for pregnant women and children. Many states, responding to recessionary fiscal constraints, proposed Medicaid cuts, and an HCFA proposal to limit state use of provider-specific taxes, threatened further cuts. Oregon's highly publicized "rationing" plan was submitted for federal approval. OBRA-90 Medicare amendments included coverage for mammograms and revised Medigap insurance regulation. In a landmark ruling, a federal district court invalidated an HHS regulation that restored $31 million in previously denied Hill-Burton credit to hospitals. Several states passed legislation expanding health coverage for the uninsured, but cuts were made as well. Numerous proposals were introduced to produce more universal health coverage. A number of cases interpreted consumer rights under the COBRA health insurance continuation and hospital antidumping laws. Low-income people continued to litigate their rights under federal and state health programs.

I. Medicaid

A. Federal Developments

The Omnibus Budget Reconciliation Act of 1990 (OBRA-90) /1/ adopted numerous Medicaid changes. /2/ Several provisions made further improvements in coverage for children and pregnant women, including mandatory coverage of all children born after September 30, 1983, with family incomes up to 100 percent of the federal poverty level; /3/ mandatory continuation of coverage for pregnant women through the postpartum period; /4/ mandatory continuation of coverage for infants until age one; /5/ a requirement that states accept and process applications for pregnant women and children born after September 30, 1983, at "outstationing" locations, including disproportionate share hospitals and federally qualified health centers; /6/ liberalization of the pregnant women presumptive eligibility option; /7/ and exemption of pregnant women from the requirement to cooperate in establishing paternity and obtaining child support. /8/
OBRA-90 clarified the states' option to make disability-based Medicaid determinations, even after a disability determination is made for the same individual by the Social Security Administration (SSA), until the time that SSA's determination is "final." /9/ The enactment represented a partial repudiation of controversial federal rules that had provided that SSA's initial determinations of nondisability were binding on Medicaid agencies. /10/

OBRA-90 substantially revised Medicaid's prescription drug coverage rules. When a drug manufacturer enters into a special rebate agreement with a state, the state must, subject to certain exceptions, cover all of that manufacturer's "covered outpatient drugs." /11/ State prior authorization systems must provide 24-hour telephone response and permit three-day drug supplies in emergency situations. /12/ OBRA-90 also improved and clarified existing Medicaid coverage requirements on home and community-based services, medically needy eligibility, Qualified Medicare Beneficiary coverage, spousal impoverishment, and alcohol and drug treatment. /13/ Another OBRA-90 provision of note requires institutional Medicaid providers to inform their adult patients about state law rights to health care treatment decisionmaking, including the right to make "advance directives." /14/

OBRA-90 also confirmed states' ability to use provider-specific taxes to help fund their Medicaid programs. /15/ A large number of states have adopted such taxes to preserve--and in some cases expand--coverage. The OBRA-90 provision was adopted in response to Health Care Financing Administration (HCFA) regulatory proposals effectively to gut the use of such funding. However, despite the OBRA-90 amendment, in September 1991, HCFA adopted a controversial new rule severely limiting states' ability to use provider-specific taxes, effective in 1992. /16/ Following hearings in October, legislation was introduced to bar HCFA from implementing the new rules. /17/

B. State Developments

1. Cutbacks

Responding to recessionary fiscal constraints and a 23-percent increase in program spending, /18/ at least half of the states sought to impose cuts in Medicaid eligibility and services in 1991. /19/ Thus, for example, Illinois, Massachusetts, Michigan, and Ohio sought to cut coverage for general assistance recipients; Florida and Connecticut reduced medically needy eligibility levels; California, the District of Columbia, and Michigan reduced AFDC payments, resulting in diminished Medicaid eligibility; and Florida, Massachusetts, Michigan, Missouri, Montana, Nevada, Washington, and other states all sought to institute various cuts and restrictions in services covered. /20/

Furthermore, states continued to show interest in mandatory managed care programs. /21/ Several states, including California, Illinois, Massachusetts, and New York, adopted legislation mandating increased utilization of such programs. New York's plan was scheduled to go into effect in the fall of 1991. /22/
Advocates experienced some success in protecting clients from some of these cuts. In Florida, after the state reduced its medically needy eligibility level, a federal court required the state to redetermine individuals' eligibility for Medicaid on other grounds before terminating their medically needy benefits. Florida state courts relied on due process and lack of gubernatorial authority, and a federal court in New York relied on inadequate notice to beneficiaries to enjoin cutbacks in eligibility and services.

The State of Oregon has developed a highly publicized proposal to revise its Medicaid program. Families and children with incomes up to the federal poverty level will be covered; however, service coverage will be limited to those services on a prioritized list that the state elects to fund. Because the proposed program is inconsistent with numerous federal Medicaid requirements, special permission must be obtained from HHS to implement it. In August, Oregon submitted a waiver request seeking such permission; a decision was expected by early 1992.

The Oregon rationing proposal is controversial because it focuses on poor women and children; because it consciously excludes medically necessary services, based in part on a "cost/benefit" analysis; because of questions about the manner in which the priorities were established; and because of questions about whether the state will fund an adequate number of services.

2. Provider Participation

Considerable attention has been focused on the difficulties that Medicaid beneficiaries experience in finding providers who will serve them. In the Omnibus Budget Reconciliation Act of 1989 (OBRA-89), Congress codified a regulatory requirement that reimbursement rates be sufficient to provide beneficiaries with access to services equal to that available to the general population in the beneficiary's area. In 1990, the district court held in Clark v. Kizer that California's reimbursement rates for dentists violated these requirements. Last year, a congressionally mandated commission recommended that Medicaid payment rates be raised to Medicare levels to promote access.

OBRA-89 required states to submit their reimbursement rates for obstetrical and pediatric services by April 1st of each year for federal approval. In 1991, the second year for these submissions, HCFA approved 34 states' submissions, disapproved the plans of 17 other states, and held at least four administrative hearings on disapproved plans. However, HCFA's substantive guidelines for making such decisions remain unclear.

3. Early and Periodic Screening, Diagnosis, and Treatment

Congress recently enhanced the scope of the critically important Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid service for children. During 1991, federal administrative actions helped clarify important features of EPSDT coverage. An HCFA oversight review found that Texas's program violated federal requirements by imposing "amount, duration, and scope" limits on treatments, and by denying treatments for conditions
whose existence was known prior to an EPSDT screen. /37/ The review was guided by a 1991 HCFA policy transmittal. /38/

Another important HCFA policy memorandum clarified that lead blood level assessments must be included for all children through age five as part of mandatory EPSDT screens. /39/ Such tests are necessary to detect lead poisoning, one of the most widespread and debilitating conditions affecting poor children. /40/ Plaintiffs in California successfully challenged the state's failure to require lead blood assessments. /41/ In October, the federal Centers for Disease Control announced a lowering of the lead blood level that defines lead poisoning. /42/ HCFA has indicated that it will incorporate this new standard in EPSDT. /43/

4. Long-Term Care

Advocates in California obtained a preliminary injunction against the state's failure to implement the nursing facility quality-of-care improvements mandated by OBRA-87. /44/ However, the litigation was partly overshadowed by a dispute between California and HCFA that resulted in a potential dilution of the guidelines used by surveyors to assess nursing facility compliance. /45/

Advocates had several successes in improving coverage under home and community-based (HCB) long-term care programs. Two significant decisions involved Colorado's program. In one case, the federal court found that the state's eligibility screens conflicted with the Medicaid Act and due process. /46/ In a second case, a state appeals court reversed the lower court's ruling that Colorado was not obligated to implement its statewide program in all counties. /47/ A state court in Delaware held that due process prohibited HCB services from being terminated without proof that a beneficiary's condition has changed. /48/

5. Other Litigation Developments

During 1991, courts reached conflicting decisions on the application of Medicaid's "availability" rule. /49/ A federal court in Minnesota found that the state had violated the rule by counting court-ordered support payments in the payor's income. /50/ However, federal courts in Alaska /51/ and New York /52/ reached the opposite conclusion. The Ninth Circuit rejected an availability argument in upholding Oregon's right to apply the AFDC lump sum disqualification rule to Medicaid. /53/ A federal court in New York found that the state's reliance on stale data when implementing a reduction in resource eligibility levels violated the availability rule. /54/

Action in two cases followed the OBRA-90 amendment on Medicaid disability determinations. The Ninth Circuit remanded a case that had partially rejected HCFA's pre-OBRA-90 policies. /55/ Advocates in Utah settled the Perea case, /56/ the last pre-OBRA-90 decision to invalidate HCFA's policy. /57/

The Tenth Circuit upheld HCFA's policy requiring physical therapy to be provided as part of mandatory "outpatient hospital" services. /58/ Three cases in California provided guidance on
eligibility and services coverage where Medicaid's citizenship requirements are at issue. The California Court of Appeals addressed the scope of "limited scope" Medicaid services /59/ and the prohibition on requiring individuals seeking such coverage to provide information on immigration status. /60/ A federal court confirmed that Medicaid eligibility cannot be denied or delayed pending documentation of satisfactory immigration status or receipt of INS verification. /61/

II. Medicare

A. Legislative and Administrative Developments

OBRA-90 adopted several provisions of special interest to beneficiaries, /62/ including coverage of "screening mammography" for early detection of breast cancer; /63/ limited coverage of injectable drugs for osteoporosis; /64/ establishment of Part B premiums for the next five years; /65/ increase in the annual Part B deductible to $100; /66/ and substantial revision of the regulation of Medicare Supplemental ("Medigap") Insurance policies and sales practices. /67/ OBRA-90 also adopted a treatment decision/advance directives requirement for Medicare-certified facilities /68/ virtually identical to that adopted under Medicaid. /69/

Two regulatory initiatives received considerable publicity: a proposed rule establishing national physician fee schedules due to become effective in 1992, /70/ and a "safe harbor" rule specifying various provider practices deemed to be exempt from antikickback sanctions. /71/ Significant cuts incorporated in the fee schedules were roundly criticized, and the schedules were subsequently withdrawn. /72/ Less noticed were administrative actions more directly affecting beneficiaries, including proposed regulations on aggregation of claims for appeals; /73/ new policy manual provisions detailing HMO appeals processes; /74/ and a memorandum to intermediaries reiterating that "rules of thumb" cannot be used to assess skilled nursing coverage. /75/

One study reported that government failure to publicize Qualified Medicare Beneficiary coverage /76/ had resulted in fewer than half of all potentially eligible individuals' obtaining coverage. /77/ The General Accounting Office issued a report criticizing PRO (Peer Review Organization) quality monitoring of Medicare HMOs. /78/ Complaints were aired alleging improper telemarketing and other abuses in the durable medical equipment industry. /79/

B. Litigation

The Third Circuit upheld Pennsylvania's "balance billing" law against claims that it was preempted by the Medicare Act. /80/ A federal district court overturned Medicare's restrictive interpretation of the skilled nursing facility transitional coverage provision of the Medicare Catastrophic Coverage Repeal Act. /81/ Summary judgment motions were heard in two cases challenging "national coverage decision" rules. /82/
III. Hill-Burton

A. Flagstaff Medical Center v. Sullivan

In Flagstaff Medical Center v. Sullivan, /83/ a federal district court found that HHS had illegally made a retroactive change in the "two-day rule," /84/ and that Flagstaff Medical Center (FMC), in Flagstaff, Arizona, had illegally abandoned its Hill-Burton obligations in 1980. As a result, all eligible indigent patients who received care from FMC between 1980 and 1990 are entitled to refunds and to cancellation of outstanding debts. In addition, FMC owes more than $400,000 in prospective care to the community. Indigent patients also raised charges against FMC based on the Arizona consumer fraud statute, the Arizona Anti-Racketeering Act, and state contract law. Proceedings on the consumer fraud and racketeering charges, and an application for attorney fees based on state contract law, are currently stayed pending an appeal in the Ninth Circuit. /85/

The court's invalidation of the two-day rule may have a national impact of up to $31 million in additional funds for uncompensated care for indigents. Prior to 1987, HHS prohibited Hill-Burton facilities that failed to make eligibility determinations within two days of a patient's request for uncompensated care from taking credit for the care that they provided. In 1987, HHS adopted new regulations that set forth weaker requirements under which hospitals would be held to a "substantial compliance" standard. /86/ Under the substantial compliance standard, hospitals that failed to make two-day determinations were no longer denied credit automatically, but were reviewed on an individual basis for systematic violations.

In 1988, HHS adopted an "interpretive change" that retroactively reinstated credit to all facilities that, prior to 1987, had been denied credit as a result of failure to comply with the two-day rule. /87/ The result was that HHS automatically reinstated $31 million in credit nationwide to facilities that previously had been denied credit as a result of their failure to comply with the two-day rule--including $41,547 to FMC.

In Flagstaff Medical Center, the court invalidated the 1988 retroactive change, finding that it was inconsistent with the Hill-Burton Act and that it was adopted in violation of the Administrative Procedure Act's notice and comment requirements. HHS is appealing this decision.

B. Definition of "Facility"

In a program policy notice, HHS enunciated a shift in policy to permit Hill-Burton facilities to obtain credit for uncompensated care provided in structures that are not physically connected to the structure that actually received the Hill-Burton assistance. /88/ The notice stated that, in order for the facility to obtain credit, the assisted and unassisted structures must be part of the same corporate entity and must be located within the same health service area. Facilities wishing to obtain credit for care provided in unassisted structures must provide documentation establishing that the above requirements are met. In addition, all Hill-Burton regulatory
requirements apply to the assisted structure, including community service requirements, and failure to comply may subject all care provided, in either the assisted or unassisted structure, to noncredit.

The National Health Law Program followed up this policy notice with a letter to the HHS Region IX Office for Civil Rights (OCR) asking whether community service obligations apply to services provided in a "building" that is outside of the facility that originally received Hill-Burton assistance. OCR responded by stating that "facility" refers to the entity or hospital itself, not just to a particular building. /89/ Therefore, services in all parts of the facility are subject to the community service requirements. The letter noted, however, that when the facility operates at two or more "independent" sites, it is not clear whether the obligation applies to each site, and determinations would need to be made on a case-by-case basis.

IV. Health Care for the Uninsured Poor

A. State Developments

1. Legislative and Administrative Developments

A number of states passed legislation expanding health care for the uninsured or implementing previously passed legislation; others cut back on existing commitments.

Kentucky passed and implemented legislation establishing a hospital indigent care program funded by provider assessments and federal Medicaid matching funds. /90/ The Minnesota Legislature passed a universal health bill, including a new state program subsidizing coverage for individuals and small groups, as well as extensive insurance market reform; the bill was vetoed by the governor. /91/ New Connecticut laws provided for grants to community-based primary care providers, obligated primary care providers participating in a state loan repayment program to provide free care and to accept Medicaid and Medicare assignment, and established a task force to recommend a program through which health care professionals donate their services to the uninsured and underinsured. /92/

Maine passed legislation requiring certificates of need for nonhospital technology; Maine also continued the Maine Health Program, a program of subsidized insurance, but froze new intake. /93/ Georgia passed laws extending its certificate of need requirements to nonhospital technology and giving the state health planning agency authority to impose free care requirements on facilities as a condition of approving certificates of need. /94/

Idaho adopted medically needy Medicaid coverage, repealed the previous year's legislation transferring responsibility for the medically indigent from the counties to the state, and created a task force to assess all relevant issues associated with providing health coverage for the uninsured. /95/ New Jersey continued its Uncompensated Care Trust Fund for an additional year, until the end of June 1992, and adopted a number of other reforms, including subsidized
prenatal care and a variety of cost-containment measures. /96/ Rhode Island, Vermont, and Louisiana passed laws limiting traditional, small group insurance underwriting and marketing practices, such as differences in rates attributable to health status, cancellation of policies because of high medical claims, and use of preexisting condition exclusions and waiting periods. /97/

The Oregon Health Services Commission completed its list setting priorities for health services for both the Medicaid program and other programs slated to provide health coverage for other uninsured people. /98/ Pursuant to previous legislation, Washington promulgated regulations establishing eligibility standards for free hospital care. /99/ California established its Major Risk Medical Insurance Board, providing health coverage for otherwise uninsurable Californians. /100/

Massachusetts enacted a three-year delay, until 1994, of the "play or pay" program, under which employers who do not insure their workers will have to pay taxes to support a public program providing health coverage for the uninsured. /101/ Illinois eliminated its state-funded Aid to the Medically Indigent (AMI) program and cut back on General Assistance medical coverage, eliminating hospital services for adults. /102/ Virginia cut funding for its indigent health care trust fund by 50 percent. /103/

Several states passed legislation allowing insurers to sell "bare bones" health insurance policies, exempt from state-mandated insurance benefit laws, to certain small groups. /104/ These laws are frequently proposed as a means of making insurance more affordable to small businesses. However, reports by Families U.S.A. conclude that elimination of mandated benefits neither addresses the problem of rising health costs nor meaningfully addresses the needs of the uninsured. /105/

Bills in at least 13 states proposed single-payor universal health systems. /106/ The Montana legislature passed a resolution urging the adoption of a national, single-payor health plan. /107/ State commissions on the uninsured completed their work and released reports in a number of states, including Minnesota, New Jersey, and Maine (Health Insurance Continuity Task Force). /108/

2. Litigation

Challenges to health facilities' tax-exempt status could reemerge as a handle for requiring more adequate provision of charity care. The Texas Attorney General sued Methodist Hospital, the largest nonprofit hospital in the state, seeking to revoke the hospital's tax-exempt status under state law for the hospital's failure to provide sufficient charity care. /109/ Pursuant to previously decided litigation, the Utah State Tax Commission released final property tax exemption standards, which included requirements that hospitals make their services available to patients regardless of ability to pay and that a hospital's "gift" to the community exceed its potential property tax liability. /110/ Allegheny County, Pennsylvania, pursued administrative remedies challenging the tax-exempt status of eight Pittsburgh-area hospitals. /111/
For the second year in a row, a Kansas court issued a temporary restraining order enjoining reductions in both eligibility and services (including hospital coverage, substance abuse treatment, and mental health) in the state's General Assistance program and in the "Medi-Kan" program of health care for General Assistance recipients. Plaintiffs contend that the state constitution requires provision of necessary services. /112/

A California superior court has ruled that county medical care recipients are entitled to notice and hearing whenever providers are denied payment. /113/ Other California courts enjoined reductions in county health care programs, /114/ and one county entered into a settlement agreeing not to implement previously planned cutbacks challenged on the basis of statutory mandates and notice requirements. /115/ Finding that plaintiffs lacked standing, the California Supreme Court rejected taxpayers' suit to establish, pursuant to a "spending limit" provision in the state constitution, a state duty either to reinstate the state's indigent health care program or to finance new county indigent health care obligations. /116/

B. Federal Developments

Several bills in Congress propose solutions to both the problem of the uninsured and the health cost crisis affecting the whole health system. At least three major reform bills propose a "play or pay" approach patterned on the recommendations of last year's Pepper Commission Report. These bills would require employers either to provide a required level of health benefits or to pay a tax supporting a new public program; they also would substitute an expanded public program for the current Medicaid program and would impose a range of restrictions on traditional insurance underwriting and marketing practices that limit availability of health insurance. /117/

Another series of bills proposes "single-payor" solutions in which a single public program covering all Americans would take the place of the current "multi-payor" system of private insurance and public programs. /118/ The credibility of "single-payor" proposals may be bolstered by a General Accounting Office (GAO) report stating that savings achieved by applying the universal coverage and single-payor features of the Canadian system to the United States would be more than enough to cover all currently uninsured Americans. /119/

Other bills do not provide for universal coverage, but attempt to make private insurance more available through features such as tax incentives, preemption of state health benefit mandates, premium subsidies, and limits on traditional insurance underwriting and marketing practices. /120/ One provision of OBRA-90 establishes a tax credit for low-income families who buy health insurance or participate in a health plan that covers a child. /121/

Bills in the House of Representatives propose new standards tying health care facilities' federal tax exemptions to provision of charity care. /122/ The federal law and rulings governing tax-exempt status have not changed in several years, and the GAO has called for stricter standards. /123/ The Internal Revenue Service has intensified its scrutiny of indigent care provided by nonprofit hospitals. /124/
Numerous proposals by interest groups and health policy commentators received widespread attention in 1991. The Journal of the American Medical Association, stating that "an aura of inevitability is upon us," devoted a special two-volume issue to showcasing a broad range of proposals for coverage of the uninsured, including the AMA's employer mandate proposal, Physicians for a National Health Program's single-payer proposal, and the Heritage Foundation's proposal to require heads of households to purchase insurance and substitute a system of refundable tax credits for the current tax exclusion for company-provided plans. /125/

Position papers and proposals have been published by many other groups, including the 1989 Advisory Commission on Social Security (Steelman Commission) (Medicaid expansion); the National Governors Association (reform of Medicaid, including federal takeover of long-term care costs, encouragement of state experimentation, and removal of federal barriers such as ERISA preemption); the American Hospital Association (phased in combination of employer-based coverage and a public program); the American Nurses Association ("play or pay," with emphasis on primary care and maternal and child health); the AFL-CIO (national health insurance as a long-term goal, more modest reforms for the present); the National Commission on Children ("play or pay," including preventive and prenatal care); the Blue Cross and Blue Shield Association (insurance underwriting reforms, "bare bones" policies, Medicaid expansion); and the Health Insurance Association of America (insurance underwriting reforms).

V. COBRA Continuation Coverage

A. Federal Legislation

Under amendments made by OBRA-90, states may use Medicaid funds to pay COBRA insurance premiums for those individuals (1) who are entitled to COBRA continuation coverage under a group health plan of an employer with 75 or more employees, (2) whose incomes do not exceed 100 percent of the federal poverty level, and (3) whose resources do not exceed twice the SSI limit. States, however, must determine that payment of COBRA premiums will likely result in cost savings as compared to expected Medicaid expenses. /126/

B. Litigation

Generally, federal law provides that COBRA continuation insurance coverage will terminate when a person either becomes covered under another group health plan or becomes entitled to Medicare. /127/ It is not clear, however, whether COBRA continuation coverage is available to individuals who are already covered by another insurance policy or who are entitled to or already receiving Medicare when a COBRA qualifying event occurs. In National Companies Health Benefit Plan v. St. Joseph Hospital of Atlanta, /128/ the Eleventh Circuit held that, unless a "significant gap" in coverage exists without the COBRA continuation policy, the
preexisting coverage is a bar to election of COBRA coverage. This decision is consistent with a Fifth Circuit case, /129/ but contrary to a Tenth Circuit case. /130/

National Companies also stands for the proposition that employers may be equitably estopped from denying COBRA coverage to individuals who otherwise would have been ineligible for the coverage, when those individuals have relied upon representations by the employers (such as relying upon assertions that the individual is eligible for COBRA coverage and, as a result, forgoing securing other insurance coverage). /131/

One court held that the COBRA 60-day election period is a minimum--not a maximum--election period, and that incapacity during the election period tolls the running of the election period. /132/ The Fifth Circuit addressed how to determine whether an employer falls within the "fewer than 20 employees" exemption for COBRA obligations, and what an employer's liability is for failure to give COBRA rights notice. /133/

VI. Patient Dumping

Several courts have ruled on various issues under the hospital patient antidumping statute. /134/ Burditt v. HHS /135/ upheld civil penalties assessed against a statutorily defined "responsible physician" for violating antidumping provisions respecting an emergency medical condition (in this case, active labor) and treatment versus transfer. The court held that the physician could not have stabilized the medical condition of the patient without treating her. Furthermore, the court held that the physician had transferred the patient without meaningfully determining whether the risks of the transfer were outweighed by the benefits of treatment at another facility. The Burditt analysis is useful in both pregnancy-related cases and cases unrelated to pregnancy.

The District of Columbia Circuit has ruled that the antidumping statute's medical screening and treatment protection extends to any individual, regardless of whether the individual is insured. /136/ The court also held that the right to "appropriate medical screening" requires that the same level of treatment be provided to all patients in similar medical circumstances. The court rejected the theory that a misdiagnosis violated the medical screening provisions of the statute. /137/

The Tenth Circuit has ruled that defendant hospitals bear the burden of proving that a dumping violation has not occurred because the patient refused treatment, and that jury instructions stating that patient-plaintiffs bear the burden of showing that they did not refuse treatment are reversible error. /138/

footnotes


3. 42 U.S.C. Secs. 1396a(a)(10)(A)(i)(III), 1396a(a)(10)(A)(i)(VII), 1396a(l)(1)(D), 1396a(l)(2)(C), and 1396d(n)(2). Eventually, all such children through age 18 will be covered. States must already cover infants and children through age five with family incomes up to 133 percent of poverty. Id. at Secs. 1396a(a)(10)(A)(i)(IV) and 1396a(a)(10)(A)(i)(VI).

4. Id. at Sec. 1396a(e)(6).

5. Id. at Sec. 1396a(e)(4).

6. Id. at Sec. 1396a(a)(55). This provision further requires states to use shortened forms for such applications.

7. Melden, Gates, & Parks, supra note 2, at 104.


9. Id. at Sec. 1396a(v). “Final” administrative determination means up to the time of an Appeals Council determination. HCFA, State Medicaid Manual Secs. 3270.1 and 3272.2.

10. 42 C.F.R. Sec. 435.541 (effective Jan. 10, 1990). Advocates should be aware of a related matter: When an individual is determined to be Medicaid-eligible based upon disability before an SSA denial, that individual is entitled to retain Medicaid until he or she exhausts all SSA administrative appeals. HCFA, State Medicaid Manual Sec. 3272.2. This right applies irrespective of whether the state has adopted the 42 U.S.C. Sec. 1396a(v) option.

11. 42 U.S.C. Secs. 1396a(a)(54) and 1396s. "Covered outpatient drug" is defined at 42 U.S.C. Sec. 1396s(k)(2); it can include over-the-counter drugs. Id. at Sec. 1396s(k)(4). Regarding exceptions, see Melden, Gates, & Parks, supra note 2, at 109.

12. 42 U.S.C. Sec. 1396s(d)(5).


14. 42 U.S.C. Secs. 1396a(a)(57) and 1396a(w).

15. OBRA-90, supra note 1, at Sec. 4701 (adding 42 U.S.C. Secs. 1396a(t) and 1396b(i)(11)). Section 4701 also imposed a moratorium through December 31, 1991, on HCFA’s adoption of regulations limiting state use of donations.


20. Id. See also NATIONAL GOVERNOR'S ASS'N, FISCAL SURVEY OF THE STATES (Apr. 1991).

21. Such programs are authorized by 42 U.S.C. Sec. 1396n(b). See generally Melden, Managed Care: How to Challenge Inadequate Access for Medicaid Beneficiaries, 25 CLEARINGHOUSE REV. 228 (July 1991).


27. See, e.g., Fox & Leichter, Rationing Care in Oregon: The New Accountability, 10 HEALTH AFFAIRS 8 (Summer 1991).


33. 42 U.S.C. Sec. 1396r-7.


36. OBRA-89, supra note 30, at Sec. 6403 (amending 42 U.S.C. Sec. 1396a(a)(43) and adding 42 U.S.C. Sec. 1396d(r)).


38. Dallas Regional Medical Servs. Letter No. 91-37 (May 15, 1991). The letter states that it is based on policy clarifications received from the HCFA Central Office.


43. HCFA, Medicaid Regional Memorandum No. 91-94 (Region IX, Sept. 16, 1991).


49. 42 U.S.C. Sec. 1396a(a)(17)(D) (prohibiting states from attributing income or resources to an individual unless the income or resource is "actually available").


52. Himes v. Sullivan, Civ. 91-6172L (W.D.N.Y. Sept. 4, 1991), appeal pending, No. 91-6217 (2d Cir. filed Oct. 1, 1991) (Clearinghouse No. 46,978). At issue was the state's failure to disregard court-ordered support payments and mandatory payroll deductions.

53. Smith v. Concannon, 938 F.2d 966 (9th Cir. 1991) (Clearinghouse No. 45,037). The Iowa Supreme Court reached a partially inconsistent result in LaBeaux v. Iowa Dep't of Human Servs., 465 N.W.2d 541 (Iowa 1991) (attributing child's lump sum income to the other family members violates deeming prohibition, 42 U.S.C. Sec. 1396a(a)(17)(D)).


63. 42 U.S.C. Secs. 1395m(c), 1395x(s)(13), and 1395x(kk). Several other conforming amendments were made as well.

64. Id. at Secs. 1395x(s)(2)(O) and 1395x(jj).

65. Id. at Sec. 1395r(e)(1)(B). Part B premiums had previously been recalculated annually, so as to cover 25 percent of program costs.

66. Id. at Sec. 1395l(b).
67. Id. at Sec. 1395ss (as revised by OBRA-90, supra note 1, at Secs. 4351-61); id. at Sec. 1395zz. The OBRA-90 amendments require, among other things, standardization of policy coverage, guaranteed renewability, new protections against duplicative purchases, and the establishment of advisory services to assist beneficiaries.

68. Id. at Sec. 1395cc(a)(1). Conforming amendments were made to other provisions as well.

69. See supra note 14 and accompanying text.


73. 56 Fed. Reg. 28353 (June 20, 1991).


75. HCFA, Program Memorandum No. A-91-4 (June 1991), reprinted in 1 Medicare & Medicaid Guide (CCH) 4105.70.

76. 42 U.S.C. Secs. 1396a(a)(10)(E)(i) and 1396d(p).


84. Under the "two-day rule," HHS automatically denied credit to facilities that failed to provide eligibility determinations within two days of a patient's request.


94. O.C.G.A. 31-6-2, 40, 45, and 47.

95. 1991 Idaho Sess. Laws ch. 233 (H.B. 378); Idaho House Concurrent Res. 23.

96. N.J. S.B. 3251.


100. Cal. Code Reg. tit. 10, ch. 5.5 (Major Risk Medical Ins. Bd.).


106. These states included Massachusetts, Missouri, California, Oklahoma, Ohio, Illinois, Indiana, Minnesota, New York, California, Washington, Oregon, and Vermont.


117. See, e.g., S. 1227, S. 1177, H.R. 2535.

118. E.g., S. 1446, H.R. 1300, H.R. 650.
119. GAO, CANADIAN HEALTH INSURANCE, LESSONS FOR THE UNITED STATES (June 1991).


121. OBRA-90, supra note 1, at 104 Stat. 1388, 1111(b)(2)(B).


126. OBRA-90, supra note 1, at Sec. 4713 (amending 42 U.S.C. Sec. 1396a(u)(1)-(4)).

127. 29 U.S.C. Sec. 1162(2)(D).


130. Oakley v. City of Longmont, 890 F.2d 1128 (5th Cir. 1989).


132. Id.


134. 42 U.S.C. Sec. 1395dd.

135. Burditt v. HHS, 934 F.2d 1362 (5th Cir. 1991) (Clearinghouse No. 46,971).


137. Id. at 1041.