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Representation of Clients in Matters Relating to Hospital Bills

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may remedy the defect either by declaring the provision equally operative upon all persons similarly situated, or by declaring the provision inoperative as to all of them.⁶¹ In deciding whether benefits should be extended or extinguished, the court must be responsive to the dominant legislative purpose.⁶²

The 1939 amendments to the original Social Security Act first authorized payments to family members of the worker spouse. In keeping with the purpose of Social Security, "to provide a systematic program of protection against economic and social hazards," they were intended "to afford more adequate protection to the family as a unit."⁶³ The laudable purpose of "more adequate protection" should be extended to families regardless of their non-compliance with traditional family structures. If an equal protection challenge to the Act is successful, the only resolution which preserves the original purpose is to extend the benefits without regard to sex.

61. *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535 (1942); *Iowa-Des Moines Nat'l Bank v. Bennett*, 284 U.S. 239, 247 (1931).
62. *Frontiero v. Richardson*, 411 U.S. 677 (1973).
63. H.R. REP. NO. 728, 76th Cong., 1st Sess. (1939).

IV. CONCLUSION

Legislative revision would probably be a more efficient and realistic method of completely neutralizing the sex bias in the Social Security Act than challenging each provision on a case-by-case basis. Unfortunately, such an extensive revision does not appear imminent, and current economic conditions accentuate the need for immediate action to secure equal benefits for non-traditional families. Multiple litigation challenging these provisions could have the dual effect of prompting Supreme Court review and encouraging Congress to take action.

It is evident that a concise standard of decision has not been developed for challenging sex classifications on equal protection grounds. Therefore, in utilizing the present strict scrutiny and reasonable relationship tests, it becomes crucial to concentrate on the ultimate disadvantage to the woman wage-earner due to sex bias in the Social Security Act. The present trend indicates that such an approach will maximize the chances that a challenge of sex discrimination will be successful.

REPRESENTATION OF CLIENTS IN MATTERS RELATING TO HOSPITAL BILLS

by Stephen Axelrad,* Patricia A. Butler,** and Kenneth R. Wing***

I. INTRODUCTION

Legal aid clients' problems often include unpaid medical bills (such as bills for hospitalization or physician services), or denial of access to health care facilities. Unpaid medical bills frequently can be handled as other collection issues—settled or defended according to the principles of consumer law¹—but certain problems may arise that are unique to the

medical care situation, such as pre-admission deposits required for hospitalization.² Effective solution of these prob-

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1. See generally, NATIONAL CONSUMER LAW CENTER, II CONSUMER LAW HANDBOOK (1972), vol. 2, chap. 2; B. Schick, *A Primer on the General Law Applicable to Abusive, Unfair and Harrassing Collection Practices*, 6 CLEARING-

HOUSE REV. 145 (July 1972); C. BROSNAHAN, DEBT COLLECTION TORT PRACTICE (1971) (pertains mainly to California law, but is a good reference); *Regulation and Licensing of Collection and Commercial Agencies or Representatives Thereof*, 54 A.L.R. 2d 881 (1957); Greenfield, *Coercive Collection Tactics*, 1972 WASH. U.L.Q. 1. In the experience of the National Consumer Law Center physicians turn bills over to collection agencies primarily to establish bad debts for income tax purposes, but do not intend to pursue collection. For instance, the physicians do not provide adequate information for the collection agency to collect the debt, and when the debtor challenges the collection attempt and the agency seeks more information from the physician, the physician will probably advise the agency to drop the collection effort.

2. Prepayment or pre-admission deposits are such a common problem that they deserve special attention. Some hospitals require deposits on unreasonable terms; for instance, that the patient pay an amount which is more than the predicted cost of his hospitalization. Imposing a deposit is a severe hardship on the patient, and it often denies hospitalization to patients who may

lems requires understanding the various relationships between the government, private medical care providers, and consumers of medical care services. The legal and financial structure of provider institutions, particularly non-profit hospitals, imposes a number of duties and responsibilities on those institutions which may require them to provide care for poor people. In addition, governmental beneficiary programs and governmental obligations may impose a duty on a public institution, or a private institution with public funding, to provide free or below cost care to the poor.

be able to pay for their hospitalization over time, but cannot pay in cash in advance. There has been no universally successful way to attack the validity of these deposits and prepayment requirements, but there are a number of possible approaches depending upon the situation.

Medicare regulations generally prohibit a hospital or nursing home from requiring a prepayment or deposit for covered services (even for the deductible or copayment amounts which the patient will ultimately have to pay) as a precondition to admission. 20 C.F.R. §405.610 (1970). Only if all of the following conditions are met may a hospital or nursing home collect the patient's Part A deductible (§84): (a) the facility regularly requires prepayment from all other patients with similar insurance; (b) the patient is expected to incur expenses for the services of a physician salaried by the hospital or nursing home, which services are subject to Part B deductible and co-insurance provisions; (c) plus either of the following: the patient is not enrolled in Part B and has no equivalent protection or the patient does have Part B coverage but has not met the Part B deductible or cannot prove that he has. Medicare Part A Intermediary Manual, HIM-13 §3307; Medicare Hospital Manual, HIM-10 §301; Medicare Skilled Nursing Facility Manual, HIM-12 §254. The facility may charge a pre-admission deposit for non-covered services or services determined to be too costly. (See 42 U.S.C. §1395cc(a)(2)(B) (1935). This provision is a term of the Medicare participation agreement between the hospital and the Social Security Administration, and may be enforced by Medicare recipients as third-party beneficiaries of the contract.

The Medicaid law does not specifically forbid a provider from imposing prepayment deposits as a condition for admission, but such a prohibition is implicit from the fact that the federal regulations require providers to accept Medicaid payments as full payment, 45 C.F.R. §250.30(a)(6) (1969). See *Yanez v. Jones*, 361 F.Supp. 701 (N.D. Utah 1973). Furthermore, the federal statute spells out the kind of copayments which a state may impose upon Medicaid beneficiaries, 42 U.S.C. §1396a(a)(14) (1972). In a state which does not impose copayment for the given service, the provider has no authority to collect from the Medicaid patient. In a state which permits providers to collect copayment, one might argue that the provider could collect estimated copayment as a preadmission condition. This issue is not addressed in federal Medicaid regulations, but arguably is illegal based on (a) the Medicare regulations cited above, 20 C.F.R. §405.610 (1970), and (b) the compelling purpose of Medicaid to provide health care for the poor, unlike Medicare, whose beneficiaries comprise both rich and poor.

Corum v. Beth Israel Medical Center, 373 F.Supp. 550 (S.D. N.Y. 1974) held that hospitals which received Hill-Burton funds cannot count medical services toward their Hill-Burton obligation to provide a reasonable volume of free or below-cost care unless a determination is made at the time of admission that the patient will be given free medical care, 42 U.S.C. §291c(e); if enforced, this will eliminate pre-admission deposits for such patients. It is also possible that pre-admission deposits violate the community services requirement of the Hill-Burton Act or the obligation of tax-exempt hospitals to provide services to all those in the community able to pay imposed by Rev. Ruling 59-545. See 7 CLEARINGHOUSE REV. 587 (Feb. 1974).

This article is designed to acquaint Legal Services attorneys with a range of government health programs for which their clients may be eligible, and a number of legal theories that may impose a duty to provide care on public or private medical care institutions. The primary objective is to provide background material to assist the attorney in getting medical bills paid or defending a collection action. The article also includes a discussion of legal duties to provide care that will be useful in advising clients and consumer groups of their rights and of the programs and services that should be available in the community.

II. IS THE CLIENT ELIGIBLE FOR MEDICAID?

Medicaid³ is a federal and state program to pay for medical care for the poor. All states have Medicaid programs. To be eligible a person must be either on AFDC or SSI.⁴ In some states people are eligible for Medicaid if they would be on AFDC or SSI if their incomes or resources were lower. Check with your county welfare department (for AFDC persons) and the district office of the Social Security Administration (for SSI persons) for details about your state's eligibility standards for Medicaid.

If the client applied for welfare but was not informed about his eligibility for Medicaid, the local welfare department has violated federal regulations.⁵ If the client is eligible for Medicaid, but had not applied before receiving services, Medicaid will cover the bill if the services were rendered within three months of the date of the application for Medicaid (provided that the client was *eligible* for Medicaid when he received the services).⁶ If the client was receiving AFDC, but has just become ineligible for such aid because of increased income from employment, the family's Medicaid eligibility must continue for four months as if the family were still receiving AFDC.⁷ If the client is eligible for Medicaid but the state refuses to pay for the particular medical service, the state Medicaid plan *may* violate federal requirements;

3. 42 U.S.C. §1396 *et seq.* *Butler, The Medicaid Program: Current Statutory Requirements and Judicial Interpretations*, 8 CLEARINGHOUSE REV. 7 (May 1974).

4. 42 U.S.C. §1396a(a)(10)(A).

5. 45 C.F.R. §206.10(a)(2)(i). *Diaz v. Quitoriano*, 268 Cal. App. 2d 807, 74 Cal. Rptr. 358 (1969). An apparently untried argument is that since the county failed properly to inform about Medicaid eligibility it is liable for the medical costs which the client incurred. To assert this third-party cause of action against the county welfare department, one must find that the federal regulations give rise to an implied right of action for civil damages (see notes 29-31 and accompanying text). Local court procedures on impleader and third-party defendants may prohibit such an indemnification attempt. A more serious obstacle is sovereign immunity, which the county may raise. *Edelman v. Jordan*, 94 S.Ct. 1347 (1974). *Edelman* could be distinguished on the ground that counties are not the same as states for purposes of sovereign immunity under the eleventh amendment. See 94 S. Ct. at 1258, note 12, *but see Douglas* dissent at 1366. To distinguish the case in this way one would probably have to show that the county was not acting directly as a state agent in failing properly to notify applicants of their right to apply for Medicaid. The likelihood of success of this theory depends very much upon state law on these issues.

6. 42 U.S.C. §1396a(a)(34).

7. 42 U.S.C. §1396a(e), 45 C.F.R. §248.10(b)(1)(iii).

hospitalization, for instance, is a required service,⁸ but length of a hospital stay may be limited

If the hospital treated your client knowing that he was eligible for Medicaid but now refuses to bill Medicaid, he may have a defense against a hospital collection action on the ground that the Medicaid statute implicitly requires the hospital to bill the Medicaid agency.⁹ This argument, relying on the theory of the client's detrimental reliance and the general public policy of the Medicaid statute, is more difficult if the hospital did not know or have reason to know that the client was eligible for Medicaid when it admitted or treated him (for instance, because the client had not applied or had not yet received his card). Providers are generally not required to participate in Medicaid or accept Medicaid patients. However, if a hospital receives or has received Hill-Burton Hospital Construction Act funds or federal tax exempt status (see discussion *infra*), it is required as a condition of receiving those funds to accept Medicaid patients.¹⁰

III. IS THE CLIENT ELIGIBLE FOR MEDICARE?

Medicare is the federal health insurance program for the aged and the disabled who receive Social Security disability benefits.¹¹ Medicare is administered by the Social Security Administration (SSA). It covers hospital, nursing home, and home health care services automatically (Part A) and physician services only if the Medicare beneficiary subscribes to the federal Supplementary Medical Insurance program (Part B). All persons on Medicaid who are eligible for Medicare should have been enrolled in Part B by their state Medicaid agencies. Although most older people on Social Security know about Medicare eligibility, some disability recipients may not know. The local district office of the Social Security Administration handles all questions about Medicare.

Eligibility for Medicare is usually not a problem. But problems often arise concerning the limits which Medicare imposes on services for which it will pay. The law permits insurance companies which administer payment under the program (usually Blue Cross for Part A and Blue Shield for Part B) to determine after they receive a bill (which is usually long after the service has been rendered or the patient has been discharged from the institution) that the service was either not "medically necessary," was a routine physical examination or was "custodial," which means that it did

not require the services of a skilled nurse.¹² The client can appeal this decision through the SSA appeals process and can eventually seek judicial review.¹³ Many individual cases which challenge Medicare claims denied on these grounds have been successful.¹⁴ In the meantime, however, one must postpone the collection efforts of the hospital until disposition of the Medicare claim.

A procedure to indemnify Medicare beneficiaries for unpaid hospital claims is available because of the 1972 Social Security Act Amendments, P.L. 92-603: the *waiver of liability* provision.¹⁵ The SSA will assume the costs of medical care which was denied because it was medically unnecessary or custodial if both the medical provider and the Medicare beneficiary did not actually know that the service would not be covered and could not be expected to know of non-coverage by exercising "due diligence." Requirements of due diligence for medical providers are spelled out in proposed regulations.¹⁶ Even if the hospital or physician is deemed to know that a service was not covered, the Medicare beneficiary can still be indemnified for the costs of the care by SSA if the beneficiary applies for indemnification.

Since the waiver provision applies only in cases where services were rendered after October 31, 1972, many clients who are now being billed for hospital services are ineligible to apply for the waiver. In such cases another Medicare defense is possible. Because Medicare does not require that the provider seek authorization from SSA before providing the services, the program relies heavily on internal hospital committees (called Utilization Review Committees), composed of physicians, to monitor whether Medicare patients need continued hospitalization.¹⁷ Although the requirement that such committees exist and make decisions about a Medicare patient's medical need for continued hospital care has been mandated since enactment of Medicare, it is still not observed by all hospitals. As a complete or partial defense to a hospital bill which Medicare has refused to pay, one can present the hospital's failure to perform utilization review within the requirements of the Medicare law (which includes, among other things, that patients be notified if the committee recommends that their stay be terminated).¹⁸ After receiving such notice a patient is covered by Medicare for three extra days.¹⁹

Four possible defenses may be raised to a hospital collection action where the hospital has failed to comply with Medicare utilization review (UR) requirements.²⁰ First, if

8. 42 U.S.C. §1396d(a)(1).

9. *Knickerbocker Hosp. v. Downing*, 317 N.Y.S. 2d 688 (1971); *Society of Hospitals v. Mogensen*, 319 N.Y.S. 2d 258 (1971), *rev'd on other grounds*, 168 N.Y.L.J. 73, at 2 (1972); *Mt. Sinai Hosp. v. Korngay*, 347 N.Y.S. 2d 807 (1973); *Brooklyn Hospital v. Criss*, 349 N.Y.S. 2d 488 (1973).

10. In *Cook v. Oschner*, 319 F.Supp. 603 (E.D. La. 1973), the court ordered the Secretary of HEW to promulgate regulations requiring Hill-Burton hospitals to accept Medicaid beneficiaries under the community service requirement, and regulations have now been promulgated. 39 Fed. Reg. 31767-68 (Aug. 30, 1974). A tax-exempt hospital may also have to accept persons covered by Medicaid or other adequate sources of third-party reimbursement as being persons able to pay to qualify for tax-exempt status under Rev. Ruling 69-545. See 7 CLEARINGHOUSE REV. 587 (Feb. 1974). *EKWRO v. Simon*, No. 74-1293 (D.C. Cir., Oct. 9, 1974), discussed *infra*.

11. 42 U.S.C. §§1395 *et seq.*

12. 42 U.S.C. §§1395y(a)(1), (7) and (9). For a discussion of this policy, see Health Law Project, *Medicare Level-of-Care Determinations*, 6 CLEARINGHOUSE REV. 234 (Aug.-Sept. 1972).

13. 42 U.S.C. §1395g.

14. *E.g.* *Sowell v. Richardson*, 319 F.Supp. 689 (D. S.C. 1970); *Ridgely v. Secretary of HEW*, 345 F.Supp. 983 (D. Md. 1972), *aff'd* 475 F.2d 1222 (4th Cir. 1973); *Bremer v. Richardson*, 347 F. Supp. 465 (D. Neb. 1972); *Hultzman v. Weinberger*, No. 73-1917 (3rd Cir., April 3, 1974).

15. 42 U.S.C. §1395pp.

16. 39 Fed. Reg. 12763 (1974).

17. 42 U.S.C. §1395x(k) (1935), 20 C.F.R. §§405.1035 (1966) and 405.1627 (1968).

18. 42 U.S.C. §1395x(k)(4) (1935); 20 C.F.R. §405.1035(g) (1966).

19. 42 U.S.C. §1395f(a)(7) (1935).

20. A model answer raising the defense is available in Volume 6 of the MATERIALS ON HEALTH LAW (1972 ed.) at 225, prepared by Health Law Project and National Health Law Program.

the hospital had no UR plan at all, or if its plan on paper did not meet statutory requirements, one might argue that the hospital's contract to provide medical care to the Medicare patient was illegal and void *ab initio*, since the hospital undertook to serve the patient as a Medicare provider, and is required as a condition of Medicare participation to establish a UR system.²¹ Second, one can argue that a hospital's failure to *comply* with its UR plan is a failure of a contractual condition or a breach of contract.²² Third, one can argue that the Medicare recipient is a third-party beneficiary of the agreement between the government and the hospital.²³

21. *Supra* n. 17. When performance, such as providing medical care, is part of an illegal contract, the courts will not enforce the contract on behalf of the wrongdoers. *Hartman v. Lubar*, 133 F. 2d 44,45 (D.C. Cir. 1942). Courts have refused to enforce contracts for services performed by unlicensed facilities or persons on the ground that such performance is illegal. *Spivak v. Sachs*, 16 N.Y. 2d 163, 211 N.E. 2d 329 (1965); *Carmine v. Murphy*, 285 N.Y. 412, 35 N.E. 2d 19 (1941). And a court has held that a lease entered into in violation of a housing code was void and that the tenant had no contractual obligation to pay rent. *Brown v. Southall Realty Co.*, 237 A.2d 834 (D.C. Ct. App. 1968). The statutory requirement for Utilization Review demonstrates a public regulatory policy similar to licensing standards or housing codes so that a court should deny the hospital recovery for medical care provided in violation of the UR requirements.
22. Courts do imply conditions or promises into contracts to promote justice and fairness, whether or not the parties have expressed the intent to include such terms in their agreement. In *Javins v. First National Realty Corp.*, 428 F.2d 1071 (D.C. Cir. 1970), the court implied the requirement that a landlord comply with the provisions of the D.C. Housing Code as a term of a lease. One can argue that compliance with a UR plan is an implied term of any contract (express or implied) between a hospital and a Medicare recipient for medical services.

Failure of a constructive condition precedent would completely discharge the contractual duty of the Medicare patient to pay the hospital bill. On the other hand, breach of an implied promise to perform UR would not necessarily discharge the duty to pay; the hospital would be liable for damages resulting from the breach, which could be set off against the bill for services. In *Javins* the court merely adjusted the tenant's rent, but did not eliminate entirely the rent obligation. If one cannot convince the court that compliance with the Medicare UR requirements is sufficiently important to be a condition precedent to the Medicare recipient's duty to pay, one must be prepared to argue that the hospital owes damages equal to the value of the medical services disallowed by Medicare. The fact that the occurrence of a condition precedent does not involve any uncertainty and that the hospital's failure to comply with its UR plan is willful should strengthen the argument against finding substantial performance by the hospital and support a discharge of any contractual duty to pay. *Jacob and Youngs, Inc. v. Kent*, 230 N.Y. 239, 129 N.E. 889 (1921).

23. 42 U.S.C. § 1395cc; although the terms of the agreement do not specifically include a commitment to perform Utilization Review, this term would probably be implied into the agreement. See 42 U.S.C. § 1395cc(d) and sources cited *supra* n. 17. The requirement of Utilization Review was intended at least partially to benefit Medicare recipients, S. Rep. No. 404, 89th Cong., 1st Sess.: 47 (1965), although it was at least equally intended to save money for the federal government. There is mixed authority on whether individual members of the public can be protected as intended third-party beneficiaries of contracts which the government makes to benefit the general public. CALAMARI AND PERILLO, *THE LAW OF CONTRACTS* § 247 (1970) (individuals may be so protected); RESTATEMENT 2d CONTRACTS § 145 (in general, individuals are not so protected); *Euresti v. Stenner*, 458 F.2d 1115 (10th Cir. 1972) holds that the

Fourth, an argument closely related to the third-party beneficiary argument is that there is a private right of action implied on behalf of beneficiaries of the Medicare law.²⁴

Whether a court will accept any of these Medicare UR defenses depends ultimately on the policy considerations involved rather than on a strict analysis of contract law, as the landlord-tenant cases in the District of Columbia²⁵ demonstrate. Important factors in arguing policy considerations are the congressional intent to regulate for the benefit of Medicare recipients,²⁶ the demands of fair dealing²⁷ in providing appropriate utilization review, and the justifiable expectations²⁸ of Medicare recipients that they are receiving all statutory protections to which they are entitled. It is essential to emphasize the importance which Congress placed on utilization review. Both the statutory requirement that the federal government bar the hospital from further Medicare participation²⁹ or reduce payment to it³⁰ for failure to conduct UR and the legislative history of Medicare³¹ and subsequent legislative analysis³² and developments³³ demonstrate such congressional concern. If the policy arguments can be advanced successfully, there is ample contract law and related theories on which to base a successful collection defense.

poor do have a right to enforce the terms of contracts between the federal government and hospitals which were adopted for their benefit. If state law permits arguing that the Medicare patient is a third-party beneficiary of the contract between the hospital and federal government, the patient could assert as a defense to a collection action the same claim that the federal government could raise in refusing to reimburse a provider with a deficient Utilization Review system—the statutory prohibition on payment to an institution which does not comply with the UR requirements. 42 U.S.C. § 1395f(a)(7), § 1395x(k) and § 1395cc(d).

24. Courts have found such private rights of action under other governmental programs. *Euresti v. Stenner*, 458 F.2d 1115 (10th Cir. 1972); *Gomez v. Florida State Employment Service*, 417 F.2d 569 (5th Cir. 1969). Under Medicaid, a court found that recipients of the program had an implied right of action under the federal regulations against the state, but not against the individual providers who violated the federal regulations. *Yanez v. Jones*, 361 F.Supp. 701 (N.D. Utah 1973). This case is inconsistent with other decisions on this issue in the Circuit Courts of Appeal, and so should not bar the defense. A memorandum discussing these cases and the third-party beneficiary/private right of action theories is available from the National Health Law Program.
25. *Brown v. Southall Realty Co.*, 237 A.2d 834 (1968); *Javins v. First Nat'l Realty Corp.*, 428 F.2d 1071 (D.C. Cir. 1970).
26. *Javins v. First Nat'l Realty Corp.*, 428 F.2d 1071, 1080 (D.C. Cir. 1970); *Gomez v. Florida State Employment Service*, 417 F.2d 571-72, 575-76 (5th Cir. 1969); *Euresti v. Stenner*, 458 F.2d. 1115, 1118 (10th Cir. 1972).
27. *Javins v. First Nat'l Realty Corp.*, 428 F.2d 1071, 1081 (D.C. Cir. 1970); CORBIN, *CONTRACTS* §§ 632, 653 (1952); CALAMARI AND PERILLO, *CONTRACTS* § 141 (1970).
28. *Javins v. First Nat'l Realty Corp.*, 428 F.2d 1071, 1075, 1079, 1081 n.56 (10th Cir. 1972).
29. 42 U.S.C. §§ 1395x(k)(1) and (3) (1935).
30. 42 U.S.C. § 1395cc(d) (1935).
31. S. Rep. No. 404, 89th Cong., 1st Sess. 47 (1965); H.R. Rep. No. 213, 89th Cong., 1st Sess 40-41 (1965).
32. Staff of Senate Finance Comm., 91st Cong., 2d Sess., *Medicare/Medicaid: Problems, Issues and Alternatives*, 105-109 (1970).
33. In 1972 Congress extended more comprehensive Utilization Review requirements to the Medicaid program, 42 U.S.C. §§ 1396b(h)(1) and (i)(4) (1972).

IV. IS THE CLIENT ELIGIBLE FOR SERVICES PROVIDED BY THE VETERAN'S ADMINISTRATION OR THE INDIAN HEALTH SERVICE OR PUBLIC HEALTH SERVICE?

If your client is a veteran, an Indian, a merchant seaman, or a dependent of such person, he may be eligible for hospital and other medical care through special federal hospital systems. Although there appears to be no right of indemnity against one of these providers by an eligible person who is being sued by a hospital for the costs of a hospital stay,³⁴ you should be aware of these eligibility categories in order to advise the client to seek care at these special facilities in the future.

The Veteran's Administration is the nation's largest health center, with 166 hospitals. To be eligible for its hospital services one must be a veteran seeking care for (a) a service connected disability; (b) a non-service connected disability associated with a service connected disability; (c) a non-service connected disability if the veteran was discharged for line-of-duty disabilities. Veterans who are over 65 or have served during a war period or after January 31, 1955, are also eligible for care for non-service connected disabilities. The last four groups are eligible for VA health benefits only if they are financially unable to pay for the care themselves.³⁵

The Public Health Service operates hospitals in selected areas of the country for merchant seamen, coast guards and their dependents, and Indians.³⁶ Eleven PHS hospitals operate in coastal areas to serve those eligible.

Fifty-one additional hospitals on or near Indian reservations are run by PHS through the Indian Health Service to whom administrative authority has been delegated.³⁷ Any person who can provide evidence of any "reasonable factor of Indian descent"³⁸ is eligible for IHS health services. However, regulations permit the IHS to establish priorities for treatment within the limits of available funds.³⁹

V. IS THE CLIENT ELIGIBLE FOR LOCAL OR STATE GOVERNMENT FINANCED MEDICAL CARE?

Even if your client is not eligible for Medicaid, Medicare, or the other federal health programs, the state or local government may still be responsible for the cost of his medical care. At common law there was no duty on the state or any of its political subdivisions to provide medical care to indigent people. The poor depended upon charity for their medical care as well as relief in general. However, as medical care became recognized as an important human service, almost every state passed some form of statutory authority mandating that the state or some level of government provide health

care services to the poor either directly or through private facilities with financing from the state or local government. For example, the law of Arizona requires that counties assume responsibility for medical care to indigent residents.⁴⁰

Other jurisdictions place the financial responsibility on the state government, as in Massachusetts, or on "public welfare districts," as in New York. Without presenting a thorough survey of all states, it is safe to say that all states have some provisions imposing a duty for care to indigents, either by providing for a system of hospitals, or by requiring a financial reimbursement scheme. This duty, however, may not be concisely stated and may have to be inferred from a number of vaguely worded statutory provisions. California is a good example of this:

Every county and every city and county shall relieve and support all incompetent, poor indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives and friends, by their own means or by state hospitals or either state or private institutions.⁴¹

This has been interpreted by California case law, when read in conjunction with other provisions of the California Code, to mean that the county must provide for some level of medical care and hospitalization to all its indigent residents.⁴²

One major issue that remains unresolved is the interface between these laws and the Medicaid system. Does the Medicaid coverage provided to some categories of indigent people replace the state duty to provide care to all indigent people under these previous state law requirements? As long as there are indigent people not receiving care for any reason, and the statutory basis for the duty to provide care is explicit or is interpreted to mean that the obligation runs to *all* indigent people, then Medicaid does not replace the pre-existing duty. Using the California example, even with the broad range of people covered under the California Medicaid (Medi-Cal) program there are still some categories of indigents (*e.g.* illegal aliens, people without permanent residence) who are not eligible for Medicaid. Moreover, there are certainly many people who may be considered indigent under the pre-existing duty requirements, but not under Medicaid, *e.g.* people who must spend down to qualify or people slightly above the Medicaid standards of eligibility. A recent Attorney General's opinion in California concluded that California's Medi-Cal program did not provide care to all indigents or supersede the county's duty.⁴³

34. Cf. 42 U.S.C. §24a(c).

35. 38 U.S.C. §610 (1958); 38 C.F.R. §17.47 (1959). For a more detailed description of veteran's health benefits, see Merrill, *Medical Care in the Veterans Administration System*, 6 CLEARINGHOUSE REV. 424 (Nov. 1972).

36. 42 U.S.C. §§249-253 (1944).

37. 42 U.S.C. §2001 (1954).

38. U.S. Dep't of Health, Education and Welfare, *Indian Health Manual*, §2-1.2A(5).

39. 42 C.F.R. §36.11 (1959).

40. ARIZ. REV. STAT. 11-291. In a very important decision, the Supreme Court recently decided that a provision of this statute that imposed a one-year residency requirement was unconstitutional. *Memorial Hospital v. Maricopa County*, 94 S. Ct. 1076 (1974). This case characterized medical care as a fundamental interest (although not a fundamental right) comparable to welfare benefits. This is the first recognition by the Court of the importance of health care to poor people.

41. California Welfare and Institutions Code §17000.

42. See *City of San Francisco v. Collins*, 216 Cal. 187 (1932), *Goodall v. Brite*, 11 Cal. App. 2d 540 (1936), *County of San Diego v. Vilorio*, 276 Cal. App. 2d 350 (1969), *Mooney v. Pickett*, 4 Cal. 3d 669 (1971).

43. 56 Ops. Cal. Att'y Gen. 568 (1973).

VI. IS THE CLIENT ELIGIBLE FOR CARE UNDER THE PUBLIC OBLIGATIONS OF PRIVATE NON-PROFIT HOSPITALS?

Under any of a series of relationships to the federal government, private non-profit hospitals may incur obligations to provide free or below-cost care to the indigent. Both the receipt of federal Hill-Burton funds and the receipt of tax-exempt status carry such obligations. Since the litigation strategy with respect to these particular obligations has been discussed at length elsewhere,⁴⁴ only the basic legal theories are reviewed here.

Many hospitals have received federal Hill-Burton construction funds and have contracted to provide "a reasonable volume of services to persons unable to pay therefor..."⁴⁵ HEW has issued regulations interpreting what quantity of free services satisfies this obligation and requiring states to enforce this obligation.⁴⁶ Several cases have established that indigent persons have standing to enforce this obligation on the basis that a civil remedy may be implied for those clearly within the protective realm of legislation, and also on a third-party beneficiary contract theory. Although these cases were brought to compel hospitals to treat indigent persons, the same theory can be used also as a defense against a collection action by a Hill-Burton funded hospital in jurisdictions which recognize the third-party beneficiary theory,⁴⁷ or as an implicit right under federal law in states that do not recognize the standing of third parties beneficiaries.⁴⁸

In many states (California, for instance), the agencies which have the primary responsibility for enforcing the Hill-Burton obligation have failed to promulgate regulations, in open defiance of federal law.⁴⁹ Legal Services attorneys should assist their client communities in negotiating with such state agencies to obtain proper regulations and enforcement.

Hospitals that have received state or federal tax-exempt status may also have a duty to provide free services to the poor. In *Eastern Kentucky Welfare Rights Organization v. Schultz*,⁵⁰ the district court concluded that non-profit hospi-

itals must provide free services to the poor in order to qualify for tax-exempt status under Section 501(c)(3) of the Internal Revenue Code. The Court of Appeals for the District of Columbia Circuit disagreed and in a 2-1 split decision reversed, holding that the I.R.S. could properly define "charitable" in terms of community benefit and the general promotion of health, as long as the hospital is required to accept Medicare, Medicaid and other patients who could pay the cost of their care either directly or through third party reimbursement, and as long as the hospital is also required to provide indigent persons with medical care in the hospital's emergency room.⁵¹ Many states have a similar requirement that hospitals must be operated exclusively for charitable purposes to qualify for exemption from property or *ad valorem* taxes.⁵² In a recent Missouri decision, the court stripped three hospitals of their exemption from *ad valorem* taxes after finding that they used their profits to further a policy of unlimited expansion of hospital facilities while turning away almost all persons unable to pay.⁵³ A private right of action may be implied under these statutes in a similar manner to that suggested above under the Hill-Burton Act.⁵⁴

Vigorous collection efforts by non-profit hospitals can be explained in part by the board of trustees' fiduciary duty to preserve and protect corporate assets, which include collectible debts from persons who are unable to pay.⁵⁵ These hospitals, however, arguably have other fiduciary duties obligating them to provide charitable services to persons unable to pay. A non-profit hospital with collection practices which do not make adequate provision for persons unable to pay may be violating the following fiduciary duties.⁵⁶ First,

44. Schwartz and Rose, *Opening the Doors of the Non-Profit Hospital to the Poor*, 7 CLEARINGHOUSE REV. 655 (March 1974); Schwartz, *Expanding the Quantity of Medical Services Available to the Poor—Suing the Private Hospitals Under the Internal Revenue Code*, 7 CLEARINGHOUSE REV. 587 (Feb. 1974); *Provision of Free Medical Services by Hill-Burton Hospitals*, 8 HARV. CIVIL RIGHTS-CIVIL LIBERTIES L. REV. 351 (1973); Silver, *The Legal Accountability of Nonprofit Hospitals*, REGULATING HEALTH FACILITIES CONSTRUCTION 183 (Havighurst ed. 1974); Rose, *The Hill-Burton Act—The Interim Regulation and Service to the Poor: A Study in Public Interest Litigation*, 6 CLEARINGHOUSE REV. 309 (1972); Rose, *The Internal Revenue Service's 'Contribution' to the Health Problems of the Poor*, 21 CATH. U.L. REV. 35 (1971).

45. 42 U.S.C. § 291 *et seq.* (1944).

46. 42 C.F.R. § 53.111 (1972).

47. See *Burlington County Memorial Hospital v. Smith* (N.J. Dist. Ct., Burlington County, Sept. 21, 1973), which resulted in a stipulated dismissal. [Clearinghouse No. 12,059B Answer and Counterclaim (5pp.); 12,059E Amended Answer (2pp.); 12,059F Defendant's First Set of Interrogatories (37pp.).]

48. See *Euresti v. Stenner*, 458 F.2d 1115 (10th Cir. 1972); *Cook v. Oschner Foundation Hospital*, 319 F.Supp. 603 (E.D. La. 1973).

49. 42 C.F.R. § 53.111.

50. 370 F.Supp. 325 (D. D.C. 1973).

51. *Eastern Kentucky Welfare Rights Organization v. Simon*, No. 74-1293 (D.C. Cir. Oct. 9, 1974). Plaintiffs have petitioned for an en banc hearing by the circuit court, and if this is denied, a petition for a writ of certiorari would seem likely to the Supreme Court. The proper construction of "charitable" in Section 501(c)(3) of the Internal Revenue Code is also the subject of litigation in federal courts in other circuits, and the Supreme Court may eventually have to settle the question.

52. See the state-by-state analysis in II-A HOSPITAL LAW MANUAL, *Taxation* (Aspen Corp.).

53. *Jackson County v. State Tax Commission*, No. 765,274 (Mo. Cir. Ct., April 17, 1974), reported at 8 CLEARINGHOUSE REV. 372 (Sept. 1974) (Clearinghouse No. 13,286A).

54. See n.44, *supra*.

55. "The [governing] board must also enforce any rights to which the hospital is entitled. This includes the collection of just claims for hospital services using legal process when justified. Accounts receivable are assets of the institution and should be collected unless it is determined that the patient has no funds for their payment. It is immaterial that the hospital is organized as a charitable corporation. It should give charitable services only when the patient does not have sufficient funds to pay the costs of his care." Harty, *Survey of Hospital Law*, in AMERICAN HOSPITAL ASSOCIATION, READINGS IN HOSPITAL LAW. at 3 (1964).

56. See, *Are Voluntary Hospitals Above the Law?* 8 CLEARINGHOUSE REV. 344 (September 1974). In *Stern v. Lucy Webb Hayes National Training School for Deaconesses and Missionaries*, 367 F.Supp. 536, 540 (D. D.C. 1973), the court held that patients had standing to bring a class action for declaratory and injunctive relief to prevent continued injury to Sibley Hospital caused by the breach of self-dealing and mismanagement of hospital assets. In a later opinion, July 30, 1974, the court held that declaratory and injunctive relief should be granted after finding that the trustees had acted improperly.

such collection practices may jeopardize the hospital's tax-exempt status under state and federal law, in violation of the fiduciary duty to preserve and protect corporate assets, one of which is its tax-exempt status.⁵⁷ Second, the hospital's by-laws and articles of incorporation may indicate that the hospital is to provide charitable services for the sick and the poor; a policy of seeking payment from persons unable to pay may violate the fiduciary duty to carry out the purpose of the corporation and may also constitute ultra vires conduct.⁵⁸ Third, the hospital may have received private contributions expressly limited to, for instance, provision of medical care for persons unable to pay; the hospital may be violating its fiduciary duty to make proper use of this money, or may be able to make it available to your client.

VII. COULD THE CLIENT HAVE RECEIVED CARE FROM A HOSPITAL EMERGENCY ROOM?

Apart from any obligation to provide free or below cost care to poor people, a hospital may incur a tort liability if it refuses a patient access to emergency treatment. Although this is obviously not a defense to the collection of an unpaid hospital bill, it should be kept in mind when advising clients as to the services that should be available to them.

Under the common law rule that still prevails in some jurisdictions, there was no duty for a public or private hospital to provide emergency care for all people requesting help.⁵⁹ This is a result of the traditional tort principle that there is no general duty to take affirmative action to protect or aid someone in peril. This notion has received considerable criticism and the law has been changed both legislatively and judicially in several jurisdictions. The modern approach is that a hospital which has established an emergency room, and is therefore holding itself out to the public as an available emergency service, is under a duty to take some sort of appropriate action.

The leading case on this issue is *Manlove v. Wilmington General Hospital*⁶⁰. The court held that a hospital with an emergency room must provide care in the case of an "unmistakeable emergency." The hospital in that case had refused to admit a child without the request of the child's physician, who was unavailable. The basis for the court's decision was that there had been reliance by the plaintiff, thereby carving out an exception in rather traditional terms to the original tort principle denying affirmative duties to act. The court explicitly stated, however, that a private hospital without an emergency room would be under no obligation at all. The court also rejected the theory that the hospital was a quasi-public institution, due to its non-profit tax status, and that it therefore owed a duty to provide care to the public. (In

light of the recent decision in *EKWRO v. Simon*,⁶¹ regarding the duty of hospitals with tax exempt status to provide emergency room care, this theory may still be worth urging. The *Manlove* principle, the affirmative duty to provide some kind of care in emergencies, has been recognized in at least five other jurisdictions.⁶²

In some states, statutes impose a duty on all hospitals to provide emergency medical care in some form to all people. For example, in Illinois:⁶³

Every hospital required to be licensed by the Department of Public Health pursuant to the Hospital Licensing Act, approved July 1, 1953, as now or hereafter amended, which provide general medical or surgical hospital services shall provide a hospital emergency service in accordance with rules and regulations adopted by the Department of Public Health and shall furnish such hospital emergency services to any applicant who applies for the same in case of injury or acute medical condition, injury or serious illness.

In California the state licensing law includes a provision⁶⁴ that:

Emergency services and care shall be rendered without first questioning the patient or any other person as to his ability to pay therefor, provided that the patient or his legally responsible relative or guardian shall execute an agreement to pay therefor or otherwise supply insurance or credit information promptly after the services are rendered.

If a health facility subject to the provisions of this chapter does not maintain an emergency department, its employees shall nevertheless exercise reasonable care to determine whether an emergency exists and shall direct the persons seeking emergency care in obtaining such services, including transportation services, in every way reasonable under the circumstances.

VIII. IS YOUR CLIENT SUFFERING FROM DRUG ABUSE OR ALCOHOLISM?

The Drug Abuse Office and Treatment Act of 1972 contains a provision requiring private and general hospitals receiving any federal money to admit and treat drug abusers suffering from emergency medical conditions.⁶⁵ The Com-

61. *Supra*, n.50.

62. *See, e.g.*, *Mercy Medical Center of Oshkosh, Inc. v. Winnebago County*, 58 Wis. 2d 260, 206 N.W.2d 198 (1973).

63. Chap. 111½, No. 86.

64. CALIFORNIA HEALTH AND SAFETY CODE §1317. For a more detailed discussion of other possible legal bases for this duty, see Culle, *Hospital Duty to Provide Emergency Medical Care for the Indigent and Medically Indigent*, 4 CLEARINGHOUSE REV. 297 (November 1970).

65. "Drug abusers who are suffering from emergency medical conditions shall not be refused admission or treatment, solely because of their drug abuse or drug dependence, by any private or public general hospital which receives support in any form from any program supported in whole or in part by funds appropriated to any Federal department or agency." 21 U.S.C. §1174(a).

57. "If the corporation is so organized and operated that it qualifies for a tax exemption, the governing board must treat this exemption as an asset of the corporation to be preserved and protected as any other asset. The hospital attorney should advise the governing board when a contemplated activity jeopardizes this tax exempt status." II HOSPITAL LAW MANUAL, *Governing Board*, (Aspen Corp.) at 25.

58. *Id.* at 9. *See also* FLETCHER CORPORATION FORMS (1960), §14137.

59. *Birmingham Baptist Hospital v. Crews*, 229 Ala. 398, 157 So. 224 (1934). *See generally*, 35 A.L.R. 3d 841.

60. 53 Del. 338 (1961).

prehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act Amendments of 1974 contains a provision intended to assure that alcoholics will be able to receive treatment in public and private hospitals receiving federal funds.⁶⁶ The Secretary of HEW is required to make

66. "Alcohol abusers and alcoholics who are suffering from medical conditions shall not be discriminated against in admission or treatment solely because of their alcohol abuse or alcoholism, by any private or public general hospital which receives support in any form from any program supported in whole or in part by funds appropriated to any Federal department or agency." 42 U.S.C. §246(a), P.L. 93-282.

regulations and to enforce these provisions.⁶⁷ Litigation strategy similar to that used to obtain access of poor persons to hospitals under the Hill-Burton Act can be used to obtain access for drug and alcohol abusers. The Secretary can be required to promulgate regulations and individual hospitals can be sued to force compliance.⁶⁸

67. 21 U.S.C. §1174(b) and 42 U.S.C. §246(b), respectively.

68. For a more detailed discussion, see, *Hospitals May Not Refuse Treatment to Drug and Alcohol Abusers*, 8 CLEARINGHOUSE REV. 426 (October 1974).

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Occupational Safety and Health Protection for Farmworkers

The Occupational Safety and Health Act, 29 U.S.C. §§651 *et seq.*, was enacted in 1970 to provide a safe and healthy working environment for all American workers, including farmworkers. The Act envisioned promulgation of health and safety standards which employers would be obligated to implement, providing safe and healthy working conditions for all employees. Unfortunately, this protection has not been extended to the farmworkers of America.

Farmworkers sorely need the health and safety protections intended by the Act. Agriculture is the third most hazardous industry in the United States, and farmworkers suffer the lowest life expectancy of any group in the country. While the typical white American male is expected to live 72 years and the typical ghetto resident 55 to 60 years, the farmworker has a life expectancy of only 49 years. There are numerous aspects of agricultural work—from farm equipment to field sanitation to labor camp conditions—to which safety and health standards could and should be addressed.

Currently, however, there are only four standards in the Act applicable to agriculture, and only one, the temporary labor camp standard (29 C.F.R. 1910.142), is generally applicable to farmworkers.¹ Ironically, OSHA has had a published policy of not enforcing this standard: OSHA field offices were instructed to inspect a labor camp only when a complaint or catastrophe report was filed. OSHA now promises to change its enforcement policy in agriculture to

1. Regulation of pesticides, the area of most hazard to the farmworker, has been ceded to the Environmental Protection Agency in spite of initial responsibility for this area on the part of OSHA, and in spite of the absence of enforcement authority on the part of the Environmental Protection Agency. An adverse decision with regard to OSHA's responsibility in this area has been appealed to the United States Court of Appeals for the District of Columbia. *Omica v. Brennan*, No. 74-54 (D.C. Cir. filed 1974).

conform with general enforcement for other industries, after promulgation of a new temporary labor camp standard.

This proposed standard (30 Fed. Reg. 34057) makes a number of extreme changes in the present standard:

- (1) the housing standard will no longer be applicable to temporary farmworker housing owned, managed or controlled by the employer unless the farmworker can establish that he was required by his employer or by practical necessity to utilize such housing;
- (2) housing shall no longer be required to be structurally sound, in good repair and in sanitary condition, providing protection against the elements—only a water-proof roof will be required;
- (3) only 50 square feet per employee shall be provided within the shelter—no square footage of space is required for nonworking children of employees;
- (4) there is no space requirement between beds and thus no limit on the number of beds or occupants of any one dwelling;
- (5) only one toilet per 15 employees is required; where there are over 150 employees, only one toilet for each additional 40 employees is required;
- (6) no windows are required so long as some ventilation is provided; and no screening is required so long as insects are kept out;
- (7) no electricity is required so long as some form of lighting is provided;
- (8) garbage, toilet, bathing and handwashing facilities need not be accessible to the sleeping area.

Ninety percent of the changes in the revised proposed standard have either weakened the existing requirements or made them practically nonenforceable. These revisions are particularly horrifying in light of the fact that the Department of Labor, HEW and the Farmers Home Administration have found that the majority of existing farmworker housing is substandard, unsafe and deteriorated. If the subminimal standard above were enacted, it is hard to imagine how the already squalid living conditions of the farmworkers could improve.

Since the Occupational Health and Safety Act was enacted and four standards were picked up for agriculture from other areas, no new standards have been promulgated in