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Appendix I - Health Policy at the Crossroads - New Directions for Insured and Uninsured

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X. APPENDICES

APPENDIX I

HEALTH POLICY AT THE CROSSROADS – NEW DIRECTIONS FOR THE INSURED AND UNINSURED

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Testimony to the

U.S. BIPARTISAN COMMISSION ON COMPREHENSIVE HEALTH CARE

Ameritrust Auditorium
Cleveland, Ohio
July 6, 1989

I. WITNESSES

I am John C. Morley, President and CEO of Reliance Electric Company; Vice Chairman of the Board of Trustees of University Hospitals of Cleveland; a member of the Visiting Committee of the School of Medicine at Case Western Reserve University, and a member of the Board of Directors of United Way Services of Cleveland.

With me today are Powell Woods, Vice President of Human Resources for Nestle Enterprises, and Charles Weller, an attorney with Jones, Day, Reavis and Pogue.

We represent a bold new private sector initiative called *Cleveland Health Quality Choice* and the *Health Policy Coalition*.

II. SUMMARY

As we all know, the cost of health care in the United States is high and continues to increase:

for the patients and beneficiaries who receive health care, for the physicians and hospitals who provide the care, and for the employers and employees, public and private, and taxpayers who pay for the care. For example, 15% of the average American worker's compensation—wages and benefits—now goes to pay for health care. That's a five-fold increase in about 20-years. (See charts).

Today, as the CEO of a private payer for employee health care, my testimony makes three points.

First, we are deeply concerned about the problem of access to health care for millions of Americans, including the 37 million without health insurance. As the cost of health care rises, the problem of access becomes greater.

Second, as indicated by studies from the medical community, we are wasting in this country \$150 billion annually on unnecessary or ineffective health care. This staggering number approximates the size of the federal budget deficit. If we can redirect this \$150 billion, we can dramatically improve access for the uninsured, improve the quality of health care for all, and gain control over a major factor driving the cost of health care.

Third, I am announcing today an example of the bold, new direction that we need to take. Cleveland Health Quality Choice is a program to identify quality health care outcomes, to encourage and support quality and efficient health care providers and concurrently broaden health care access to quality and efficient providers.

Cleveland Health Quality Choice has been initiated by ten CEOs of major American organizations—Ameritrust, BP America, General Electric Lighting Group, LTV Steel, Nestle Enterprises, Ohio Bell, Parker-Hannifin, Reliance Electric, Sherwin-Williams and Jones, Day, Reavis & Pogue. These ten CEOs are personally stepping forward to make an effort to reform our health care system.

Beginning with this core company involvement, Cleveland Health Quality Choice will grow into a broad, regional initiative based on three principles of opportunity:

- 1) *choice* — give the American worker and the American people greater choice on the quality and cost of their health care;

- 2) *quality* — give the American people and the medical community the information that does not exist today on the quality of health care;

- 3) *incentives* — make public and private health insurance incentives more oriented towards outcomes and efficiency. Today, the insurance reimbursement system pays for procedures regardless of results and costs. We need to become more efficient and to pay for what we do *for* patients, not for what we do *to* patients. We must move from a pay-for-service system, to a reimbursement system based upon quality, efficiency and results.

III. BACKGROUND: DANGERS AND OPPORTUNITIES

A. *Perilous Times for the Insured and the Uninsured*

Everyone here is familiar with the staggering problems we face as a nation in health care:

- America spends twice as much as Japan on health care, and 50% more than any other major country—nearly 12% of GNP; \$600 billion in 1989.
- None of these other countries have 17% of the population (37 million in the U.S.) uninsured.
- Medicare, Medicaid and private health insurance plans face ominous short-term and long-term financial problems.
- Employee and retiree health care costs are out of control.
- The elderly are largely without protections against the high costs of long term care.
- Approximately \$150 billion of our annual health care expenditures are wasted.
- The medical community and patients are increasingly burdened with outside intervention by public and private payers.

B. *Three Principles of Opportunity for New Directions*

1. *Choice.* Few workers know that 15% of their compensation goes to health care, and few Americans know that 12% of the GNP goes to health care. Thus, there is a great opportunity to give the American people—worker, patient and taxpayer—a direct choice in the quality and cost of their health care.

2. *Quality.* It is now clear that there is precious little scientific information available to patients and the medical community on what medical treatments work best. Thus, there is another great opportunity to do the research on quality, and to make it available to patients and to the medical community.

3. *Incentives.* Public and private health insurance in the United States is still plagued with the wrong incentives. We estimate that about 80% of the American people receive their health insurance benefits in ways that encourage overutilization and inefficiency, rather than in ways that encourage doctors and hospitals to provide the best quality care at the lowest cost. Thus, there is a third, great opportunity, incentive reform.

Combined, these three opportunities provide a new direction for American health care and will give the American people new choice and control over their health care.

IV. New Directions: Action

1. *Cleveland Health Quality Choice*. Cleveland Health Quality Choice is proceeding on two tracks at the same time. First, we are implementing, now, health insurance benefit plans that allow employees and their families to choose their health care providers using the best quality/cost information that is available today. Second, to improve this information and feedback process, we are developing, in cooperation with local hospitals and doctors, a community-wide quality/cost measurement system.

2. *Partnership with Congress*. The Health Policy Coalition is willing to work in partnership with Congress to implement the three principles of opportunity and to pursue the new directions in health care policy we so urgently need. If we can redirect the \$150 billion that is wasted annually on unnecessary or ineffective medical care, we can preserve health benefits for the 210 million Americans that currently have them, and improve access for those that do not. Two examples of the partnership we propose are discussed next.

3. *COSE Bill – Building on Success*. You heard John Polk testify earlier today about a Cleveland success story. COSE provides health insurance benefits for 100,000 Cleveland-area employees that work for small employers and their families. Nationally, the largest group of uninsured Americans are affiliated with small employers. The Health Policy Coalition has proposed federal legislation that will help take this Cleveland success to other communities and help reduce the number of uninsured Americans significantly. (See Health Policy Coalition testimony, "Federal Risk Pool Legislation for the Uninsured: Ominous Risks, Better Alternatives").

4. *Federal Funding of Quality Measurement Research*. We strongly endorse the concept behind a number of bills pending before Congress that will significantly increase federal funding for much needed research on the quality of health care. (See Health Policy Coalition testimony, "New Directions in Health Policy—Federal Legislation to Expand Medical Quality Research").

However, we urge that three basic provisions be added. First, the research must be made available on a reasonable basis to patients from the outset. Second, the research must be made available to patient demonstration projects which will experiment to find the best ways to disperse the information to the American public. Third, Cleveland Health Quality Choice should be designated as a location for a patient demonstration project.

V. CONCLUSION

Fundamentally, the principles of opportunity and choice we see are rooted in the American Revolution we so proudly celebrated just two days ago. Their applicability to health care was forcefully stated in 1972 by Senator Kennedy: "I believe deeply that the people have been given less

say in the area of health care than in almost any other area of American life. In no other area do they have so little choice or control.”

On this point, we strongly agree with Senator Kennedy. The American people have far too little choice or control over the cost and quality of health care. We believe that health policy is at a critical crossroad. It is imperative that we make the right decision. Cleveland Health Quality Choice represents the bold, new direction that we need to take.

*CEO STEERING COMMITTEE
CLEVELAND HEALTH QUALITY CHOICE*

1. Chairman, Mr. Morley, Reliance Electric
2. Mr. Bell, Ohio Bell
3. Mr. Biggar, Nestle Enterprises
4. Mr. Breen, Sherwin-Williams
5. Mr. Hoag, LTV Steel
6. Mr. Jarrett, Ameritrust
7. Mr. Mosier, BP America
8. Mr. Parker, Parker-Hannifin
9. Mr. Opie, General Electric Lighting Group
10. Mr. Pogue, Jones, Day, Reavis & Pogue

APPENDIX II

LEGAL RIGHT TO HEALTH CARE SERVICES AND NON-GOVERNMENTAL THIRD-PARTY HEALTH COVERAGE IN OHIO – THE MAZE WITH FEW EXITS

SUSAN O. SCHEUTZOW

I. ACCESS TO AFFORDABLE NON-GOVERNMENTAL THIRD-PARTY HEALTH CARE COVERAGE

Non-governmental third-party health care coverage is generally available from insurance companies, which are regulated by the Ohio Department of Insurance,¹ and generally group and non-group policies; health maintenance organizations (“HMOs”) which are regulated by the Ohio Department of Insurance,² and enroll groups and individuals; and employers’ self-insurance plans which are regulated in a very limited manner by the Ohio Department of Insurance³ and by the Employee Retirement Income Security Act of 1974 (“ERISA”),⁴ and provide group coverage for employees.

A. *Legally Mandated Coverage of Persons - Initial Coverage*

1. *Insurance Companies*

Generally there is no legal right to purchase or be covered by insurance; insurance companies may exclude whomever they choose from coverage except for the following three situations: if a policy offers coverage for an insured’s children, adopted children must be covered as other children;⁵ if a policy offers coverage for an insured’s children, newly-born children must be covered from the moment of birth;⁶ and an insurer may not discriminate in offering insurance based upon an applicant’s sexual preference or on whether the person has sought a test for acquired immune deficiency syndrome (“AIDS”). An insurer may refuse to issue a policy to a person who has tested positive for HIV or has been diagnosed as having AIDS or an AIDS related disease. An insurer may require an HIV test as part of other health testing.⁷

Generally, except as provided above, insurance companies may refuse to issue policies on whatever grounds the insurance company determines. Discrimination in premium rates for individuals of essentially the same health status, however, is not permitted.⁸ Insurance companies may simply refuse to offer policies to persons with certain medical conditions.

¹ OHIO REV. CODE ANN. § 3923 (Baldwin 1990).

² OHIO REV. CODE ANN. § 1742 (Baldwin 1990).

³ *See id.*

⁴ Employee Retirement Income Security Act of 1974, 29 U.S.C. § 1001, Pub. L. 93-406, Title I, 2, September 2, 1974, 88 Stat. 832.

⁵ OHIO REV. CODE ANN. § 3923.40 (Baldwin 1990).

⁶ OHIO REV. CODE ANN. § 3923.26 (Baldwin 1990).

⁷ OHIO REV. CODE ANN. § 3901.45 (Baldwin 1990).

⁸ OHIO REV. CODE ANN. § 3923.15 (Baldwin 1990).

Group Policies are issued to employers insuring at least 10 employees, or to an association or labor union insuring at least 25 persons.⁹ Generally, a large employer, association, or labor union will negotiate coverage for all its employees and will not permit exclusions on the basis of health status. Small groups do not have the bargaining power of large groups and may need to agree to exclude certain employees from coverage in order to obtain group coverage for other employees.

Insurance companies do not have to offer open enrollment periods in which anyone may purchase insurance, with the limited exception that insurance companies which were previously hospital service associations (generally, Blue Cross plans) must provide an open enrollment period of at least 30 days a year for persons who wish to purchase non-group policies. However, the insurance company may impose underwriting restrictions which may include health screening.¹⁰

2. Health Maintenance Organizations

HMOs may not refuse coverage to persons in a group based on health status.¹¹ While an HMO may discriminate in offering non-group coverage on the basis of health condition,¹² HMOs usually must offer an open enrollment period. After an HMO has furnished services for at least 24 months, the HMO must hold at least a 30-day open enrollment period annually in which it accepts persons regardless of their health status up to the HMO's capacity for enrollees. The Ohio Superintendent of Insurance may waive the requirement for an open enrollment period, permit a limit on the number of individuals accepted, or permit underwriting restrictions in order to:

- Preserve the HMO's financial stability;
- Prevent excessive adverse selection by prospective enrollees;
or
- Avoid the creation of unreasonably high or unmarketable charges by the HMO.¹³

HMOs are not required to enroll anyone who is confined to a health care facility because of a chronic illness, permanent injury, or other infirmity that would cause economic impairment to the HMO.¹⁴

3. Employers' Self-Insurance Plans

There is no requirement (except, perhaps, for a contractual claim based upon the facts of each situation) for a self-insured plan to include all employees.

⁹ OHIO REV. CODE ANN. § 3923.12 (Baldwin 1990).

¹⁰ OHIO REV. CODE ANN. § 3941.52 (Baldwin 1990).

¹¹ OHIO REV. CODE ANN. § 1742.16 (Baldwin 1990).

¹² *Id.*

¹³ *Id.*

¹⁴ See generally OHIO REV. CODE ANN. § 1742.12 (Baldwin 1990).

4. Summary

A person desiring third-party coverage who is excluded from coverage based upon health status has no right to purchase insurance coverage or to be covered under an employer's plan of self-insurance. Such individuals may not be refused group HMO coverage or nongroup HMO coverage during an open enrollment period, provided the open enrollment period has not been waived or underwriting restrictions imposed.

B. *Legally-Mandated Coverage of Persons - Continued Coverage*

Once an individual is enrolled in an insurance plan, certain restrictions exist on the ability of an insurer to terminate coverage.

1. *Continuation Rights Under Group Plans - Insurance, HMOs, Employers' Self-Insurance*

Both state and federal law provide that individuals covered under group plans offered by employers (including insured plans, HMOs, and self-insurance plans) must be permitted to continue group coverage at group rates when their employment is terminated or when their coverage would otherwise be terminated under the group plan (e.g., continued coverage of family members in the event of the death of the insured employee). State law provides for five months coverage.¹⁵ Federal law provides for continued coverage for eighteen months if termination under the group plan occurs because of loss of employment or reduction in the number of hours worked of the insured, thirty-six months in all other cases.¹⁶

2. *Conversion Rights from Group Coverage*

- a. Insurance group plans - State law provides that certain individuals who are terminated from a group plan, such as a person terminating employment, or a spouse or dependent child in the case of divorce from the insured or when a child reaching a limiting age under the policy, must be given the right to purchase a non-group policy.¹⁷
- b. Group HMO plans - Any person enrolled in a group HMO plan shall have the option to convert to a direct-pay basis if entitlement to participate in the group plan terminates.¹⁸
- c. Employers' self-insured plans - There is generally no requirement for conversion policies, although some employers will try to make such policies available.

¹⁵ See generally OHIO REV. CODE ANN. § 3923.30 (Baldwin 1990) regarding insured plans, OHIO REV. CODE ANN. § 1742.34 (Baldwin 1990) regarding health maintenance organizations, and OHIO REV. CODE ANN. § 3923.38 (Baldwin 1990) regarding self-insured plans.

¹⁶ See generally Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), Pub. L. 99-272, Title X, which applies to insurance plans, HMOs, and plans of self-insurance.

¹⁷ OHIO REV. CODE ANN. § 3023.122 (Baldwin 1990).

¹⁸ OHIO REV. CODE ANN. § 1842.13 (Baldwin 1990).

3. *Conversion Rights from Insurance Non-group Policy*

Individuals losing coverage under a non-group policy, e.g., family members when the insured dies, or if there is a divorce from the insured, must be given the ability to purchase a non-group policy.¹⁹

4. *Summary*

A person losing third-party coverage under a group or non-group policy due to some reason other than non-renewal by the insurance company has the right to continue to purchase insurance from the insurance company in some form.

C. *Cancellation and Non-Renewal of Coverage*

1. *Insurance Group Plans*

Cancellation and non-renewal of group policies are issues of negotiation between the group policy holder and insurance company.

Insurance company may not terminate coverage of a dependent of an insured when the child reaches a limiting age if the dependent is mentally retarded or physically handicapped and not capable of self-sustaining employment.²⁰

2. *Non-Group Insurance Policies*

An insurance company may not cancel a non-group insurance contract or fail to renew a non-group insurance contract except on the anniversary date of the policy. Therefore, coverage under a non-group policy is guaranteed for a year provided the insured meets the terms of the policy such as payment of premium.²¹

An insurance company may not use age or deterioration of health as a reason to refuse to renew a policy converted to a non-group policy from a group policy.²²

An insurance company may not terminate coverage of a dependent of an insured when the child reaches a limiting age under the policy if the child is mentally retarded or physically handicapped and not capable of self-sustaining employment.²³

3. *Health Maintenance Organizations*

An HMO may not cancel or fail to renew a contract due to the enrollee's health status.²⁴ An HMO may not terminate coverage of a dependent of an enrollee when the dependent reaches a limiting age under the policy if such dependent is mentally retarded or physically handicapped and not capable of self-sustaining employment.²⁵

¹⁹ OHIO REV. CODE ANN. § 3923.22 (Baldwin 1990).

²⁰ OHIO REV. CODE ANN. § 3923.24 (Baldwin 1990).

²¹ OHIO REV. CODE ANN. §§ 3923.04(C), (M) (Baldwin 1990).

²² OHIO REV. CODE ANN. §§ 3923.122(L), (M) (Baldwin 1990). See I B 2 a above.

²³ OHIO REV. CODE ANN. § 3923.24 (Baldwin 1990).

²⁴ See OHIO REV. CODE ANN. § 1742.16 (Baldwin 1990).

²⁵ OHIO REV. CODE ANN. § 1742.11 (Baldwin 1990).

4. *Employers' Self-Insurance Plans*

There is no regulation of self-insured plans termination of an insured's coverage. Contractual rights may exist depending upon representations made to the employee.

5. *Summary*

An insurance company may choose, based upon the health of an insured, not to renew a policy on any anniversary date of the policy except for non-group policies converted from group policies.

D. *Legally-Mandated Coverage of Medical Conditions*

1. *Insurance Companies-Group and Non-Group Policies*

Insurance companies are generally permitted to exclude any illness or injury from coverage and impose limitations on coverage of pre-existing conditions. Individual policies are subject to restrictions on the method by which medical conditions may be excluded.²⁶

Exceptions:

- a. AIDS - Cannot be excluded from coverage if the person was not aware of the existence of AIDS or of a positive test for HIV at the time of application.²⁷
- b. Newly-Born Children - must be covered from the moment of birth, including treatment for congenital defects and birth abnormalities.²⁸ Any general exclusions would apply to newly-born children also, but the waiting period may not be imposed on newly-born children.²⁹
- c. Outpatient Kidney Dialysis - If kidney dialysis services are provided, outpatient kidney dialysis services must be provided on an equal basis.³⁰
- d. Outpatient Services for Mental Disorders - If policy provides coverage for mental or emotional disorders, coverage must be provided for outpatient mental health services for at least \$550 per year.³¹
- e. Alcoholism - Policy must provide alcoholism treatment for at least \$550 per year.³²

While generally an insurance company may place stringent restrictions on pre-existing conditions, a court has held that exclusion for pre-existing conditions does not apply to congenital conditions without manifest symptoms prior to purchase of an insurance contract unless the contract specifically states that unknown congenital conditions will be excluded.³³

²⁶ See OHIO REV. CODE ANN. § 3923.04(E) (Baldwin 1990), which provides that all exceptions to coverage be captioned and clearly set forth in the policy, and OHIO REV. CODE ANN. § 3923.04 (Baldwin 1990), which provides that chronic disease or physical condition may only be excluded by name or specific description.

²⁷ OHIO REV. CODE ANN. § 3901.45 (Baldwin 1990).

²⁸ OHIO REV. CODE ANN. § 3923.26 (Baldwin 1990).

²⁹ *Id.*

³⁰ OHIO REV. CODE ANN. § 3923.25 (Baldwin 1990).

³¹ OHIO REV. CODE ANN. § 3923.28 (Baldwin 1990).

³² OHIO REV. CODE ANN. § 3923.29 (Baldwin 1990).

³³ *Goshorn v. Hosp. Care Corp.*, 46 Ohio App.3d 47, 545 N.E.2d 930 (1989).

2. *Health Maintenance Organizations*

To be licensed as an HMO, the HMO must provide basic health services, including physician services, inpatient hospital services, and outpatient medical services without limitation for pre-existing conditions.³⁴

3. *Employers' Self-Insured Plans*

Generally, self-insurance plans are permitted to exclude any illness or injury and impose limitations on coverage of pre-existing conditions.

Self insurance plans must provide coverage for up to \$550 per year for alcoholism services and, if the plan offers benefits for mental or emotional disorders, coverage must be provided for outpatient services for at least \$550 per year.³⁵

4. *Summary*

Expensive health conditions may be excluded from coverage and stringent pre-existing condition limitations applied, except HMOs must provide basic service coverage without pre-existing condition limitations.

II. ACCESS TO AFFORDABLE OR FREE NON-EMERGENCY HEALTH CARE

A. *Hospital Services*

1. *Generally No Right to Hospital Care*

It is well established that, absent any regulation or statute providing otherwise, a private hospital is under no obligation to admit any patient it does not desire, and may refuse treatment to a patient for the reason that the patient cannot pay or for any other reason.³⁶

2. *Public Hospitals*

There is *no* requirement in Ohio that county or municipally-owned hospitals provide free or low-cost care to those unable to pay.³⁷ Generally, however, the provision of care for those unable to pay is part of the stated purpose of such public hospitals.

3. *Municipalities*

Ohio law *permits*, but does not require, municipalities to levy a tax for hospital services and to give the tax revenues to a corporation "which maintains and furnishes a free public hospital for the benefit of the inhabitants of the municipal corporation, or not free except to such inhabitants as, in the opinion of majority of the trustees of such hospital, are unable to pay."³⁸

³⁴ OHIO REV. CODE ANN. §§ 1742.01(G), 1742.16 (Baldwin 1990).

³⁵ OHIO REV. CODE ANN. § 3923.30 (Baldwin 1990).

³⁶ See *LeJeune Rd. Hosp., Inc. v. Watson*, 171 So.2d 202 (Fla. Ct. App. 1965); *Fabian v. Matzko*, 344 A.2d 569, 236 Pa. Super. 267 (1975).

³⁷ See OHIO REV. CODE ANN. §§ 339, 749 (Baldwin 1990).

³⁸ 35 OHIO REV. CODE ANN. § 749.01 (Baldwin 1990).

4. *Hill-Burton Obligations*

- a. Free Care Obligation - The Hospital Survey and Construction Act of 1944 ("Hill-Burton Act") requires facilities receiving financial assistance to provide a reasonable volume of services to those unable to pay for such care.³⁹
- b. Level of Free Care - Lesser of 3% of the facilities annual operating costs or 10% of the assistance provided.⁴⁰

Those hospitals receiving assistance pursuant to Title VI of the Public Health Services Act have a 20-year obligation; those hospitals receiving assistance pursuant to Title XVI have an indefinite obligation.⁴¹
- c. Those Eligible for Free Care - Two classes of persons are eligible for Hill-Burton coverage:
 - (1) persons whose individual or family income is at or below the current poverty level and who do not have third-party or governmental coverage - eligible for free care;
 - (2) persons whose individual or family income exceeds the poverty level but is not greater than twice the poverty level and who do not have third-party or governmental coverage - the hospital has discretion as to whether it will provide services and as to whether it will charge for services according to a sliding scale.⁴²
- d. Allocation of Care - Hospital may have an allocation plan as to how it will distribute its free care to those unable to pay.⁴³

5. *Tax-Exempt Hospitals*

To qualify for tax exemption, a hospital must be organized and operated exclusively for religious, charitable, scientific, literary, or educational purposes or for the prevention of cruelty to children or animals or for testing for public safety purposes.⁴⁴

Hospitals qualify for federal income tax exemption by furthering a "charitable" purpose. Charitable does *not* mean that the hospital may not charge fees for its services, but that the needs of the public are served rather than the needs of private individuals. The needs of the public have been held to be served by the promotion of health.⁴⁵

Therefore, tax-exempt hospitals have no obligation to care for those who are unable to pay.

³⁹ 42 U.S.C. § 291 (1990).

⁴⁰ 42 C.F.R. § 124.503 (1989).

⁴¹ 42 C.F.R. § 124.501 (1989).

⁴² 42 C.F.R. § 124.505 (1989).

⁴³ 42 C.F.R. § 142.506 (1989).

⁴⁴ I.R.C. § 501(c)(3) (1987).

⁴⁵ See Rev. Rul. 69-545, 1969-2 C.B. 117; Rev. Rul. 83-157, 1983-2 C.B. 94.

B. *Physicians' Services*

There is no duty generally imposed upon physicians to provide uncompensated care. The American Medical Association's Principles of Medical Ethics specifically state:

VI - A Physician shall, in the provision of appropriate patient care, except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

There is no requirement in the Ohio Physician's Practices Act that physicians provide uncompensated care.⁴⁶

C. *Ancillary Services*

Pharmacy, lab services, etc. are treated the same as physician services - no obligation for free care.

III. ACCESS TO AFFORDABLE OR FREE EMERGENCY CARE

A. *Hospital Services*

1. *Patient's Right to Emergency Care*

Some courts have recognized a patient's right to receive emergency care from a private hospital when a patient relies upon a well-established custom of hospitals providing emergency care - therefore, a private hospital may be liable for not providing care to those in need of emergency services.⁴⁷

The requirement that the hospital provide the care does not relieve the patient of the obligation to pay for the care.

2. *COBRA "Anti-Dumping" Provisions*

a. *Mandatory emergency care for persons with medical emergencies or in active labor* - The Consolidated Omnibus Budget Reconciliation Act of 1985 § 9121, entitled "Examination and Treatment of Emergency Medical Conditions and Women in Active Labor," effective August 1, 1986,⁴⁸ placed three responsibilities on any hospital which provides emergency care and receives Medicare reimbursement:

- (1) hospital must examine *all* patients seeking emergency care to see if a medical emergency exists or if the person is in active labor;
- (2) if a medical emergency exists or the person is in active labor, the hospital must stabilize the patient or transfer the patient to a facility which can provide stabilization; and

⁴⁶ See generally OHIO REV. CODE ANN. § 4731.22 (Baldwin 1990). See also, *Hiser v. Randolph*, 126 Ariz. 608, 617 P.2d 774 (Ct. App. 1980) holding that a physician is free to contract for his services as he sees fit and, absent contractual obligations, a physician may refuse to treat any patient even in an emergency.

⁴⁷ See *Wilmington Gen. Hosp. v. Manlove*, 174 A.2d 135, 54 Del. 15 (1961); *Guerrero v. Cooper Queen Hosp.*, 112 Ariz. 104, 537 P.2d 1329 (1975); *Thompson v. Sun City Community Hosp., Inc.*, 141 Ariz. 597, 688 P.2d 605 (1984).

⁴⁸ See COBRA, *supra* note 16 § 9121.

(3) the hospital is prohibited from transferring an unstable patient unless the facility the patient is transferred to can offer better treatment and the medical risks of transfer are less harmful than continued treatment at the transferring hospital, or upon the patient's consent.

b. Penalties - Possible suspension or expulsion from the Medicare program plus up to \$25,000 fine for each violation.⁴⁹

Private cause of action by patient.

Facility which suffers a financial loss due to an inappropriate transfer may sue transferring hospital.

c. Payment for Care - COBRA § 9121 does not relieve the patient of the responsibility to pay for care - just guarantees that care will be rendered regardless of ability to pay.⁵⁰

Patients who are unable to pay for care may be discouraged from seeking hospital services because of the resulting financial obligation.

d. Public Policy Reasons for COBRA § 9121 - Extensive transfer of patients unable to pay for services regardless of medical needs of the patients.

e. COBRA § 9121 as a Solution to the Problem of the Uninsured and Underinsured - Those unable to pay for services will be able to receive emergency medical services and delivery services. Since the payment obligation remains on the patient, those in need of care still may not seek such care.

3. *Tax-Exempt Hospitals*

Generally, a tax-exempt hospital has an obligation to provide an open emergency department regardless of patient's ability to pay.⁵¹

4. *Joint Commission on Accreditation of Health Care Organizations ("JCAHCO")*

JCAHCO accreditation standards provide that emergency departments of hospitals must assess all patients and either treat the individuals or refer them to an appropriate setting, and that unless extenuating circumstances are documented, no patient is to be arbitrarily transferred to another hospital if the hospital where he is initially seen has the means to provide adequate care.⁵²

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ See Rev. Rul. 69-545, 1962-2 C.B. 117; but see Rev. Rul. 83-157, 1983-2, C.B. 94, holding that a hospital which did not have an emergency department due to local health planning guidelines nevertheless qualified for tax-exemption.

⁵² JCAHCO 1989 Accreditation Manual for Hospitals, Standards ER 1.2, 1.6.

B. *Physician Services*

1. *COBRA "Anti-Dumping" Provisions*

Physicians who participate in transfers in violation of COBRA § 9121 may also be subject to \$25,000 fine for each violation.⁵³

Physician's services for persons with medical emergencies or in active labor must be made available by the hospital. Patient is not relieved of the obligation to pay, so may be discouraged from seeking services.⁵⁴

C. *Summary*

Emergency hospital services (and physician services incident thereto) should, by law, be available to everyone regardless of ability to pay. However, since the patient is not relieved of the obligation to pay, many patients may delay or not obtain care.

⁵³ See COBRA, *supra* note 16, at § 9121.

⁵⁴ See III A 1 above.