Denver Law Review

Volume 71
Issue 4 *Tenth Circuit Surveys*

Article 15

January 2021

Health Law Survey

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Recommended Citation
A. Mark Isley, Health Law Survey, 71 Denv. U. L. Rev. 981 (1994).

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HEALTH LAW SURVEY

INTRODUCTION

The nation's health care system has recently undergone unprecedented scrutiny. Politicians from the White House to Capitol Hill, health care professionals and experts, policymakers, and the general public agree that at some level the present health care system needs to change. Of course, determining the extent of such a change prompts a highly political, ideological, and even emotional debate. Court decisions that interpret and apply health laws expose important health care issues and problems. Consequently, these decisions facilitate reform by guiding law and policymakers to problem areas within the health care system. Therefore, current health law cases warrant investigation.

Over the past year, the Tenth Circuit ruled on numerous health-related issues. Several of these rulings undoubtedly will impact the health care system. This Survey discusses three notable Tenth Circuit cases concerning issues in health law arising under the Emergency Medical Treatment and Active Labor Act (EMTALA),[1] the Medicare Act,[2] and § 510 of the Employee Retirement Income Security Act (ERISA).[3] Part I considers the issues of patient stabilization and physician liability under EMTALA.[4] Part II analyzes the issue of "Sole Community Hospital" status under the Medicare Act.[5] Finally, part III discusses the issue of health benefit discrimination under ERISA.[6]

I. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT: *DELANEY V. CADE*[7]

A. *Background*

1. Stabilization of an Emergency Medical Condition

EMTALA primarily functions to prevent private hospital emergency rooms from transferring and denying available medical care to patients who cannot afford to pay for treatment, a phenomenon known as "patient dumping."[8] Participating Medicare hospitals with emergency rooms must sufficiently examine the patient to determine whether an "emergency

1. 42 U.S.C. § 1395dd (1988 & Supp. III 1991).
2. 42 U.S.C. § 1395 (1988 & Supp. III 1991).
3. 29 U.S.C. § 1140 (1988).
4. *See infra* part I discussing Delaney v. Cade, 986 F.2d 387 (10th Cir. 1993).
5. *See infra* part II discussing Community Hosp. v. Sullivan, 986 F.2d 357 (10th Cir. 1993).
6. *See infra* part III discussing Phelps v. Field Real Estate Co., 991 F.2d 645 (10th Cir. 1993).
7. *Delaney*, 986 F.2d at 387.
8. Diana K. Falstrom, Comment, *Decisions Under the Emergency Medical Treatment and Active Labor Act: A Judicial Cure for Patient Dumping*, 19 N. KY. L. REV. 365, 365 (1992); John P. Halfpenny, Comment, *Taking Aim at Hospital "Dumping" of Emergency Department Patients: The COBRA Strikes Back*, 31 SANTA CLARA L. REV. 693, 693-94 (1991).

medical condition"[9] exists.[10] If such an emergency situation does exist, then the hospital is obligated under the act to either provide treatment or to transfer the patient.[11] Transfer is permitted only if the patient has requested transfer after being fully informed of the risks, the physician has certified in writing (either directly or by countersignature) that the benefits of transfer outweigh the risks, or the patient has stabilized.[12] One issue addressed in *Delaney v. Cade* concerned whether the plaintiff's condition was indeed stabilized prior to her transfer.[13]

Several courts have addressed the issue of a patient's stabilization under EMTALA. The Tenth Circuit found the following cases relevant to *Delaney*: *Deberry v. Sherman Hospital Ass'n*,[14] *Burditt v. United States Department of Health & Human Services*,[15] and *Cleland v. Bronson Health Care Group*.[16] In *Deberry*, the plaintiff claimed that her daughter had not been properly stabilized before being discharged from the defendant hospital.[17] Denying the defendant's motion to dismiss,[18] the district court noted that hospital violations of EMTALA occur in one of two ways.[19] First, *if* an emergency medical condition *does* exist, the hospital can violate the act by failing to determine "the nature of the [patient's] emergency condition."[20] Second, *if* the nature of the emergency condition *is discovered*, the hospital can violate the act by transferring or releasing the patient without stabilizing the patient's condition.[21] The court concluded that an inquiry into the occurrence of either violation requires a factual determination, thereby rendering dismissal inappropriate.[22]

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9. 42 U.S.C. § 1395dd(e)(1) (Supp. III 1991).

"Emergency medical condition" is defined as:

(A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part; or

(B) with respect to a pregnant women [sic] who is having contractions—

(i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or

(ii) that transfer may pose a threat to the health or safety of the woman of the unborn child.

Id.

10. Falstrom, *supra* note 8, at 369-70.

11. *Id.*

12. *Id.* at 370-72. "The term 'stabilized' means, with respect to an emergency medical condition . . . that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility, or . . . that the woman has delivered . . . ." *Id.* (citing 42 U.S.C. § 1395dd(e)(3)(B) (Supp. III 1989-1992)).

13. *See Delaney*, 986 F.2d at 391-93.

14. 741 F. Supp. 1302 (N.D. Ill. 1990).

15. 934 F.2d 1362 (5th Cir. 1991).

16. 917 F.2d 266 (6th Cir. 1990).

17. *Deberry*, 741 F. Supp. at 1303.

18. *Id.* at 1307.

19. *Id.* at 1305.

20. *Id.*

21. *Id.*

22. *Id.* at 1305.

In *Burditt*, the defendant doctor appealed the imposition of civil monetary penalties against him for failing, among other things, to properly stabilize a patient before her transfer.[23] The Fifth Circuit held that Dr. Burditt failed to properly stabilize the patient because he did not provide the treatment that medical experts would normally provide to prevent the potentially adverse consequences to the patient.[24] As in *Deberry*, the *Burditt* court determined the question of patient stabilization by considering facts.

In *Cleland*, the plaintiffs appealed the dismissal of their claim that the defendants failed to stabilize the patient's condition.[25] Upholding the dismissal, the Sixth Circuit found that the patient could be considered stabilized within the meaning of EMTALA because the patient was not acutely distressed and neither the doctors, the patient's parents, nor the patient himself indicated a deteriorating condition.[26] In other words, the doctors had no occasion to detect the patient's state of emergency.[27] Hence, the court reconciled its decision with *Deberry* by stating, "[i]f the emergency nature of the condition is not detected, the hospital cannot be charged with failure to stabilize a known emergency condition."[28]

2. Enforcement Against Hospitals and Physicians

EMTALA also provides three enforcement mechanisms:[29] (1) civil monetary penalties against hospitals or doctors who negligently violate the act;[30] (2) private civil suits against hospitals whose violations directly cause personal injury;[31] and, (3) suspension or revocation of a hospital's Medicare provider agreement.[32] Contrary to the language of § 1395dd(d)(1) imposing civil monetary penalties, § 1395dd(d)(2)(A) allowing for private civil suits only specifies the participating hospital as the object of the suit.[33] Nevertheless, the issue of a doctor's civil suit liability under the act

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23. *Burditt*, 934 F.2d at 1366, 1368-69.
24. *Id.* at 1369.
25. *Cleland*, 917 F.2d at 269.
26. *Id.* at 271.
27. *See id.*
28. *Id.*
29. *See* Halfpenny, *supra* note 8, at 704-05.
30. 42 U.S.C. § 1395dd(d)(1) (Supp. III 1991) provides:

(A) A participating hospital that negligently violates a requirement of this section is subject to a civil monetary penalty of not more than $50,000 . . . for each such violation.

(B) Subject to subparagraph (C), any physician who is responsible for the examination, treatment, or transfer of an individual in a participating hospital, including a physician on-call for the care of such an individual, and who negligently violates . . . this section, . . . is subject to a civil monetary penalty of not more than $50,000 for each such violation . . . .

31. *Id.* § 1395dd(d)(2)(A) (emphasis added) provides:

Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the *participating hospital*, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

32. *Id.* § 1395dd(d)(2)(A) (violating physicians may be excluded from Medicare and state health care programs).
33. Falstrom, *supra* note 8, at 378; *see also* Case Comment, 50 WASH. & LEE L. REV. 355, 356 (1993) (EMTALA creates a private cause of action against hospitals but not against doctors). *Compare* 42 U.S.C. § 1395dd(d)(1) (Supp. III 1991) *with* § 1395dd(d)(2)(A).

has been the source of litigation.[34] The Tenth Circuit considered this issue in *Delaney*.[35]

The leading case on this issue is *Baber v. Hospital Corp. of America*.[36] In *Baber*, the plaintiff sued the physicians for allegedly violating EMTALA by inadequately addressing his sister's emergency medical condition.[37] The district court granted summary judgment in favor of the defendant physicians.[38] The Fourth Circuit affirmed, holding that EMTALA does not provide for private civil suits against physicians.[39] The Fourth Circuit further explained that only the Department of Health and Human Services can bring an action against a physician to impose administrative civil monetary penalties and/or to prohibit the physician's involvement in Medicare programs.[40] The court based its decision on its failure to find contrary congressional intent in EMTALA's legislative history.[41]

The plaintiff argued against summary judgment based on *Burditt*[42] and *Sorrells v. Babcock*.[43] Yet, the Fourth Circuit found neither case persuasive.[44] *Burditt* involved a doctor's appeal from the assessment of administrative civil monetary penalties by the Department of Health and Human Services, not a private civil suit against a physician.[45] The court in *Sorrells* merely held that the federal courts have jurisdiction over EMTALA actions against emergency room physicians.[46] While the *Sorrells* court questioned Congress' intent behind allowing the Secretary to recover monetary penalties in cases where a patient brought the suit,[47] the Fourth Circuit considered the *Sorrells* analysis to be mere dictum, and illustrative of the court's confusion of the issues.[48]

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34. *See* Falstrom, *supra* note 8, at 384; *see also* Robert A. Bitterman, Note, *A Critical Analysis of the Federal COBRA Hospital "Antidumping Law": Ramifications for Hospitals, Physicians, and Effects on Access to Healthcare*, 70 U. DET. MERCY L. REV. 125, 172-73 (1992) (discussing cases that have addressed the civil liability of physicians under EMTALA).

35. *See Delaney*, 986 F.2d at 393-94.

36. 977 F.2d 872 (4th Cir. 1992).

37. *Id.* at 874.

38. *Id.*

39. *Id.* at 876-77. Several federal district courts agree on this issue. *See* Jones v. Wake County Hosp. Sys., Inc., 786 F. Supp. 538, 545 (E.D.N.C. 1991) (COBRA does not provide a private cause of action against a physician); Lavignette v. West Jefferson Medical Ctr., No. CIV.A.89-5495, 1990 WL 178708, at *2 (E.D. La. Nov. 7, 1990) (holding the express language and legislative history of EMTALA indicate it was not intended to provide a private cause of action against physicians); Verhagen v. Olarte, No. 89CIV.0300(CSH), 1989 WL 146265, at *6 (S.D.N.Y. Nov. 21, 1989) (construing EMTALA as excluding a federal private claim against a physician).

40. *Baber*, 977 F.2d at 877.

41. *See id.*; H.R. REP. No. 241, 99th Cong., 2d Sess., pt. 3, at 6-7 (1986), *reprinted in* 1986 U.S.C.C.A.N. 726, 728.

42. 934 F.2d 1362 (5th Cir. 1991).

43. 733 F. Supp. 1189 (N.D. Ill. 1990).

44. *See Baber*, 977 F.2d at 877; *see also* Case Comment, *supra* note 33, at 358 (explaining the *Baber* court's distinction of *Burditt* and *Sorrells*).

45. *Id.* at 877-78; *see Burditt*, 934 F.2d at 1366.

46. *Baber*, at 878; *see Sorrells*, 733 F.Supp at 1195.

47. *Baber*, 977 F.2d at 878; *see Sorrells*, 733 F. Supp. at 1194.

48. *See Baber*, 977 F.2d at 878. *But see* Bitterman, *supra* note 35, at 172 (citing *Sorrells* as authority for holding physicians liable in private civil suits); Falstrom, *supra* note 8, at 384.

B. *Tenth Circuit Decision:* Delaney v. Cade[49]

1. Facts

The plaintiff, Ms. Delaney, sustained serious injuries in an automobile accident.[50] Her injuries included a transected aorta, face and knee lacerations, arm and neck fractures, and a broken nose.[51] The emergency room at St. Joseph Memorial Hospital (St. Joseph) received Ms. Delaney immediately following the accident.[52] While at St. Joseph, the defendant, Dr. Cade, treated only her knee injuries; he neither ordered x-rays nor performed a physical examination.[53] At that time, Ms. Delaney still had feeling in her legs and she complained of chest pains.[54] Two hours after her arrival at St. Joseph, Dr. Cade transferred her to Central Kansas Medical Center (Central).[55] By the time she arrived at Central, the feeling in her legs had disappeared.[56] Ms. Delaney received further medical treatment at Central before being transferred again to the University of Kansas Medical Center (K.U.).[57] At K.U., doctors discovered Ms. Delaney's clotted transected aorta.[58] They performed surgery, but Ms. Delaney remained permanently paralyzed.[59]

Ms. Delaney sued Dr. Cade, St. Joseph, and Central under § 1395dd of EMTALA for failing to stabilize her condition prior to her transfer.[60] The district court concluded that the facts alleged did not support a claim against either hospital and thus granted those defendants full summary judgment.[61] The district court also found that EMTALA does not allow private civil suits against physicians; therefore, the court granted Dr. Cade partial summary judgment on that issue.[62] Ms. Delaney appealed these judgments.[63] The Tenth Circuit reversed in part, holding that the evidence may support a claim against the hospitals under § 1395dd, but affirmed the lower court's grant of partial summary judgment for Dr. Cade.[64]

2. Opinion

The Tenth Circuit first addressed whether Ms. Delaney's condition had been stabilized before she was moved to Central. The court cited

49. 986 F.2d 387 (10th Cir. 1993).
50. *Id.* at 388.
51. *Id.* at 388 n.1.
52. *Id.* at 388.
53. *Id.*
54. *Id.* at 388-89.
55. *Id.* at 388-89.
56. *Id.* at 389.
57. *Id.*
58. *Id.*
59. *Id.*
60. *Id.* at 388.
61. *Id.*
62. *Id.*
63. *Id.*
64. *Id.*

Deberry v. Sherman Hospital Ass'n[65] for the rule that hospitals can violate § 1395dd of EMTALA by failing to stabilize a patient's emergency medical condition before the patient is released or transferred.[66] The court held, based on *Deberry*, that *all* expert testimony introduced on the summary judgment issue must be considered to determine whether a material deterioration of the plaintiff's condition was likely during the transfer (that is, whether the defendant hospitals properly stabilized Ms. Delaney).[67] Ms. Delaney disputed the district court's finding that she had conceded the stabilization issue.[68] Furthermore, Ms. Delaney alleged that the feeling she had in her legs before transfer had dissipated by the time she arrived at Central—a material deterioration of her condition during the transfer.[69] Considering these allegations, the court found that the evidence offered by Ms. Delaney presented a genuine issue of material fact concerning the stabilization of her condition.[70] The court then reversed the summary judgment for the hospitals on that issue.[71]

The Tenth Circuit next considered the issue of a physician's civil liability under § 1395dd of EMTALA.[72] The court followed *Baber* and the statute's language in holding that § 1395dd does not allow individuals to bring civil suits against physicians who allegedly violate the act, but that individuals can bring civil suits against an offending hospital.[73] Thus, the Tenth Circuit affirmed the district court's summary judgment for the defendant doctor.[74]

C. *Analysis*

The Tenth Circuit properly followed other decisions that applied a fact-based analysis to the issue of patient stabilization.[75] The definition of "stabilized" is sufficiently vague to require significant fact-finding and weighing of evidence.[76] Congress may have intended to be unspecific in its definition. However, more specificity and clarity in the definition of "stabilized" would provide a useful guide for the fact-finding process. Given the present definition and the circumstances of Ms. Delaney's case, the Tenth Circuit correctly left the question open for an adversarial consideration of the alleged facts. Ruling one way or the other as a matter of

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65. 741 F. Supp. 1302 (N.D. Ill. 1990).
66. *Delaney*, 986 F.2d at 391-92.
67. *Id.* at 392. For definition of "stabilized" see *supra* note 12.
68. *Delaney*, 986 F.2d at 392-93.
69. *See id.* at 393.
70. *Id.*
71. *Id.*
72. *See id.*
73. *Delaney*, 986 F.2d at 393-94.
74. *Id.* at 394.
75. *See, e.g.*, Burditt v. United States Dep't of Health and Human Serv.'s, 934 F.2d 1362, 1369 (5th Cir. 1991)(stabilization question depended upon testimony by medical experts); Cleland v. Bronson Health Care Group, 917 F.2d 266, 271 (6th Cir. 1990)(held to be stabilized because no facts indicating otherwise); Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302, 1305 (N.D. Ill. 1990)(definition of "to stabilize" is obviously factual question). *See supra* notes 13-27 and accompanying text (discussing these cases more fully).
76. *See* definition of "stabilized" *supra* note 12.

law on this issue when an actual factual dispute exists would accomplish nothing. The Tenth Circuit's decision may influence other courts to resist ruling on similar issues before trial.

On the issue of a physician's civil liability under EMTALA, the court properly held that no such liability exists based on the actual language of the statute and on other court decisions.[77] It does seem anomalous, however, that both negligent hospitals and negligent doctors may incur administrative monetary penalties, but only negligent participating hospitals may be sued by private individuals.[78] Even though a hospital may be appropriately considered vicariously liable for the negligent acts of its physicians, it is usually an individual physician who makes the medical decisions, examines or fails to examine the patient, and provides or fails to provide the treatment.

The legislative history fails to directly address the reason for immunizing physicians from private civil liability, but the Judiciary Committee expressed its concern that overly severe penalties might defeat the goal of the act to increase availability of emergency care, thereby leading some hospitals to close their emergency rooms to avoid penalty risks.[79] In addition, the committee expressed concern that more severe penalties might exacerbate the medical malpractice crisis.[80] The Judiciary Committee believed the present penalties constituted a sufficient deterrent against emergency room abuses.[81] Perhaps the committee also felt that creating a private cause of action against physicians under the act would be superfluous in light of common law malpractice suits.

To make the act's penalty provisions more consistent, Congress could allow for limited physician civil liability. For example, Congress could cap the amount of available damages. Congress could also require the aggrieved patient to choose between suing the physician under the act, or suing the physician under a common law action. While congressional concerns about the potentially adverse effects of imposing overly harsh penalties are certainly understandable, allowing an injured patient some level of personal redress through the act, even if limited, should accomplish the goals of the act, yet dodge adverse repercussions.

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77. *See, e.g.*, Jones v. Wake County Hosp. Sys., Inc., 786 F. Supp. 538, 545 (E.D.N.C. 1991) (COBRA does not provide a private cause of action against a physician); Lavignette v. West Jefferson Medical Ctr., No. CIV.A.89-5495, 1990 WL 178708, at *2 (E.D. La. Nov. 7, 1990) (holding the express language and legislative history of EMTALA indicate it was not intended to provide a private cause of action against physicians); Verhagen v. Olarte, No. 89CIV.0300(CSH), 1989 WL 146265, at *6 (S.D.N.Y. Nov. 21, 1989) (construing EMTALA as excluding a federal private claim against a physician).

78. *See supra* part I.A.2.

79. *See* H.R. REP. No. 241, 99th Cong., 2d Sess., pt. 3, at 6 (1986), *reprinted in* 1986 U.S.C.C.A.N. 726, 728.

80. *Id.*

81. *Id.* at 7, *reprinted in* 1986 U.S.C.C.A.N. 726, 729.

II. "SOLE COMMUNITY HOSPITAL" UNDER THE MEDICARE ACT: *COMMUNITY HOSPITAL V. SULLIVAN*[82]

A. *Background*

Originally, the Medicare Act provided reimbursement to participating hospitals for the "reasonable cost" of care given to Medicare recipients.[83] In 1983, Congress changed the system by replacing the "reasonable cost" system with the "prospective payment system" (PPS).[84] The PPS paid set amounts to hospitals based on the diagnoses of patients.[85] Congress hoped this new system would encourage hospital efficiency by rewarding cost-efficient services.[86] However, because smaller rural hospitals are often less efficient than larger urban medical centers, these rural hospitals received disproportionately fewer Medicare reimbursements than their urban counterparts.[87] In response to this adverse effect, Congress allowed certain rural hospitals, those defined as "sole community hospitals" (SCHs), to receive more Medicare funds.[88]

Congress originally defined SCH in fairly general terms.[89] In 1989 Congress narrowed the definition by requiring, among other things, that SCHs be more than 35 miles from other hospitals or that SCHs be the only source of hospital services due to a lack of "other like hospitals."[90] The phrase "like hospitals" did not exist in the former definition.[91]

Pursuant to the authority granted in the statute, the Secretary of Health and Human Services promulgated corresponding administrative regulations concerning SCH status.[92] The regulations define "like hospital" as one providing "short-term acute care."[93] In addition, the regulations state that hospitals with SCH status under the original system would

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82. 986 F.2d 357 (10th Cir. 1993).

83. 42 U.S.C. § 1395ww (1982)(amended 1983); *see id.* at 358;.

84. 42 U.S.C. § 1395ww(d) (1988)(amended 1989); *see Community Hosp.*, 986 F.2d at 358;

85. 42 U.S.C. § 1395ww(d) (1988); *see Community Hosp.*, 986 F.2d at 358.

86. H.R. REP. No. 25, 98th Cong., 1st Sess. 132 (1983), *reprinted in* 1983 U.S.C.C.A.N. 219, 351; *see Community Hosp.*, 986 F.2d at 358.

87. Robin E. Margolis, *Healthtrends*, HEALTHSPAN, May 1992, at 21.

88. 42 U.S.C. § 1395ww(d)(5)(c)(ii) (1988); *see id.*

89. 42 U.S.C. § 1395ww(d)(5)(C)(ii) (1988)(amended 1989) provided:

> [T]he term "sole community hospital" means a hospital that, by reason of factors such as isolated location, weather conditions, travel conditions, or absence of other hospitals (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographical area who are entitled to benefits under part A of this subchapter.

90. 42 U.S.C. § 1395ww(d)(5)(D)(iii) (Supp. III 1991) (emphasis added) provides:

> [An SCH is] any hospital(I) that the Secretary determines is located more than 35 road miles from another hospital, (II) that, by reason of factors such as the time required for an individual to travel to the nearest alternative source of appropriate inpatient care . . ., location, weather conditions, travel conditions, or absence of other *like hospitals* (as determined by the Secretary), is the sole source of inpatient hospital services reasonably available to individuals in a geographic area who are entitled to benefits under part A of this subchapter, or (III) that is designated by the Secretary as an essential access community hospital . . . .

91. *See* 42 U.S.C. § 1395ww(d)(5)(C)(ii) (1988)(amended 1989).

92. 42 C.F.R. § 412.92 (1990).

93. *Id.* § 412.92(c)(2).

not be required to meet the new standards,[94] and SCH status would not be revoked unless the conditions surrounding the conferral of the status changed.[95]

In *St. Mary's Hospital & Medical Center v. Heckler* (*St. Mary's*),[96] the district court found that St. Mary's Hospital qualified as a SCH because nearby Community Hospital, unlike St. Mary's Hospital, provided limited *osteopathic*[97] care; St. Mary's Hospital provided more extensive *allopathic*[98] care.[99] This difference in treatment methodologies distinguished the two hospitals sufficiently enough to permit SCH status for St. Mary's Hospital.[100] Based on the reasoning of the *St. Mary's* case, Community Hospital also applied for SCH status, resulting in the recent Tenth Circuit decision.[101]

B. *Tenth Circuit Decision:* Community Hospital v. Sullivan

1. Facts

Community Hospital v. Sullivan involved the same two hospitals as in *St. Mary's Hospital & Medical Center v. Heckler.*[102] Community Hospital (Community) provides short-term, acute osteopathic[103] care in Grand Junction, Colorado.[104] The nearest osteopathic hospital is located 500 miles away in Albuquerque, New Mexico.[105] However, St. Mary's Health Center (St. Mary's), a short-term, acute allopathic[106] care hospital, is located only a few blocks away from Community.[107] In addition, St. Mary's has SCH status under an obsolete statutory and regulatory procedure.[108] The basis

94. *Id.* § 412.92(b)(5) provides:

> A hospital that has been granted an exemption from the hospital cost limits under § 413.30(e)(1) of this chapter before October 1, 1983, or whose request for the exemption was received by the appropriate intermediary before October 1, 1983, and was subsequently approved, will be automatically classified as a [SCH] unless that classification has been canceled under paragraph (b)(3) of this section, or there is a change in the circumstances under which the classification was approved.

95. *Id.* § 412.92(b)(3) provides, "An approved classification as a [SCH] will remain in effect without need for reapproval unless there is a change in the circumstances under which the classification was approved."

96. No. CIV.84-Z-1474, 1985 WL 56559 (D. Colo. Feb. 7, 1985).

97. Osteopathy is "[a] school of medicine based upon the idea that the normal body when in 'correct adjustment' is a vital machine capable of making its own remedies against infections and other toxic conditions. Practitioners use the diagnostic and therapeutic measures of ordinary medicine in addition to manipulative measures." STEDMAN'S MEDICAL DICTIONARY 1004 (5th unabr. lawyer's ed. 1982). Practitioners are doctors of medicine. Community Hosp. v. Sullivan, 986 F.2d 357, 362 n.2 (10th Cir. 1993).

98. Allopathy is "substitutive therapy; a therapeutic system in which a disease is treated by producing a second condition that is incompatible with or antagonistic to the first." *Id.* at 44.

99. *St. Mary's*, 1985 WL 56559 at *1; *see Community Hosp.*, 986 F.2d at 359.

100. *St Mary's*, 1985 WL 56559 at *1-2.

101. *See Community Hosp.*, 986 F.2d at 359.

102. *Id.*

103. *See supra* note 97 (definition of osteopathic).

104. *Community Hosp.*, 986 F.2d at 359.

105. *Id.*

106. *See supra* note 98 (definition of allopathic).

107. *Community Hosp.*, 986 F.2d at 359.

108. *See id.*; St. Mary's Hosp. & Medical Ctr. v. Heckler, No. CIV.84-Z-1474, 1985 WL 56559 at *1. The *St. Mary's* case was decided before the current statutes and regulations went

for St. Mary's SCH status arose from the fact that Community provided only osteopathic care with limited services, (that is, no intensive care, therapeutic radiology, or emergency department), while St. Mary's provided allopathic care.[109]

Relying on the *St. Mary's* decision and the 500-mile distance between Community and the nearest osteopathic hospital, Community applied for SCH status in 1990.[110] The Secretary of Health and Human Services refused to grant SCH status to Community on the grounds that Community and St. Mary's fit the definition of "like hospitals."[111] On appeal, the district court relied on the *St. Mary's* decision, reversed the Secretary's ruling, and ordered the Secretary to grant Community SCH status.[112] The Secretary appealed to the Tenth Circuit.[113]

2. Opinion

The Tenth Circuit reversed the district court's decision.[114] The court applied a standard of review deferential to the Secretary's findings and quickly dispensed with Community's first two arguments: collateral estoppel and inappropriate deference to the Secretary's interpretation.[115] The court held that the Secretary was not collaterally estopped from raising the "like hospitals" issue because the facts and law had significantly changed from those existing at the time of the *St. Mary's* decision.[116] Specifically, Community's services had changed, as had the statutory and regulatory procedure.[117] On the issue of inappropriate deference to the Secretary's interpretation, the court ruled that deference to the Secretary was appropriate for two reasons: (1) Congress explicitly granted the Secretary the authority to administer the statute, and (2) the Secretary reasonably interpreted it.[118]

The third and primary substantive issue in the case involved the proper interpretation of the regulatory definition of "like hospitals."[119] Community first argued that the Secretary's interpretation of the phrase conflicted with congressional intent by creating an unfair economic imbalance between the two fundamentally different hospitals.[120] Community further argued that the administrative regulations permitting the Secretary to revoke the SCH status of grandfathered hospitals due to changed circumstances[121] conflicted with the "like hospitals" regulation.[122] Specifi-

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into effect. *See Community Hosp.*, 986 F.2d at 360. *See also supra* notes 88-94 and accompanying text.

109. *Community Hosp.*, 986 F.2d at 359; *see St. Mary's*, 1985 WL 56559 at *1.
110. *Community Hosp.*, 986 F.2d at 359.
111. *Id.*
112. *Id.*
113. *Id.* at 358.
114. *Id.* at 360.
115. *Id.* at 360.
116. *Id. See supra* notes 95-100 and accompanying text (discussing the *St. Mary's* decision).
117. *Community Hosp.*, 986 F.2d at 360.
118. *Id.*
119. *See id.* at 361; 42 C.F.R § 412.92(c)(2) (1990).
120. *See Community Hosp.*, 986 F.2d at 361.
121. *See* 42 C.F.R. § 412.92(b)(3), (5) (1990); *supra* notes 93-94 and accompanying text.

cally, Community asked how the Secretary could deny Community SCH status on the basis of changed circumstances while simultaneously allowing St. Mary's' SCH status to continue despite the changed circumstances.[123] Finally, Community argued that the allopathic and osteopathic distinction made the two hospitals different by nature.[124]

The court first held that because the statute clearly seeks to reimburse rural hospitals that are the only available means of *standard* medical care, and not those hospitals in the same rural area that provide *specialty* care, the need to analyze the statute's legislative history was eliminated.[125] Second, the court held that the grandfather regulation[126] requiring SCH applicants such as Community to meet the present statutory and regulatory scheme, while exempting those with prior SCH status such as St. Mary's, did not invalidate the "like hospitals" regulation merely because a different regulatory mechanism applied to the grandfathered hospitals.[127] Finally, the court held that the district court incorrectly applied the *St. Mary's* decision to Community's case.[128] The court found the osteopathic/allopathic distinction irrelevant under the present regulations.[129] "Like hospitals," as used in the statute and defined in the regulation, include those hospitals located within 35 miles of each other that provide short-term, acute care regardless of the type of care otherwise provided.[130] The court applied this definition and found that both hospitals provided short-term, acute care within 35 miles of each other, and thus concluded that Community did not qualify for SCH status.[131]

C. *Analysis*

The Tenth Circuit's decision turns on the definition of "like hospitals" as defined in title 42 § 412.92 of the 1990 Code of Federal Regulations.[132] Because a like hospital, St. Mary's, was within 35 miles of Community, Community did not meet the requirements of the statute and could not receive SCH status.[133] This decision seems logical and appropriate. It requires a strict application of a relatively clear statute and regulation to the facts. The court's decision does not sidestep the issue, convolute the meaning of the statute, or boldly override the controlling legislation. The court found the statute and definitions to be clear and

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122. *Community Hosp.*, 986 F.2d at 361.
123. *Id.*
124. *Id.* at 362.
125. *Id.* at 361 (citing *Public Hosp. Dist. No. 1 v. Sullivan*, 806 F. Supp. 1478, 1485 (E.D. Wash. 1992)). "There is no indication in the language of the statute that Congress intended that the government subsidize specialty hospitals located in the same rural community." *Id.*
126. *See* 42 C.F.R. § 412.92(b)(5) (1990); *supra* note 89 and accompanying text.
127. *Community Hosp.*, 986 F.2d at 361-62.
128. *Id.* at 362.
129. *See id.*
130. *Id.*
131. *Id.* at 363.
132. 42 C.F.R. § 412.92 (1990). *See supra* text accompanying note 93.
133. *Community Hosp.*, 986 F.2d at 363.

applied the law to Community's case. When the requirements for SCH status were not met, the court properly denied Community that status.

Nevertheless, the result is troublesome. Because Community is an osteopathic hospital and St. Mary's is an allopathic hospital, the two hospitals provide fundamentally different *approaches* to acute medical care, not different *specialties*.[134] Therefore, patients who prefer one approach over the other are limited to one such hospital within a 35-mile radius. The Tenth Circuit's decision sets a precedent that two hospitals are "like hospitals" regardless of the fact that they provide two completely different types of acute care. Because the court's decision turned primarily on the definition of "like hospitals," that definition should be narrowed to prevent "unlike" hospitals from being considered "like." This would permit patients to chose the *type* of short term acute care they desire. A narrower definition is also consistent with Congress' goal in granting SHC status to prevent additional charges from being passed on to the patients who have no opportunity to use a less expensive hospital if only one hospital is in the community and if Medicare reimbursement is limited.[135] Patients in Grand Junction, Colorado who wish to undergo osteopathic care are denied this opportunity to shop around.

Furthermore, this decision leaves Community economically disadvantaged compared to St. Mary's. With the SCH reimbursements, St. Mary's may be more cost competitive than Community and ultimately cause Community's closure. Such a result conforms neither to Congress' apparent intent (to reimburse less efficient rural hospitals so they can remain open) nor to the needs of rural communities (availabilty of medical care).

Even though the court's decision seems unfair, the court may have had little choice. Given the clear statutory and regulatory definitions, the decision for Community may have set a snowballing precedent. Most rural hospitals, if not all, would be able to ride on the coattails of grandfathered hospitals and gain SCH status,[136] effectively rendering the new regulations useless. Moreover, as Community implicitly argued, the changes in Community's medical services and the changes in the law itself strongly suggest that St. Mary's' SCH status should be revoked.[137] Therefore, to avoid similar inequitable results in the future, either the statute and regulations need to be further amended or the agency responsible for determining SCH status should do its job and revoke unnecessary grants.

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134. For definitions of osteopathy and allopathy, see *supra* notes 97-98; *see also Community Hosp.*, 986 F.2d at 362 n.2 (distinguishing the practices of osteopathic and allopathic medicine).

135. *Community Hosp.*, 986 F.2d at 361.

136. *See Community Hosp.*, 986 F.2d at 361.

137. *See id.* at 361.

III. Section 510 of ERISA and Interference with Employee Health Benefits: *Phelps v. Field Real Estate Co.*[138]

A. *Background*

Congress enacted ERISA[139] as a means of uniformly regulating private employee benefit programs.[140] ERISA applies to both pension and welfare or health benefit plans.[141] This statute serves as a guide for private, self-insured employers to determine their employees' benefits.[142] Section 510 of ERISA forbids both employer discrimination against, or discharge of, employees who rightfully file benefit claims, and further forbids employer interference with employees' rights to receive benefits under a benefit plan.[143] In other words, the statute prohibits discrimination or discharge not only for actually filing a benefit claim, but also for the probability or possibility of filing a claim.[144]

As suggested above, ERISA cases usually follow one of two scenarios: (1) the employer discharges the employee, supposedly for a legitimate reason, but the employee alleges that the employee's effect, or expected effect, on benefit costs actually motivated the discharge; or (2) the employee claims that the employer changed or stopped the employee's benefit plan to conserve costs.[145] *Phelps* involved the first of these scenarios.[146]

In discharge cases, the employee must generally show three elements: (1) the employer engaged in prohibited conduct; (2) to interfere, (3) with the employee's right to receive benefits.[147] If the employer masks the motive with a legitimate reason for the discharge, however, the employee's burden of proof becomes extremely difficult.[148] In *Gavalik v. Continental Can Co.*, the Third Circuit Court of Appeals held that ERISA cases require proof of a specific intent to discriminate or interfere with a benefit right.[149] The court added that circumstantial evidence may be used to

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138. 991 F.2d 645 (10th Cir. 1993).

139. 29 U.S.C. §§ 1001-1461 (1988 & Supp. IV 1992).

140. Carl A. Greci, Note, *Use It and Lose It: The Employer's Absolute Right Under ERISA Section 510 to Engage in Post-Claim Modifications of Employee Welfare Benefit Plans*, 68 Ind. L.J. 177, 179 (1992). ERISA applies to benefit plans financed through the employer's own assets (self-insured benefits), not to commercial insurance benefits. *See id.* at 177-78.

141. *Id.* at 179, 181; *see* 29 U.S.C. § 1002(1)-(2) (1988).

142. Arthur S. Leonard, *Ethical Challenges of HIV Infection in the Workplace*, 5 Notre Dame J. L. Ethics & Pub. Pol'y 53, 63 (1990).

143. Joan Vogel, *Containing Medical and Disability Costs by Cutting Unhealthy Employees: Does Section 510 of ERISA Provide a Remedy?*, 62 Notre Dame L. Rev. 1024, 1041-42 (1987). ERISA § 510 provides:

> It shall be unlawful for any person to discharge, fine, suspend, expel, discipline, or discriminate against a participant or beneficiary for exercising any right to which he is entitled under the provisions of an employee benefit plan . . . or for the purpose of interfering with the attainment of any right to which such participant may become entitled under the plan . . . .

29 U.S.C. § 1140 (1988).

144. *See* Vogel, *supra* note 143, at 1042.

145. Greci, *supra* note 140, at 184-85.

146. *See* Phelps v. Field Real Estate Co., 991 F.2d 645, 645 (10th Cir. 1993).

147. Gavalik v. Continental Can Co., 812 F.2d 834, 852 (3d Cir.), *cert. denied*, 484 U.S. 979 (1987); Greci, *supra* note 140, at 185.

148. Vogel, *supra* note 143, at 1042.

149. *Gravalik*, 812 F.2d at 851-52.

show specific intent.[150] In *Conkwright v. Westinghouse Electric Corp.*,[151] the court ruled that an employee claiming discriminatory discharge on the basis of his age must prove that his age more probably than not motivated the employer's decision to discharge.[152]

Phelps involved allegations of such unlawful discharge based on the employee's development of Acquired Immune Deficiency Syndrome (AIDS).[153] AIDS costs both money and lives. The enormous health care costs associated with AIDS invite employers to target and discriminate against employees or potential employees who either have AIDS, have tested positive for human immunodeficiency virus (HIV)[154] infection, or present a high risk of contracting the virus.[155] Before *Phelps*, no case law existed directly addressing ERISA's protection against discriminatory discharge of an employee with AIDS.[156] Courts have granted relief under ERISA, however, to employees discharged for other illnesses.[157]

B. *Tenth Circuit Opinion:* Phelps v. Field Real Estate Co.

1. Facts

Field Real Estate Company (Field) hired John Phelps as vice-president of commercial real estate in 1985.[158] Almost two years later, Phelps tested positive for HIV; however, he exhibited no symptoms or illness.[159] Because his HIV status did not affect his ability to work, Phelps decided not to disclose his condition.[160]

The chief executive officer of Field, Douglas Poole, evaluated Phelps' performance annually.[161] On a scale of one to five, Phelps received primarily threes on his 1986 evaluation.[162] In 1987, Phelps was promoted to senior vice-president, and in his 1987 performance evaluation, he received primarily fours.[163]

In 1988, Poole received an anonymous note stating that Phelps had a fatal blood disease, and asking that he be transferred.[164] When con-

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150. *Id.*; *see also* Dister v. Continental Group, Inc., 859 F.2d 1108, 1112 (2d Cir. 1988) (stating that specific intent in ERISA claims can rarely be shown by direct evidence).

151. 933 F.2d 231 (4th Cir. 1991).

152. *Id.* at 235.

153. *Phelps*, 991 F.2d 645.

154. HIV is the virus that causes AIDS. THE SLOANE-DORLAND ANNOTATED MEDICAL-LEGAL DICTIONARY 497 (1992 Supp.).

155. *See* Vogel, *supra* note 143, at 1031, 1061.

156. *See* Leonard, *supra* note 142, at 65. *Cf.* McGann v. H & H Music Co., 946 F.2d 401 (5th Cir. 1991) (affirming an employer's absolute right to significantly reduce the maximum lifetime benefit for AIDS-related claims).

157. *See* Arthur S. Leonard, *AIDS, Employment and Unemployment*, 49 OHIO ST. L.J. 929, 950-52 (1989); *see, e.g.*, Folz v. Marriott Corp., 594 F. Supp. 1007 (W.D. Mo. 1984) (awarding equitable relief under ERISA to an employee fired after revealing that he had multiple sclerosis).

158. Phelps v. Field Real Estate Co., 991 F.2d 645, 646-47 (10th Cir. 1993).

159. *Id.* at 647.

160. *Id.*

161. *Id.*

162. *Id.*

163. *Id.* at 647.

164. *Id.*

fronted, Phelps admitted that his condition was fatal and that he kept it confidential for fear of losing his job and health insurance.[165] Poole reassured Phelps; however, Poole expressed concern about the effects of Phelps' condition on corporate liability and the acquisition of "key man" insurance for Phelps if Field were sold.[166] At Poole's request, Phelps produced a letter signed by a physician stating that Phelps' condition could adversely affect his insurability but that his condition did not presently affect his job performance.[167] Phelps still did not reveal the true nature of his condition.[168] Phelps gave the letter to Poole, who expressed confidence in Phelps' working capabilities.[169]

Later in 1988, Poole advertised for a commercial real estate division manager, describing a position similar to Phelps' job.[170] In early 1989, Phelps received all fours on his evaluation, but a performance comment stated that commercial sales growth had been poor.[171] Phelps responded that outside factors including a poor economy stunted the division's growth.[172]

In August 1989, a memo leaked regarding changes in the commercial division and the hiring of a new general manager of sales and leasing.[173] Two days later, Field discharged Phelps; the reasons given were the division's poor performance and the company's reorganization.[174] At that time, Phelps revealed that he had AIDS and that discharging him would terminate his health insurance benefits.[175] Poole stated that he was not aware Phelps had AIDS and offered him a position as a real estate agent with the option of continuing his health insurance at his own expense.[176] Phelps rejected the offer and filed suit against Field, claiming violations under § 510 of ERISA.[177]

The district court found that Poole did know the true nature of Phelps' illness but that Phelps failed to prove a discriminatory motive.[178] Phelps' personal representative appealed,[179] and the Tenth Circuit affirmed.[180]

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165. *Id.*
166. *Id.*
167. *Id.* at 647-48.
168. *Id.* at 648 n.4.
169. *Id.* at 648.
170. *Id.*
171. *Id.*
172. *Id.*
173. *Phelps*, 991 F.2d at 648.
174. *Id.* at 649.
175. *Id.*
176. *Id.*
177. *Id.* at 646. This survey does not discuss Phelps' second claim alleging discrimination against employees with handicaps under COLO. REV. STAT. § 24-34-402(1)(a) (1988). *See Phelps*, 991 F.2d at 650.
178. *Phelps*, 991 F.2d at 649-50.
179. *Id.* at 646 n.1. John Phelps died in 1992 before his case was heard on appeal. *Id.*
180. *Id.* at 651.

2. Opinion

Phelps' ERISA claim required the Tenth Circuit to determine whether the evidence suggested that Field based any part of its decision to discharge Phelps on saving expected benefit costs.[181] The court applied the rule from *Conkwright v. Westinghouse Electric Corp.*,[182] requiring Phelps to show that his medical condition, more probably than not, motivated his employer to fire him.[183] The court also applied the rules from *Gavalik v. Continental Can Co.*,[184] and *Dister v. Continental Group, Inc.*,[185] stating that Phelps could prove his claim by using circumstantial evidence because direct evidence of an improper motive is rare.[186] After briefly analyzing the district court's findings of fact; the court found that Phelps failed to show any prohibited intent on the part of his employer.[187] The court based its decision on the following facts: (1) Field discharged Phelps fourteen months after he revealed his illness; (2) the commercial sales division under Phelps did not meet growth expectations; (3) Field completely reorganized its commercial sales and leasing division; (4) at the time of Phelps' discharge, Field warned another employee who headed the commercial leasing division that his job was limited; and (5) the other employee left the company soon after the reorganization.[188]

C. *Analysis*

Phelps exposes a variety of troubling contemporary ethical and legal issues. The court's decision itself is disturbing. The Tenth Circuit applied the conventional rules concerning discriminatory discharge under § 510 of ERISA but engaged in a rather dubious factual analysis. The court seemed to slide by some very important facts in reaching its decision that strongly suggested improper motive. First, the court agreed that evidence existed to show the possible adverse effect an employee with AIDS might have on health benefits.[189] The district court found and the Tenth Circuit accepted the fact that Poole, Phelps' supervisor, knew or at least suspected that Phelps had AIDS, even though the facts also showed that Poole expressed surprise when Phelps revealed his true illness.[190] The facts show that Poole expressed concern about the effects of Phelps' illness on corporate liability and securing "key man" insurance.[191] Phelps' performance evaluations continually improved; in fact, his last evaluation contained all fours, yet Field discharged Phelps for his past performance.[192] Field fired

181. *See id.* at 649.
182. 933 F.2d 231 (4th Cir. 1991).
183. *See id.* at 235.
184. 812 F.2d 834 (3d Cir.), *cert. denied*, 484 U.S. 979 (1987).
185. 859 F.2d 1108 (2d Cir. 1988).
186. *See Phelps*, 991 F.2d at 645; *Dister*, 859 F.2d at 1112; *Gavalik*, 812 F.2d at 852.
187. *See Phelps*, 991 F.2d at 650.
188. *See id.*
189. *See id.*
190. *Id.* at 649; *see* Phelps v. Field Real Estate Co., 793 F. Supp. 1535, 1540-41 (D. Colo. 1991).
191. *Phelps*, 991 F.2d at 647.
192. *See id.* at 647-49.

Phelps without warning and without instituting a probationary employment period.[193] In light of the fact that Phelps' coworker received a warning,[194] the preceding fact becomes even more relevant. Finally, when Phelps revealed his illness, his employer offered him a demotion so that he could continue his health insurance *at his own expense.*[195] The last fact strongly suggests that Phelps' employer had considered the potential effects that Phelps' illness would have on the benefit program. Hence, circumstantial evidence of the employer's improper motive abounds.

The court should have weighted the above facts more heavily, especially given that an employer can rebut the accusation by merely presenting a legitimate reason for the discharge.[196] Apparently the division under Phelps really did experience sluggish growth. However, evidence of contributing economic factors also existed. Because AIDS not only generates costly medical expenses but also carries one of the worst stigmas of modern times, it seems highly possible, if not probable, that Phelps would not have lost his job if his employer had not known Phelps had AIDS.

Unfortunately, the AIDS epidemic continues with no certain cure or treatment in sight. Because of early detection tests and medications that delay symptoms, people known to have HIV infection live and function longer with the disease.[197] Therefore, infected persons without symptoms or illness will continue to appear in the workplace. The high costs of medical care, the availability of early detection, and perhaps lingering prejudices provide incentives to the employer to identify infected employees or potential employees. This invites discrimination.[198]

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193. *See id.* at 649.

194. *See id.*

195. *See id.*

196. *See id.* at 650. Motive may be masked by a legitimate discharge reason. *See* Vogel, *supra* note 143, at 1031, 1061.

197. *See* Leonard, *supra* note 142, at 53-54.

198. Although Colorado's amendment to its constitution (popularly known as Amendment 2), COLO. CONST. art. II, § 30(b) (Supp. 1993), is beyond the scope of this article, it does merit some attention. Amendment 2 prevents the State of Colorado and any of its cities or towns from passing laws that prohibit discrimination based on sexual orientation. Amendment 2 provides:

> No Protected Status Based on Homosexual, Lesbian, or Bisexual Orientation. Neither the State of Colorado, through any of its branches or departments, nor any of its agencies, political subdivisions, municipalities or school districts, shall enact, adopt or enforce any statute, regulation, ordinance, or policy whereby homosexual, lesbian or bisexual orientation, conduct, practices or relationships shall constitute or otherwise be the basis of or entitle any person or class of persons to have or claim any minority status quota preferences, protected status or claim of discrimination. This Section of the Constitution shall be in all respects self-executing.

Id. This type of constitutional provision simply exacerbates the problem. If such laws and ordinances are prohibited, then employers may skip the step of trying to determine whether a person has AIDS and eliminate homosexuals as a class because they (specifically homosexual males) represent a high-risk group. *See* Leonard, *supra* note 157, at 956-57.

In December 1993, the Denver District Court ruled that Amendment 2 is unconstitutional. Evans v. Romer, CIV.A. No. 92 CV 7223, 1993 WL 518586, at *9 (Colo. Dist. Ct. Dec. 14, 1993). However, this decision will probably be appealed, perhaps as high as the United States Supreme Court. Thaddeus Herrick, *Both Sides in Gay Rights Fight Claim Victory,* ROCKY MTN. NEWS, Dec. 15, 1993, at 8A. Until a final ruling of unconstitutionality is made by a higher court, the specter of other similar laws and constitutional provisions looms ominously.

High health care costs constitute the primary cause of health benefit-based discrimination. If expensive medical care costs are merely an unavoidable fact of life, however, then employers who provide health benefits should expect, prepare, and provide for employees who get sick. Furthermore, the law should strictly enforce antidiscrimination laws to diminish the incentive to discriminate against ill or potentially ill employees. Otherwise, the newly proposed national health insurance program will be the only other solution.[199] If soaring health care costs are contained, and if everyone is guaranteed some level of health care by widely distributing costs, then employers will have no reason to treat unhealthy employees differently.

Conclusion

The three cases discussed in this Survey involve two larger issues: (1) the right to quality health care and (2) the problem of high health care costs. *Delaney v. Cade*[200] and EMTALA[201] concern a patient's right to receive the best available emergency medical treatment and the liability of those who violate that right.[202] *Community Hospital v. Sullivan*[203] and the Medicare Act[204] involve the financial protection of smaller, more rural hospitals that may be the sole providers of medical care to their surrounding communities. Insuring quality health care to rural residents is the ultimate concern behind the protection of rural hospitals. In addition, the situation in *Community Hospital* arises out of high hospital costs and the inability of many patients to pay.[205] Finally, *Phelps v. Field Real Estate Co.*[206] and § 510 of ERISA[207] concern employees' rights to obtain quality health care through employer-provided health benefits. *Phelps* also exhibits the problems associated with high health care costs, and employees who require or potentially require extensive medical care.[208]

The Tenth Circuit's decisions further shape and define citizens' legal rights and obligations under the nation's health care system. The extent to which these decisions will impact health law remains to be seen, especially considering the proposed national health insurance system. Even if Congress eventually implements a new and radically different health care system, court decisions such as those surveyed here expose current health law issues and serve as guides to questions that will have to be addressed in any reformation process.

A. Mark Isley

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199. *See* Greci, *supra* note 140, at 201-02; Leonard, *supra* note 157, at 963.
200. 986 F.2d 387 (10th Cir. 1993).
201. 42 U.S.C. § 1395dd (1988 & Supp. III 1991).
202. *See supra* part I.
203. 986 F.2d 357 (10th Cir. 1993).
204. 42 U.S.C. § 1395 (1988 & Supp. III 1991).
205. *See supra* part II.
206. 991 F.2d 645 (10th Cir. 1993).
207. 29 U.S.C. § 1140 (1988).
208. *See supra* part III.