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HEALTH-CARE RIGHTS OF THE POOR:  
AN INTRODUCTION

Michele Melden, Michael Parks, and Laura Rosenthal*

INTRODUCTION

Improving access to health care is a high priority for low-income people and their advocates. A variety of tools exist to establish legal rights to reimbursement and services. Mastery of these tools can provide dramatic improvements in the lives of the poor. This article provides a brief overview of the primary reimbursement sources for health care—Medicaid, Medicare, private insurance, and state and county indigent care programs. It covers the issues involved in and approaches to insuring the uninsured. It also explains the protection of access to health care provided by the Hill-Burton program, emergency room law, and civil rights. Basic reference tools are cited in the footnotes.

I. REIMBURSEMENTS FOR HEALTH CARE

A. Medicaid

Medicaid is the program of medical assistance for the poor established by Title XIX of the Social Security Act.¹ States do not have to participate in the program. Those, however, that do must fully comply with the minimal requirements of federal law and regulation.² All states have chosen to participate.

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2. See, e.g., Schweiker v. Gray Panthers, 453 U.S. 34, 36-37 (1981) ("[s]tate Medicaid plans must comply with the requirements imposed by the Act itself and by the Secretary of Health and Human Services").
Medicaid is jointly administered and financed by the federal and state governments. The Health Care Financing Administration (HCFA) is the federal agency within the United States Department of Health and Human Services (HHS) that administers Medicaid. States must designate a “single state agency” to administer the program at the state level.

Medicaid is a means-tested entitlement program, and therefore not all of the poor qualify. Rather, people may obtain coverage if they fit within any of three major groups: mandatory categorically needy, optional categorically needy, and medically needy.

Federal law requires states to cover people determined to be “mandatory categorically needy.” Examples of the mandatory categorically needy include: recipients of Aid to Families with Dependent Children (AFDC) and Supplemental Security Income (SSI); pregnant women and infants whose incomes are below 133 percent of the federal poverty level; and Qualified Medicare Beneficiaries (QMBs). States also may choose to cover the “optional categorically needy,” such as people who would be eligible for cash assistance under the state’s AFDC or SSI program, but who have not applied. Finally, states may choose to cover the “medically needy”—those who fit into federal benefit program categories because they are aged, blind, disabled, or are parents with children whose incomes or resources are above the categorically needy levels. Those who are not eligible for Medicaid can “spend down” their excess income on medical expenses to establish Medicaid eligibility.

When determining eligibility under any of these three groups, states will apply a number of income and resource tests. In addition, a person must also

3. Federal reimbursement to the states, known as “federal financial participation,” varies from 50 to 78 percent, depending on the per capita income of the state. See 42 U.S.C. § 1396b(a)(1) (1990). Poorer states have higher matching percentages.
7. The 133 percent standard applies to infants through age five. 42 U.S.C. § 1396(a) (10) (A) (i) (VI) (1990). Children age six and older, born after September 30, 1983, with family incomes up to 100 percent of poverty must be covered. Id. at § 1396a(a) (10) (A) (i) (VII).
8. Qualified Medicare Beneficiaries (QMBs) are Medicare beneficiaries with incomes up to 100 percent of the federal poverty level and resources up to twice the SSI level. Medicaid pays their Medicare premium and cost-sharing expenses (see part II.B, infra). 42 U.S.C. §§ 1396a(a)(10)(E)(i) and 1396d(p) (1990).
9. For example, only income that is actually available to the applicant is to be considered in evaluating eligibility 42 U.S.C. § 1396a(a)(17)(B) (1990).
be a state resident and satisfy certain immigration status requirements.

The Medicaid program does not directly provide health care services to eligible people, nor does it provide recipients with money to purchase health services. Rather, Medicaid is a vendor payment program, in which medical providers and institutions that choose to participate and provide covered services are reimbursed by the program. Medicaid recipients usually receive a Medicaid identification card that they show to the participating providers to obtain medical care. Participating providers, including hospitals, clinics, nursing homes, pharmacies, doctors, and dentists, provide the services and then bill the state. States frequently seek to encourage or require recipients to receive services through “managed care” plans such as health maintenance organizations.

Under federal law, states must pay for certain services, such as inpatient hospital services, physician services, skilled nursing facility services, and Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT). States are also required, at a minimum, to ensure the availability of transportation to and from necessary medical care. States may also choose to cover other services, such as prescription drugs, private duty nursing, dental

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10. Someone present in a state with the intent to remain is considered a state resident. 42 C.F.R. §435.403(h) (1991). Individuals may not be denied eligibility due to homelessness. 42 U.S.C. §§ 1396a(a)(48) and 1396a(b)(2) (1990).

11. To obtain full scope Medicaid benefits, state residents must either be U.S. citizens or have “Satisfactory Immigration Status,” i.e., be (1) legal permanent residents, (2) permanent residents under color of law (a.k.a. PRUCOL), or (3) amnesty recipients who are (a) under age 18, (b) over age 65, (c) blind, (d) disabled, or (e) Cuban/Haitian entrants. Other amnesty recipients must be given at least pregnancy-related and emergency services. 42 C.F.R. §§ 435.405-435.408 (1991). People of other immigration status, including the undocumented, must receive coverage for treatment of emergency medical conditions. 42 U.S.C. § 1396b(v) (1990). Some states provide broader coverage, often of prenatal care and postpartum care. See e.g., CAL. WELF. & INST. CODE § 14007.5(d).

12. Federal law and policy allow exceptions for a state to make direct payments: (1) to non-cash assistance Medicaid recipients for physician and dental care, 42 U.S.C. § 1396d(a) (1990); and (2) to individuals who paid for covered services due to erroneous state determinations, HCFA STATE MEDICAID MANUAL § 6310; Memorandum PM-81-169 (Oct. 16, 1981). See also 42 C.F.R. § 431.246 (1991), which requires direct payment when a hearing officer determines that benefits were wrongfully denied.


15. 42 U.S.C. §§ 1396a(a)(10)(A) and 1396d(a) (1990).

16. Id. at §§ 1396a(a)(43) and 1396d(r) (1990). EPSDT is a program of health examinations and follow-up care for children. Many states use their own special names for their EPSDT programs.

services, and psychiatric services. A service must be "sufficient in amount, duration, and scope to reasonably achieve its purposes." In providing services, states cannot discriminate because of a person's condition. States may, however, place "appropriate limits on a service based on such criteria as medical necessity or utilization review."

Applicants for Medicaid ordinarily apply through the state welfare agency, although a new "outstationing" duty requires states to accept applications from certain pregnant women and children at designated hospitals and clinics. All people must be given the opportunity to apply for Medicaid without delay, and applications must be processed within certain time frames. States must also inform applicants and recipients of the benefits available under the program and about their rights and obligations. As with other public benefit programs, Medicaid applicants and recipients have the right to notice and an administrative hearing regarding decisions made on the eligibility and services coverage.

B. Medicare

Medicare is the federal health insurance program for the elderly and some younger disabled people. It is financed through a combination of social security payroll taxes, general revenues, and monthly premiums paid by beneficiaries, and it is administered by HCFA.

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20. Id. at § 440.230(c)(1).
21. Id. at § 440.230(d).
22. 42 U.S.C. §§ 1396a(a)(5) and 1396a(a)(55) (1990). In the case of aged, blind, or disabled people applying for SSI, states that use SSI criteria to determine Medicaid eligibility may enter into agreements with the Secretary of HHS to have the Secretary determine eligibility for Medicaid. States that have entered into such agreements are often described as "Section 1634" states, named after the section of the Social Security Act that authorizes such agreements. Id. at § 1383c (2).
23. Id. at § 1396a(a)(8) and 42 C.F.R. § 435.906 (1991).
24. 42 C.F.R. § 435.911 (1990) (applications must be processed within 90 days in cases involving disability determinations and in 45 days for all other cases). See also 42 U.S.C. § 1396a(v) (1990) and 42 C.F.R. § 435.541 (1990).
28. 42 U.S.C. §§ 1395i(a) and 1395t (1990).
Medicare differs from Medicaid in that eligibility is normally based on a person's insured status under the social security or railroad retirement program, rather than financial need. People age 65 and over, eligible for either program, are automatically eligible for Medicare. Younger disabled persons must have 24 months' cumulative entitlement to social security disability benefits before they can become eligible.

Medicare is divided into two parts for administrative purposes. Part A (Hospital Insurance) covers hospital, skilled nursing facility, home health, and hospice care. Part B (Supplemental Medical Insurance) covers several medical services usually provided on an outpatient basis, including physician care, durable medical equipment, ambulance trips, and ambulatory surgery.

To obtain reimbursement, providers submit claims for payment to private insurance companies under contract with HCFA. The provider must submit all claims for Part A services and for Part B physician services. Physicians and medical equipment suppliers may accept "assignment"—or agree to accept the Medicare payment level as payment in full. Beneficiaries denied coverage for medical services under either Part have rights to written notice and appeal.

Medicare is not a comprehensive program and excludes many medical services and items from coverage. Beneficiaries are also responsible for paying certain out-of-pocket costs, including monthly Part B premiums, an annual deductible for hospital care ($652 in 1992), and a $100 annual Part B deductible. They must also pay 20 percent of the amount approved by Medicare for each Part B service. When Medicare denies payment for services on the ground that they were not medically necessary, however, the beneficiary's liability for payment can often be waived.

The Medicare Catastrophic Coverage Act of 1988 (MCCA) would have significantly expanded coverage and limited out-of-pocket costs for

29. Id. at § 1395c; see also 42 U.S.C. §§ 426(a) and 426(b)(1990).
31. Id. at § 1395k.
32. Insurance companies administering Part A benefits are called intermediaries; those handling Part B benefits are called carriers.
34. Non-covered items include some of the most frequently used services, such as prescription drugs, eyeglasses, hearing aids, and dental care. Services found not "reasonable and necessary" are also excluded.
35. Id. at § 1395pp.
beneficiaries, but it was repealed the year after enactment.\textsuperscript{36}

Currently, Medicare employs a detailed array of coverage rules, and
determinations are often unduly strict. In addition, Medicare uses provider
reimbursement formulas and policies that are aimed at containing Medicare
program costs and giving providers incentives to limit care.\textsuperscript{37} Finally, a large
Medicare supplemental insurance (Medigap) industry has developed that
capitalizes on beneficiary concerns over noncovered medical expenses. Thus,
beneficiaries will continue to need advocacy assistance to obtain the maximum
coverage that they are due under Medicare and to address related problems.

C. \textit{Private Health Insurance}

Private insurance remains a source of health care cost coverage for some
low-income people, particularly the employed and their dependents. Under a
typical employer-based insurance plan, an employer and beneficiary make
periodic payments (premiums) in return for payment of health care expenses
by the plan. The plan defines the type and scope of services covered, and a
few plans provide comprehensive coverage. Many, however, limit the amount
of benefits payable to a person to an annual or lifetime maximum.

Almost all plans require enrollees to pay some costs themselves. Typical
out-of-pocket expenses for beneficiaries include a "deductible," an amount that
must be paid before the plan will pay, and "coinsurance," a portion of a
covered expense payable after the deductible has been met. Although many
plans limit the total yearly costs that the enrollee is required to pay, many do
not, and thus may require enrollees to pay $1,000 or more out-of-pocket
annually. Therefore, private insurance enrollees may incur significant expenses
not covered by a plan.\textsuperscript{38}

A complex combination of state and federal laws regulates private health
insurance plans. All 50 states have enacted laws regulating the sale of health
insurance and mandating the provision of certain benefits. Some states require
plans to include a procedure for settling beneficiary grievances or to provide
such a procedure through the state insurance commission. The federal

\textsuperscript{36} Medicare Catastrophic Coverage Act of 1988, Pub. L. No. 100-360, § 101 (1988); Medicare

\textsuperscript{37} Examples include the "DRG" system of hospital reimbursement, and promotion of beneficiary
enrollment in health maintenance organizations.

\textsuperscript{38} CONGRESSIONAL RESEARCH SERVICE, HEALTH INSURANCE AND THE UNINSURED:
BACKGROUND DATA AND ANALYSIS (May 1988).
Employee Retirement Income Security Act of 1974 (ERISA) also imposes requirements on employee benefit plans, including requiring that each employee be given an understandable description of the health benefits available under the plan. While ERISA, a federal law, specifically preempts state laws relating to employee benefit plans, a "saving" clause exempts state laws regulating insurance. Thus, ERISA preserves the states' mandatory benefit laws, while giving beneficiaries additional protection.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) amended ERISA and the federal tax code to require employers with 20 or more employees to offer group health insurance benefits at the group premium rate to enrollees and dependents whose coverage would otherwise terminate (COBRA continuation coverage). The law applies only to private, state, and local government employers; it does not include the federal government or religious organizations. Employees, spouses, and dependent children covered by an employer group health plan may become qualified beneficiaries when a "qualifying event" occurs. Coverage extends up to 18 months for termination or reduction of hours (up to 29 months for certain disabled people) and up to 36 months for other events. The right to extend coverage may end earlier, if the employer ceases to provide a group health plan, the beneficiary fails to pay premiums, the beneficiary becomes covered under Medicare or another group health plan that does not exclude the beneficiary's preexisting medical conditions, or in certain other circumstances.

The employers and the qualified beneficiary must give notice of the qualifying events to the health plan administrator; the administrator must then notify the beneficiary of the right to continuation of coverage. The scope of coverage available to qualified beneficiaries must be identical to that offered to non-COBRA enrollees currently covered under the plan. ERISA gives beneficiaries a private right of action against employers and plan administrators who fail to comply with the COBRA continuation law.

42. 52 Fed. Reg. 22721 (June 15, 1987); and 26 U.S.C. § 414(d) and 414(c).
43. 29 U.S.C. § 1161.
44. Id. at § 1163.
45. Id. at § 1161.
46. Id.
47. Id. at § 1132.
Beneficiaries denied coverage for health services may also assert claims and defenses arising under the insurance contract. Some courts have held that insurance policies specifically providing coverage for certain conditions must cover medical costs associated with those conditions, although the plans have been terminated. Detrimental reliance and estoppel defenses have been successfully used in some cases.48

State legislators and national groups have begun to focus on insurance industry practices that generally have been considered legal, but that exclude many high-risk people and small groups from coverage. Proposals that attempt to address these problems include limitations or outright bans on insurers' ability to impose preexisting condition exclusions, as well as limits on the variations in rates that can be charged to different subscribers and on insurers' right to reject groups that apply for coverage.49

D. Addressing the Medical Needs of the Uninsured Poor

The inability to pay for health care or insurance has disastrous implications on peoples' lives. People who lack health coverage have inferior access to care and often the result is poor health.50 Many poor people have no health coverage. In fact, only 42 percent of all people below the poverty level receive Medicaid. Even with income at 200 or even 250 percent of the federal poverty level, most people have no disposable income for health care or insurance.51 The uninsured poor in the United States include those who are disabled and do not meet the strict SSI disability criteria, young adults, childless couples, unemployable people below the age of 65, undocumented aliens, and anyone else who fails to meet Medicaid categorical eligibility criteria or is poor but not poor enough for Medicaid. Seventy-five percent are workers or their

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dependents. Minorities, young adults, people in rural areas, and people without high school degrees are disproportionately represented. 52

How has the government addressed the needs of the uninsured poor, and what handles have the advocates looked at for expanding this population’s access to health care?

1. State and County Indigent Care Programs

Traditionally, indigent health care needs have been addressed by a patchwork of programs at the state and county level. 53 These programs have been authorized by state constitutions, state statutes, and local ordinances. Some of these programs are “mandatory,” created by laws that require states or counties to provide indigent care. Others are “discretionary,” authorized—but not required—by statute. As of 1989, 16 states had statewide programs, and 28 had programs only at the county or municipal level. Six had no formal programs. Thirty-seven state or county programs were “mandatory” and seven were “discretionary.” Some courts may interpret discretionary language, such as the word “may,” as legally binding.

Poor people seeking health coverage from state and local programs have encountered numerous problems, many of which legal services advocates have actively addressed. Outright failure to fund or establish statutorily mandated programs may give rise to actions for injunctive relief, mandamus, or restitution; exclusion of medically necessary services may violate statutory requirements. Restrictive eligibility criteria may be challenged on equal protection or statutory grounds. The lack of procedural protections, such as notice of available benefits, written eligibility standards, or hearing and appeal rights, may be challenged on due process grounds.


programs often have been "the only game in town." Are there other approaches to the problem of the medically indigent?

2. Insurance for the Uninsured

Increasing interest has been shown in health care delivery and financing models that may put uninsured people on a more equal footing with the rest of the population. Approaches to "insuring the uninsured" range from incremental proposals, covering only otherwise uninsured people, to universal systems replacing private insurance. 54

At the state level, different kinds of programs have been tried: catastrophic illness programs; high risk insurance pools; multiple employer trust (METs), which help small businesses purchase more affordable insurance; Medicaid expansion, which takes advantage of available federal funds; the "employer mandate," which requires businesses to provide insurance; 55 and state-subsidized programs targeting particular groups such as pregnant women or people leaving welfare. More ambitious state insurance proposals have been advanced, including proposals for "single payor" systems that would largely replace the current private insurance system. At the national level, proposals include: universal programs that would build incrementally on the current private insurance system through employer mandates and expanded public programs; universal programs that would replace the private insurance system with a "single payor" system and; non-universal programs that would expand existing needs-based public programs or expand availability of private insurance through various incentives, including tax credits.

Many participants are entering the discussion about insurance for the uninsured and universal coverage. Clients eligible for legal services are involved because the existing system has excluded many poor people and has failed to meet the needs of many others. Providers are dissatisfied because the existing system leaves payment for uncompensated care in question. Businesses that provide health insurance are unhappy because uncompensated hospital care is reflected in their insurance premiums; they also are beginning to ask whether an employer-based insurance system puts them at a competitive

55. In Hawaii only, pursuant to an exemption from the federal ERISA statute’s preemption of such laws, see 29 U.S.C. §§ 1144(a) and 1144(b)(5).
disadvantage internationally. Small businesses are unhappy with their high premium costs. All payors and purchasers are alarmed about escalating health care costs. As the discussion heats up, legal services advocates have an essential role to play. They can help eligible client groups evaluate proposals and understand the key issues involved in designing a program to insure the uninsured. Such clients and their advocates also may be the only voice representing the interests of low-income people in a discussion in which almost everyone else—providers, payors, businesses, and non-indigent consumers—will be represented.

II. ACCESS TO HEALTH CARE

A. Hill-Burton Obligations

Hill-Burton is a federal loan and grant program established to assist states in furnishing adequate hospital, clinic, or similar services to all of their residents. In return for this federal assistance, a Hill-Burton facility is required to ensure that: (1) a reasonable volume of services will be provided to people unable to pay (the "uncompensated care" obligation), and (2) the services of the facility will be made available to all people residing or working in its geographic area (the "community service" obligation). These two


57. Some key issues involve: What level of government (federal/state/local) should be responsible? Is the goal a universal system or targeted programs? Immediate systemic change or phase-ins? Who are potential allies? Will a comprehensive plan involve subsidized private insurance? What about universal social insurance? What about funding of specific providers and facilities? How will the system deal with high-risk people and those people who fall between the cracks? If the system is less than universal, should the design prevent employers and/or individuals from dropping their existing insurance or encourage the broadest possible participation in the new program(s)? What scope of coverage is desirable? Will long-term care be included? How will costs be contained humanely? How will the system be financed? What financing mechanisms are most fair? What financing mechanisms are most effective? If the system is going to be organized at the state level, do any proposals risk violating ERISA’s preemption of state laws relating to employee benefits 29 U.S.C. § 1144(a)?


59. Id. at § 291c(e).
requirements provide minorities and the poor with substantial legal rights to health care.60

The uncompensated care obligation requires Hill-Burton facilities to provide a defined amount of free or below-cost care to low-income people who are not covered by a third-party insurer or government program61 each year for a 20-year period.62 Whenever uncompensated care is available, facilities must give all patients individual written notices that explain how to obtain free services and must make eligibility determinations within two working days after requests are made.63 The eligibility criteria are based on the federal poverty level and consider only family income, not assets. The current regulations create an entitlement to uncompensated care and an enforceable property right. Any patient wrongfully denied must be fully remedied. In addition, when applicable requirements are not met, facilities may be forced to provide additional free care.64

The community-service obligation prohibits all forms of discrimination and exclusionary admission practices by Hill-Burton facilities if they are unrelated to a patient's clear liability to pay for services or the availability of services at the facility. Facilities cannot deny emergency services to women in labor and other emergency patients because they are unable to pay. Also they cannot exclude from service Medicaid patients and patients without doctors because physicians on staff refuse to accept Medicaid or refuse to accept new patients. Persons unable to pay in advance may not be denied any service if they are able to pay in installments after the care is provided. No policy may have the effect of denying available services to patients in need but unable to pay. For example, lack of adequate translator services can violate this obligation. The community-service obligation establishes the right to treatment, but does not pay bills.

62. A directory of every facility with Hill-Burton obligations is published annually by HHS and is available from the National Health Law Program.
In contrast to the uncompensated care obligation, which is limited in time, the community-service obligation lasts forever. Both obligations, however, may be extinguished when a Hill-Burton facility is sold or transferred to a profit-making entity.65

The content of the Hill-Burton obligations—determining who a person unable to pay is, what is reasonable volume, and how services must be made available to all people—is defined by regulation.66 Separate obligations have been established for public hospitals and clinics.67

Private individuals, after exhausting their administrative remedies, have the right to sue Hill-Burton facilities and enforce compliance.68 Hill-Burton also can be a defense in a collection suit for medical bills.69 Hill-Burton generally provides a powerful but underused tool for access to health care.

B. The Right to Emergency Medical Treatment

Poor people frequently are denied essential emergency treatment because they are uninsured or on Medicaid. Although there is no general right to health care, rights to emergency medical treatment are provided under a variety of federal and state laws,70 including federal and state anti-"patient dumping" laws, state licensing statutes, tax-exempt status standards, common-law duties of care, and the Hill-Burton community-service obligation.

67. In 1986, HHS adopted regulations that provide a compliance alternative for qualified Hill-Burton public facilities (including hospitals, health clinics, laboratories, and nursing homes), 42 C.F.R. § 124.513 (1991). The alternative is available to publicly owned or operated facilities that either do not charge for medical care or have an on-site free or reduced-cost indigent medical care program. The public facility compliance alternative will certify facilities as meeting their annual uncompensated care assurance if they comply with the requirements of their HHS-approved indigent care program.
68. 42 U.S.C. § 300s-6 (1988). Exhaustion is satisfied by filing an administrative complaint and waiting a minimum of 45 days, but no more than six months, for the agency to act. All administrative complaints are to be filed with the respective Regional Health Administrator for the HHS Region in which the facility is located.
The federal anti-patient dumping statute\(^{71}\) is designed to prevent hospitals from transferring or discharging ("dumping") people in need of emergency care simply because they lack private health insurance. Under this law, hospitals and responsible physicians have the duty to screen all persons to determine whether they have an "emergency medical condition". If so, the hospital and physician must stabilize the patient before the transfer or discharge. Transfer is allowed if the doctor certifies, in writing, that the benefit of transfer outweighs the risk because proper treatment is unavailable at the current facility, or if patients themselves request transfer after giving informed consent. Violations of this statute can be challenged either by a private right of action or by an administrative complaint to the federal government. Many states now have similar anti-dumping statutes that mimic or expand on the federal law.\(^{72}\)

Other authorities may protect the right to emergency care. State hospital licensing statutes\(^{73}\) and hospital bylaws\(^{74}\) have been used to impose a "duty to treat" upon hospitals. Denials of emergency care may be the basis for challenging the tax-exempt status of a hospital for failing to provide a sufficient amount of charity care to justify its tax-exempt status. Common law also imposes a variety of duties on hospitals and physicians in the emergency care context. The negligent breach of a duty to provide emergency care can be the basis of abandonment, negligent rescue, and detrimental reliance.\(^{75}\) Finally, the Hill-Burton program requires hospitals receiving its funds to provide emergency room services to anyone, regardless of ability to pay.\(^{76}\)

Evidence of the standard of reasonable care in rendering emergency treatment can be established by reference to the professional standards of the Joint Commission on Accreditation of Health Care Organizations and the American College of Emergency Physicians. These detailed standards frequently will help to prove a violation of a duty to provide medical care.

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72. For a list of state laws, see States Take the Lead, supra note 70; and Dowell, supra note 70.
74. Stanturf v. Sipes, 447 S.W.2d 558 (Mo. 1969).
C. Civil Rights

Some hospitals and physicians still deny services to patients by discriminating on the basis of race, national origin, sex, or disability. Discrimination in health care tends to appear in more subtle practices that may not be intentionally discriminatory, but that result in a discriminatory impact.

Existing civil rights laws apply to health care. For race discrimination, Title VI of the Civil Rights Act of 1964 forbids health care facilities that receive federal funds from discriminating on the basis of race, color, or national origin. Title VI also prohibits such facilities from adopting practices that have a discriminatory effect. Furthermore, most states have statutes that forbid discrimination in "public accommodation" as well.

Access to health care may also be limited by gender. Sex discrimination in the health care context most frequently appears in practices that exclude pregnant women from services such as, excluding obstetric services from a Hill-Burton facility's allocation plan or the categorical exclusion of pregnant women from drug treatment programs.

Finally, discrimination on the basis of disability also occurs. For example, many health care providers refuse to treat people with AIDS, particularly those who are also poor. Discrimination on the basis of disability or perceived disability has long been forbidden by Section 504 of the Rehabilitation Act of 1973 and, beginning in 1992, will be subject to the requirements of the Americans with Disabilities Act of 1990. Section 504 provides that no otherwise qualified handicapped individual shall be excluded from participation in or denied the benefits of any program receiving federal financial assistance.

In addition to the traditional civil rights tools available to oppose discrimination in health care, advocates may also challenge a health care facility's tax-exempt status, on the ground that it violates public policy or laws prohibiting discrimination. A challenge to tax-exempt status would be available to fight all forms of illegal discrimination discussed above.

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79. See McNulty, supra note 77.
III. CONCLUSION

Although a general right to health care does not yet exist in this country, there are many ways to protect and expand the rights of poor people to health care. Aggressive, knowledgeable health advocacy can make a real difference in the quality of life for the poor.