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At a Glance

The political debate surrounding national health care reform was the most controversial issue in the arena of health law during 1994. In addition to reviewing the status of health care reform on the federal and state levels, this article discusses the major litigation, regulations, and research findings affecting the poor's access to health care over the past year, including issues such as:

- state and federal Medicaid developments
- managed care
- children's health
- the Americans with Disabilities Act
- the effects of AIDS on people of color
- lead poisoning
- prenatal services for undocumented women
- breast and cervical cancer screening

As a result of the delay in national health care reform, 1995 will bring increased activity in the area of state-based health initiatives. On the national level, the new year promises an interesting congressional session, with health reform, Medicaid caps, women's issues, and environmental justice at the top of the congressional agenda. In 1995, the National Health Law Program (NHeLP)'s priority will be to continue monitoring Medicaid developments and national and state health initiatives, especially in light of the expected move toward the privatization of health care for the poor. In addition, NHeLP will focus on providing assistance to advocates in states that are considering Medicaid waivers and managed care programs.

Health Reform on Hold and Other 1994 Developments in Health Law

By the National Health Law Program

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I. Health Care Reform

A. Federal Developments

At the national level, no health care reform legislation passed the Congress in 1994. The Clinton Administration proposed a complex bill that would have provided nearly universal coverage, financed primarily through a requirement that employers pay most of their workers' health insurance costs. /1/ The bill would have controlled private-sector costs by limiting increases in insurance premiums.

Ultimately, each of the bill's elements provoked powerful enough opposition to defeat reform legislation. Companies that do not cover their workers strongly opposed the employer mandate. The health insurance industry and many providers vigorously opposed limits on the amount of national resources devoted to health care. Together, these two interest groups outspent advocates of reform by an enormous margin, winning the public relations battle by convincing most of the public that reform legislation would increase bureaucracy and harm the middle-class. A huge industry-funded grassroots effort, including a significant direct-mail campaign, was also an important factor in causing calls and letters to Congress from constituents opposing reform to outnumber vastly those favoring change. Coupled with vigorous lobbying and record levels of campaign contributions, these industry tactics successfully derailed the century's strongest effort by an American President to move toward universal coverage.

The process fell apart on the Senate floor when Republicans delayed consideration of reform legislation through prolonged and repetitive speeches. The House refused to proceed until the Senate acted, as House members did not want to cast politically difficult votes that would become pointless if the more conservative Senate rejected central elements of the House bill, such as the employer mandate. Ultimately, Senate Majority Leader George Mitchell came close to agreement with a bipartisan group of Senators calling itself the "Mainstream Coalition." Time ran out, however, in the effort to find the 60 votes needed to terminate debate and vote on a health care reform proposal.

Before that point, advocates achieved significant success on many issues important to low-income consumers. For example, each bill passed by congressional committees included significant limits on copayments that could be charged to low-income people; these limits were articulated as a priority by the Congressional Black, Hispanic and Women's Caucuses. Each such bill also included significant steps to give low-income people much better access to care than that provided by

Medicaid. Most bills, for example, would have subsidized low-income people to enroll in any health plan with a price at or below the regional average.

Comprehensive reform legislation almost certainly will not pass the 104th Congress. Several different types of incremental legislation discussed in the closing days of the 1994 session may indicate possible directions of federal legislative activity in 1995:

-- The Mainstream Coalition, led by Sens. John H. Chafee (R-RI) and John B. Breaux (D-LA), proposed sliding scale subsidies of health insurance premiums.

-- Children First initiatives, which cover many currently uninsured children, were proposed by many, including Senator Tom Harkin (D-IA).

-- State flexibility legislation proposed very late in the session by Senators Bob Graham (D-FL) and Mark O. Hatfield (R-OR) would permit waivers from ERISA, Medicaid, and Medicare requirements and provide revenue from increased federal tobacco taxes.

B. State Developments

For the most part, the states also avoided any comprehensive reforms this last year. If they chose to make any changes to their health delivery systems, they were usually only incremental. A few examples:

California. The state established voluntary purchasing pools for businesses with fewer than 50 employees. /2/ To be an eligible participant, 70 percent of an employer's employees must purchase insurance through the pool and employers must pay one one-half of the premiums. /3/ Attempts to establish a state-run health care system were frustrated when Proposition 186, an initiative that would have created a single-payer system, was defeated in the November 1994 elections.

Vermont. Gov. Howard Dean's proposal to provide health insurance to the state's 68,000 uninsured fell victim to ideological inflexibility. The proposal would have provided coverage through a combination of employer and individual mandates. The Republicans debunked it as government-run health care. The Democrats criticized it because it fell way short of a single payer system. The bill died before it made it to the Senate floor for debate. /4/

Kansas. Even though it spent the last two years studying various health care proposals, Kansas decided to continue studying, for at least one more year, more proposals designed to provide coverage to its 14-percent uninsured. Last spring, Gov. Joan Finney vetoed legislation that would have established medical saving accounts. /5/

Florida. Florida formed 11 regional alliances for small businesses to buy health insurance. /6/ Republicans stymied Gov. Lawton Chiles's legislative proposal to provide coverage to Florida's uninsured and voted down a program to provide subsidies up to 250 percent of the federal poverty level. The proposal, which included authorization for an experimental Section 1115 Medicaid waiver, would have been funded, in part, with cost savings from enrolling Medicaid and expansion

groups into managed care. However, Florida submitted its waiver request anyway and received approval from HCFA to move Medicaid beneficiaries into managed care. /7/

Washington. Washington provided an exception to most states' reform efforts. /8/ It passed the most extensive health care reform law in the nation so far, requiring universal access by 1999, expanding Medicaid eligibility, establishing a uniform benefits package by 1995, instituting extensive cost-control mechanisms including a premium cap, requiring managed competition among certified health plans, expanding managed care, and instituting an employer mandate. /9/ It is unclear, however, whether the state will successfully obtain the ERISA exemption it needs to enforce an employer mandate. /10/

C. Federal and State "Experimental" Waivers

Section 1115 of the Social Security Act authorizes the Secretary of HHS to waive otherwise mandatory Medicaid Act provisions to allow "experimental, demonstration" projects which are likely to assist in "promoting the objectives" of the Medicaid Act. /11/ These waivers have become the silver bullet to accomplish health reform for the poor. During the last half of 1993 and 1994, HCFA approved waivers from Florida (September 1994), Hawaii (July 1993), Kentucky (December 1993), Rhode Island (October 1993), and Tennessee (November 1993). /12/ The following states' waivers were pending before HHS as this article went to press: Illinois, Massachusetts, Minnesota, Missouri, Ohio, and South Carolina. Other states are considering Section 1115 waivers.

The waivers are not without controversy. Typically, Medicaid is expanded to include some segment of the currently uninsured, and all recipients are enrolled in managed care plans. The National Association of Community Health Centers argues that these waivers are not experiments, just minor variations on a theme, and has challenged the Secretary's authority to grant them. /13/ Meanwhile, courts in Tennessee dismissed challenges to the "TennCare" Section 1115 waiver. /14/

During the year, legal services and consumer advocates complained that clear standards of review and public involvement were missing from the Section 1115 decisionmaking process. /15/ In September 1994, HHS issued a very general notice touching upon these issues. /16/ A Ninth Circuit decision on a Section 1115 welfare reform waiver, Beno v. Shalala, provided more specific instruction regarding the requisite nature of the Secretary's review. /17/ The court required the Secretary to consider objections raised by plaintiffs and plaintiffs' experts concerning the waiver. /18/ Finally, the National Health Law Program published an advocate's guide to Section 1115 waivers. /19/

II. Medicaid

A. Federal Developments

The 1994 Congress did not pass any major Medicaid legislation. /20/ There was, however, considerable HCFA activity on other Medicaid regulations, particularly with respect to the eligibility determination process. /21/

As always, Medicaid litigation was a mixed bag. Lower courts generally reaffirmed clients' rights to enforce the Medicaid Act through actions against state officials. /22/ One federal court in West Virginia struck down a highly restrictive "deeming" policy, /23/ while another required Medicaid transportation services to be made available to persons living in personal care homes and board-and-care facilities. /24/ A federal court in Hawaii questioned AFDC-based limits on the equity value of clients' automobiles. /25/ Courts tried to ensure that clients needing home- and community-based services would get a fair evaluation of their need for the services, although courts also made it harder to challenge the overall scope of these programs. /26/

Advocates successfully challenged excessive delays in state Medicaid fair hearing systems /27/ and in the provision of methadone maintenance services. /28/ Clients eligible for both Medicare and Medicaid may find it easier to find doctors in those states in which courts have held that doctors must be paid at full Medicare-authorized amounts. /29/ On the other hand, some restrictive state budgeting rules were upheld despite recipient objections, /30/ and the Eleventh Circuit made it clear that a federal "cap" limits the degree to which states may expand services to the elderly and disabled. /31/ States wanting to force recipients to make copayments each time they go to the doctor may see a "green light" in a Kansas case upholding a $325 copayment for inpatient hospital care; /32/ the only successful litigation against copayments was by pharmacists, who obtained a ruling that New York copayments for prescription drugs were invalid breaches of a statutory "deal" struck in the Omnibus Budget Reconciliation Act of 1990 (OBRA-90). /33/

Of interest in the Kansas copayment case was HCFA's belated denial of a state plan amendment that would have authorized the high copayments. /34/ The agency also invalidated a California attempt systematically to delay action on prior authorization treatment requests. /35/ Prorecipient HCFA action also led to the one Medicaid case to reach the Supreme Court, in which Justice Scalia refused to stay a lower court order directing Louisiana to follow federal policy by funding abortions if pregnancies had been caused by rape or incest. /36/ During 1994, courts consistently accepted HCFA's position that, at least with respect to abortion, the Medicaid Act requires all "medically necessary" treatment to be covered. /37/

B. Managed Care

As of June 1994, Medicaid enrollment in managed care plans was slightly over eight million, largely due to state waivers. /38/ In the most comprehensive review of Medicaid managed care programs published to date, managed care was found to have failed consistently to improve access, save money, or improve outcomes, particularly related to prenatal care and childhood preventive care. /39/ In another study comparing commercial HMOs with fee-for-service systems, the reviewers found that commercial HMOs lagged far behind on comprehensiveness of care, and HMO enrollees reported greater difficulties with accessibility in terms of reaching a physician, waiting times, and other "organizational barriers." /40/ According to this report, methods of quality

assessment "remain in their infancy" and "the demand for quality assessment tools has assumed new urgency." /41/

HCFA failed to finalize regulations promulgated in 1992 that would place limits on physician incentive plans used by Medicaid-participating HMOs. /42/ However, HCFA did finalize rules relating to state and federal authority to apply a full range of sanctions against Medicaid- and Medicare-participating HMOs that fail to provide necessary medical care, engage in fraudulent marketing and enrollment practices, or discriminate on the basis of medical condition or needs. /43/ These regulations also expanded state Medicaid agencies' responsibilities to include ensuring the managed care plans' proper implementation of grievance procedures. /44/

Litigation against the state Medicaid agency in California resulted in a settlement agreement that required the state to promulgate regulations clarifying managed care enrollees' due process rights. /45/

C. Early and Periodic Screening, Diagnosis, and Treatment

Several Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) cases have been decided or settled with favorable outcomes. /46/ District courts in the District of Columbia and in Texas held that individuals can sue to enforce EPSDT provisions under 42 U.S.C. Sec. 1983. /47/ The Seventh Circuit similarly rejected the state's argument that EPSDT created no enforceable rights under Section 1983 to challenge the state agency's determination of what is an "experimental" procedure. /48/ In remanding this case, the Circuit Court held that a federal court can review whether Wisconsin reasonably considered bowel-liver transplants as "experimental." /49/

An Illinois federal district court struck down the agency's "bright-line" test for the provision of orthodontic treatment without regard to medical necessity and also held that the agency was out of compliance with EPSDT informing requirements to the extent that it provided recipients with erroneous information on eligibility for orthodontic treatment. /50/ A West Virginia district court order has given rise to a tracking and case management system to ensure provision of EPSDT services to children in foster care. /51/ And, in Mississippi, a court accepted a settlement whereby the state agency agreed to cover lead blood level assessments as part of EPSDT. /52/

HCFA issued State Medicaid Manual sections to comply with OBRA-93 immunization requirements, /53/ OBRA-89 EPSDT reporting requirements, /54/ and a court order on lead blood testing. /55/ The Vaccine for Children Program, which provides free federally purchased vaccines to Medicaid-enrolled and uninsured children, children receiving services from a federally qualified health center or a rural health center, and Native American children, was officially launched on October 1, 1994. /56/ HCFA did not finalize EPSDT regulations proposed in October 1993. /57/

III. Civil Rights

A. Title VI

The past year saw increased activity involving Title VI of the Civil Rights Act. /58/ A federal district court in California issued a preliminary injunction requiring a county to assure that people of color have equal access to county-sponsored health care services. /59/ The case delayed the county's plans to rebuild its public hospital in a central county area much less accessible to the growing minority populations in east and west county areas. Notably, earlier in the year, HHS's Office of Civil Rights had concluded that the county plan did not violate Title VI. /60/ Meanwhile, legal services advocates in Washington settled their civil rights challenge to that state's exclusion of seasonal farm workers and tree planters from employer-provided health insurance under the Washington Health Service Act when the state agreed to include these populations in its program. /61/

Meanwhile, the Second Circuit dismissed a challenge to a hospital's relocation from Harlem, /62/ and a federal court in Tennessee dismissed a case seeking to require HHS to collect race-based utilization data from health care providers being supported by federal funds. /63/

In July, Attorney General Janet Reno reminded all federal departments, including HHS, that "each of you should ensure that the disparate impact provisions in your [Title VI] regulations are fully utilized so that all persons may enjoy equally the benefits of federally financed programs." /64/

B. Americans with Disabilities Act

Title II of the Americans with Disabilities Act (ADA) forbids agencies from discriminating on the basis of disability as they distribute public services. /65/ During 1994, most ADA litigation related to health care focused on home- and community-based services. With one glaring exception, now on appeal, courts were willing to require states to follow the ADA as they allocated these services. /66/ The Seventh Circuit used procedural grounds to vacate an antirecipient Illinois ruling. /67/ On the other hand, two courts did manage to ignore Department of Justice regulations, 28 C.F.R. Sec. 130(d), in holding that the ADA does not generally require services that more closely integrate disabled people within their communities. /68/ Also, the Third Circuit, deferring much too casually to a state's description of a program for persons with physical disabilities, held that, because the state said its program was meant to promote "personal control," persons with physical disabilities who also had mental disabilities could be excluded from the program. /69/

Two of the year's most interesting "disabilities act" cases did not involve Medicaid -- in fact, one case did not formally involve the ADA at all. A California woman needing home health care for her daughter with disabilities employed a health aide who visited the family every day. The mobile home park where the women lived charged "guests" a high per-day parking fee, making the home health aide's services more expensive. The Ninth Circuit held that, under the Fair Housing Act, the park's policy might impermissibly discriminate against the child on the basis of her disability, even though the policy purported to apply uniformly to all "guests." /70/ This ruling may prove helpful to advocates who are challenging policies that purport to be uniform but actually have a disparate impact on people with disabilities.

The other decision, from Florida, required a counseling program in the Miami area to continue to employ counselors who could themselves communicate in sign language, as opposed to hiring sign

language interpreters who would interpret for nonsigning counselors. /71/ Plaintiffs proved that the presence of interpreters made counseling less effective, and the program failed to show that requiring it to employ counselors who could sign would work a "fundamental alteration" in the program. The case is also noteworthy for its detailed analysis of the balance of equities.

Still at issue during 1994 was the extent to which the federal government may ignore ADA concerns as it evaluates comprehensive state Medicaid waiver proposals. The Ninth Circuit did not reach this issue in the Beno decision.

C. Immigrant Issues

The federal and state governments clashed over who should fund the provision of health care to undocumented persons. Using various constitutional theories, Florida, Texas, Arizona, and California all separately sued the federal government seeking reimbursement for the cost of providing, inter alia, emergency health care to undocumented persons. /72/

Washington and California both submitted state Medicaid plan amendments seeking federal financial participation for prenatal services provided to undocumented women. HCFA denied both amendments, and the states are currently seeking administrative review. /73/

New York is among many states creating immunization computer registry systems that currently lack any prohibitions against providing information regarding undocumented patients to INS. In November 1994, voters in California passed a ballot initiative that would make undocumented persons ineligible for publicly funded health services (except emergency care), public social services, and education. The measure also requires health, education, and service providers to report all suspected undocumented persons to the authorities. /74/

D. Women's Health

Throughout 1994, health policymakers and practitioners alike continued to place increased attention on issues concerning women's health, especially with regard to breast cancer and other reproductive health issues. /75/ Perhaps the most dramatic development in the clinical arena was the discovery and isolation of BRCA1, the gene researchers believe is responsible for 5 percent of breast cancer cases. /76/ Additionally, researchers found that a treatment consisting of lumpectomy and radiation therapy, also called breast-conserving surgery, was as effective and safe as mastectomy. /77/

More recognition was given to the racial and economic disparities that exist with regard to breast and cervical cancer treatment and survival rates. A National Cancer Institute study found that socioeconomic factors, including the lack of access to health care, accounted for African American women having poorer breast cancer survival rates than white women. /78/ Also, women who are either uninsured or on Medicaid were found more likely to have advanced breast cancer at initial diagnosis and a worse survival rate than privately insured women, indicating the need for improved access to preventive screening and treatment options. /79/ Research showed Latino and African

American women to suffer from cervical cancer at considerably higher rates than white women, a result attributed to poverty and cultural barriers. /80/

Using federal funds made available under the Breast and Cervical Cancer Mortality Prevention Act of 1990, a number of states began or continued implementation of cancer detection programs for low-income and uninsured women. /81/ In July, California's Breast Cancer Early Detection Program began providing clinical breast examinations and mammograms to uninsured women at or below 200 percent of the poverty level. /82/

IV. AIDS/HIV

The most recent Centers for Disease Control and Prevention (CDC) statistics (for 1993) showed that 55 percent of reported new AIDS cases occurred among racial and ethnic minorities. Of these cases, 66 percent were reported among blacks, 32 percent among Hispanics, 1 percent among Asian/Pacific Islanders, and 1 percent among Alaskan Natives and Native Americans. The disparity in the HIV infection rate, particularly between white and black women, continues to grow. Black women are almost fifteen times more likely than white women to contract AIDS; compared to white men, black men are five times more likely to acquire AIDS. Racial and ethnic minorities represent 75 percent of all new cases among adult and adolescent women, 51 percent among adult and adolescent men, and 84 percent of new cases in children under age 13. /83/

A study reported by CDC in August found that AZT, taken during pregnancy and labor, can reduce the risk of mothers transmitting HIV infection to newborns. However, CDC reported that the long-term effects of AZT treatment during pregnancy are uncertain for both mother and child. /84/ CDC recommends counseling HIV-positive, pregnant women about the short-term benefits of AZT and offering treatment at the mother's option. /85/

In l994, the New York legislature resolved controversy sparked when a bill mandating maternal notification of the results of a newborn's HIV test was introduced in the state assembly. /86/ Opponents of the bill argued that newborn testing would, in effect, single out pregnant women for testing, discriminating against women and discouraging prenatal care. Proponents argued that, to promote early intervention and treatment for HIV-positive children, mothers should learn about their infants' HIV test results. /87/ The new law requires providers to counsel pregnant women and new mothers about the benefits of HIV testing; it does not require mandatory notification. The cost of AZT treatment varies; the manufacturer estimates the average cost of treatment at $900. /88/

Finally, plaintiffs settled Rosetti v. Shalala, a class action challenging the denial of SSI and social security disability benefits under the pre-1993 SSA standards for determining HIV/AIDS disability. /89/ Before July 1993, when the Third Circuit struck down the former standards, numerous claims were denied because the SSA guidelines excluded many symptoms, particularly gynecological symptoms, from its definition of HIV and AIDS. Under the Rosetti settlement, claims denied under the old definition will be reviewed retroactively under the new standards.

V. Environmental Justice

On February 11, 1994, President Clinton issued Executive Order 12898, which requires all federal agencies to insure that their programs do not unfairly inflict environmental harm on the poor and members of minority groups. The order reaches any federal program, activity, or action that substantially affects human health or the environment. Federal programs are required to develop, within one year, a comprehensive "environmental justice strategy" to prevent environmental inequities. The strategy is supposed to include specific projects that can promptly be undertaken to address the problem.

Lead poisoning continued to be a major concern for legal services clients. Ellis v. Wetherbee, a federal case in Mississippi, was settled when the state Medicaid agency agreed to begin testing children using lead blood tests. /90/ A trade group representing California's paint companies announced that it would drop a lawsuit challenging the validity of the state's Childhood Lead Poisoning Prevention Act. /91/ The Act imposes fees on industries which historically contributed to environmental lead contamination causing poisoning to children. These fees are to go to financially strapped counties to assist with early detection, screening, and medical treatment and services to prevent childhood poisoning.

Footnotes

/1/ The Clinton Administration bill was introduced as H.R. 3600 by Cong. Richard A. Gephardt in the House and as S. 1757 by Senator George Mitchell in the Senate.

/2/ Cal. Ins. Code Secs. 10730 et seq. (added by 1992 Cal. Stat. 1128, Sec. 10 (effective July 1, 1993).

/3/ Id.

/4/ See Allan Holmes, States' Reform Efforts Derailed by Politics, Lobbying, and Fear, Med. & Health Updates (June 20, 1994); Vermont: Hitting the Wall, State Health Notes (George Washington University Intergovernmental Health Policy Project, Washington, D.C.); Vermont Shows How a Health Bill Can Fail, N.Y. Times, June 8, 1994, at A15; Telephone conversation with Alan Hark, Vermont Low-Income Advocacy Council (June 8, 1994).

/5/ See Holmes, supra note 4.

/6/ The Florida Corporation Health Access Act, Fla. Stat. Sec. 408.0014, Title XXIX, ch. 408 (1993).

/7/ Letter from Bruce C. Vladeck, HCFA Administrator, to Doug Cook, Director of the Florida Agency for Health Care Administration (Sept. 15, l994) (approving the "Florida Health Security" waiver).

/8/ See Health Services Act of 1993, 1993 Wash. Laws ch. 492 Secs. 280 et seq.

/9/ Id.

/10/ R. Pear, States Again Try Health Changes as Congress Fails, N.Y. Times, Sept. 16, 1994, at A1; George Anders, Some State Health Plans May Be Stalled If Congress Fails to Pass a Bill This Fall, Wall. St. J., Sept. 16, 1994, at A2.

/11/ 42 U.S.C. Sec. 1315.

/12/ HHS also approved statewide Section 1115 waivers in Oregon (March 1993) and Arizona (originally approved in 1982).

/13/ National Ass'n of Community Health Ctrs. v. Chillily, No. 1:94CV01238 (D.D.C. filed June 6, 1994) (Clearinghouse No. 50,038). The National Health Law Program (NHeLP) has filed an amicus brief in the case.

/14/ Daniels v. White, No. 79-3107-NA-CV (M.D. Tenn. June 20, 1994) (Clearinghouse No. 38,991) (expressing "skepticism" that TennCare's "new" coverage of uninsured and uninsurable is subject to Medicaid plan statutes not waived); Tennessee Medical Ass'n v. Manning, No. 93-3839-1 (Tenn. Ch. Ct. Aug. 8, 1994).

/15/ These issues are also addressed in National Ass'n of Community Health Centers, supra note 13.

/16/ 59 Fed. Reg. 49249 -- 51 (Sept. 27, 1994).

/17/ Beno v. Shalala, 30 F.3d 1057 (9th Cir. 1994), rehearing and rehearing en banc denied (9th Cir. Aug. 24, 1994), rev'g 853 F. Supp. 1195 (E.D. Cal. 1993).

/18/ Id. at 1067 -- 76.

/19/ Jane Perkins & Michelle Melden, Section 1115 Medicaid Waivers: An Advocate's Primer (1994). See also id., The Advocacy Challenge of a Lifetime: Shaping Medicaid Waivers to Serve the Poor, 28 Clearinghouse Rev. 864 -- 85 (Dec. 1994).

/20/ The Social Security Independence and Program Improvements Act of 1994, Pub. L. No. 103-296, did specify that people being terminated from SSI because their disability depended on drug or alcohol addiction would continue to get Medicaid; the Improvements Act also confirmed eligibility for a small group of disability insurance beneficiaries. More generally, Congress confirmed in the social security technical amendments and in the Elementary and Secondary Education Act of 1994 that recipients may enforce against state officials federal Medicaid requirements for state Medicaid plans -- thus squelching some of the wilder implications of Suter v. Artist M., 112 S. Ct.1360 (1992).

/21/ 59 Fed. Reg. 48805 (Sept. 23, l994) (requiring outstationing of eligibility workers at sites frequented by children and pregnant women); 59 Fed. Reg. 43050 (Aug. 22, 1994) (affecting the

way states evaluate clients' income and resources); 59 Fed. Reg. 31569 (June 20, 1994) (addressing the states' ability to use Medicaid dollars to buy private insurance policies for Medicaid-eligible families); 59 Fed. Reg. 13666 (Mar. 23, 1994) (addressing issues surrounding children and pregnant women's eligibility for Medicaid); 59 Fed. Reg. 1659 (Jan. 12, 1994) (allowing states more flexibility in operating medically needy programs); 58 Fed. Reg. 65312 (Dec. 14, 1993) and 57 Fed. Reg. 56294 (addressing the transitional Medicaid families receive when they work their way off AFDC or lose AFDC due to child support collections).

/22/ Wood v. Tompkins, 33 F.3d 600 (6th Cir. 1994); Blanchard v. Forrest, 1994 WL 495857 (E.D. La. Sept. 6, 1994) (Clearinghouse No. 49,492); Sobky v. Smoley, 855 F. Supp. 1123 (E.D. Cal. 1994); Wellington v. District of Columbia, 851 F. Supp. 1 (D. D.C. 1994) (Clearinghouse No. 48,846).

/23/ Richardson v. Lewis, No. CA 5:92-1731 (S.D. W.Va. Sept. 23, 1994).

/24/ Wolford v. Lewis, 1994 WL 448658 (S.D. W.Va. Mar. 21, l994) (Clearinghouse No. 49,091).

/25/ Gamboa v. Rubin, 1993 WL 738386 (D. Haw. Nov. 4, 1993) (Clearinghouse No.48,422).

/26/ Wood, 33 F.3d at 600; Wolford, 1994 WL 448658; Catanzano v. Dowling, 847 F. Supp. 1070 (W.D. N.Y. 1994) (Clearinghouse No.45,058); Conner v. Branstad, 839 F. Supp. 1346 (S.D. Iowa 1993); but see Skandalis v. Rowe, 14 F.3d 173 (2d Cir. 1994).

/27/ Shifflett v. Kozlowski, 843 F. Supp. 133 (W.D. Va. 1994).

/28/ Sobky, 855 F. Supp. at 1123.

/29/ Pennsylvania Medical Soc'y v. Snider, 29 F.3d 886 (3d Cir. 1994); Rehabilitation Ass'n of Va. v. Kozlowski, 838 F. Supp. 243 (E.D. Va. 1993); but see Haynes Ambulance Serv. v. Alabama, 820 F. Supp. 591 (M.D. Ala. 1993).

/30/ Cherry v. Sullivan, 30 F.3d 73 (7th Cir. 1994) (Clearinghouse No. 45,808); Noland v. Shalala, 12 F.3d 258 (D.C. Cir. 1994) (Clearinghouse No. 46,246).

/31/ Georgia Dep't of Medical Assistance v. Shalala, 8 F.3d 1565 (11th Cir. 1993).

/32/ Kansas Hospital Ass'n v. Whiteman, 835 F. Supp. 1556 (D. Kan. 1993), aff'd, 1994 WL 504421 (10th Cir. Sept. 16, 1994).

/33/ Pharmaceutical Soc'y of N.Y. v. New York State Dep't of Social Servs., 1994 WL 33369 (N.D. N.Y. Jan. 18, 1994).

/34/ Letter from Bruce Vladeck, HCFA, to Donna Whiteman, Kansas Dep't of Social and Rehabilitative Services, July 28, 1994, reprinted in CCH Medicare & Medicaid Guide Para. 42,621.

/35/ Letter from Lawrence McDonough, HCFA, to John Rodriguez, Medi-Cal, April 13, 1994 (available from NHeLP).

/36/ Edwards v. Hope Medical Group for Women, 63 U.S.L.W. 3125 (Aug. 17, 1994) (Scalia, J.).

/37/ E.g., Little Rock Family Planning Servs. v. Dalton, 1994 WL 386796 (E.D. Ark. July 25, 1994).

/38/ BNA, Health Care Policy Report (Sept. 26, 1994).

/39/ See Deborah Freund & Eugene Lewit, Managed Care for Children and Pregnant Women: Promises and Pitfalls, 3 Future of Children 92, 104 (Summer -- Fall 1993): Findings suggest that managed care is associated with a reduction in the use of specialty physicians without a commensurate increase in the use of primary care physicians. About one-third of the pediatricians in the study felt that denied referrals to specialists compromised the health of their patients.

/40/ Dana Safran et al., Primary Care Performance in Fee-for-Service and Prepaid Health Care Systems, 271 JAMA 1579 (1994).

/41/ Id. at 1585.

/42/ See 57 Fed. Reg. 59024 -- 40 (Dec. 14, 1992).

/43/ See 59 Fed. Reg. 36072 -- 87 (July 18, 1994).

/44/ See id. at. 36084 (amending 42 C.F.R. Sec. 434.63).

/45/ The proposed regulations are identified under "R-22-94" and are available from NHeLP -- Los Angeles. See also Gutierrez v. Coye, No. 949269 (Cal. Super. Ct. May 21, 1993) (stipulation and settlement agreement) (Clearinghouse No. 48,841).

/46/ But see Salgado v. Kirschner, 878 P. 2d 659 (Ariz. 1994), reprinted in [1994 New Developments] Medicare & Medicaid Guide (CCH) Para. 42,604 (contrary to 42 U.S.C. Sec. 1396d(r)(5), the Arizona Supreme Court, in dicta, narrowly interpreted Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) as a "medical necessity").

/47/ Wellington v. District of Columbia, 851 F. Supp. 1 (D.D.C. 1994) (Clearinghouse No. 48,846); Frew v. Ladd, No. 3:93-CV-65 (E.D. Tex. Aug. 10, l994).

/48/ Miller v. Whitburn, 10 F. 3d 1315 (7th Cir. 1993), modifying 816 F. Supp. 505 (W. D. Wis. 1993).

/49/ Id. at 1320 (concluding that a federal court may review whether the state agency’s definition of "experimental" considers procedures that are generally accepted by the professional medical community or for which authoritative evidence attests to the procedure’s safety and effectiveness).

/50/ Chappel v. Bradley, 834 F. Supp. 1030 (N.D. Ill., 1993), clarified by Chappel v. Wright, 1994 WL 496700 (Nov. 24, 1993), reprinted in [1994 New Developments] Medicare & Medicaid Guide (CCH) Para. 42,035 (clarifying that the state agency need not provide orthodontic care to recipients with handicapping malocclusions if such conditions are not severe enough to have a medical need for such orthodontic treatment).

/51/ Sanders v. Lewis, No. 2:92-0353 (S.D. W. Va. 1993) (consent decree). A compliance plan was agreed to by the parties in late l994.

/52/ Ellis v. Wetherbee, No. S92-0529 (S.D. Miss. May 11, l994) (Clearinghouse No. 48,639).

/53/ 42 U.S.C. Sec. 1396s(g); HCFA, State Medicaid Manual Sec. 5123.2 (Transmittal No. 8, Apr. 1994) (directing use of schedule developed by the Advisory Committee on Immunization Practices).

/54/ 42 U.S.C. Sec. 1396a(a)(43)(D); HCFA, State Medicaid Manual Sec. 5320.2, Sec. 5360 (Transmittal No. 7, Nov. 1993) (requiring use of the HCFA 416 form, which requires compilation of EPSDT utilization data by age and eligibility groups and setting an 80-percent EPSDT participation goal for each state).

/55/ HCFA, State Medicaid Manual Sec. 5123.2 (Transmittal No. 6, Oct. 1993) (requiring states to use blood lead tests, rather than the erythrocyte protoporphyrin test, when screening for lead poisoning), implementing Thompson v. Raiford, No. 3:92CV 1539-R (N.D. Tex. Sept. 24, 1993) (agreed order).

/56/ Section 1361 of the Omnibus Budget Reconciliation Act of 1993 (OBRA-93), codified at 42 U.S.C. Sec. 1396s(g). OBRA-93 also permits states to use state funds to purchase and distribute vaccines for other groups of children (e.g., children whose health insurance does not cover immunizations). While HHS had planned on establishing a national distribution system, HHS has abandoned that plan as of August 12, 1994. Now states and the federal government will work through the manufacturers to distribute vaccines to private providers. See 48 Med. & Health at 2 (Aug. 22, 1994).

/57/ 58 Fed. Reg. 51288 (Oct. 1, l993).

/58/ Civil Rights Act, 42 U.S.C. Sec. 2000d.

/59/ Latimore v. County of Contra Costa, No. C 94-1257 SBA (N.D. Cal. Aug. 1, l994) (preliminary injunction).

/60/ NAACP/LDF v. Contra Costa County, Docket No. 09-93-317 (OCR Apr. 25, l994).

/61/ Morales v. Washington Health Servs. Comm'n, No. 94-2-00015-0 (dismissed Mar. 23, l994).

/62/ Mussington v. St. Lukes-Roosevelt Hosp. Ctr., 18 F.3d 1033 (2d Cir. l994) (Clearinghouse No. 49,111).

/63/ Madison-Hughes v. Shalala, No. 3:93-0048 (M.D. Tenn. Sept. 21, l994) (dismissed for lacking subject-matter jurisdiction).

/64/ Attorney General Janet Reno, Memorandum for Heads of Departments and Agencies that Provide Federal Financial Assistance (July 14, l994).

/65/ Americans with Disabilities Act, 42 U.S.C. Sec. 12132.

/66/ Wolford, 1994 WL 448658; Easley v. Snider, 841 F. Supp. 668 (E.D. Pa. 1993); Martin v. Voinovich, 840 F. Supp. 1175 (S.D. Ohio 1993); Conner, 839 F. Supp. at 1346; see Helen L. v. Didario, 1994 WL 22714 (E.D. Pa. Jan. 27, 1994).

/67/ Frances J. v. Wright, 19 F.3d 337 (7th Cir. 1994), cert. denied, 63 U.S.L.W. 3236 (Oct. 3, 1994).

/68/ Helen L., 1994 WL 22714 at *4; Conner, 839 F. Supp. at 1355 -- 58.

/69/ Easley v. Snider, 1994 Westlaw 513970 (3d Cir. Sept. 22, 1994).

/70/ U.S. v. California Mobile Home Park Mgmt. Co., 29 F.3d 1413 (9th Cir. 1994).

/71/ Tugg v. Towey, 1994 WL 515905 (S.D. Fla. July 19, 1994).

/72/ See R. Surro, States Take Immigration Woes to Capitol with Pleas for Relief, Wash. Post, June 25, 1994, at A3; Weintraub, Wilson Sues U.S. Over Immigrants' Invasion, L.A. Times, Sept. 23, 1994, at A3; Texas to Sue Over Illegal Immigrants, Wash. Post, May 27, 1994, at A11; R. Surro, Study Boosts States' Bid for Greater Federal Burden in Immigration Costs, Wash. Post, Sept. 15, 1994, at A3; Florida to Sue U.S. for Immigrant Costs, Wash. Post, Jan. 3, 1994, at C5.

/73/ See In the Matter of California State Plan Amendment 92-04; In the Matter of Washington State Plan Amendment 93-19.

/74/ See Proposition 187 seeking, inter alia, to amend pt. 1, div. 1, of the Health and Safety Code, to add California Welfare and Institutions Code Sec. 10001.5, and to add Education Code Secs. 48215, 66010.8. Last year, after the Latino community raised civil rights concerns, the Virginia legislature deferred a proposal which would have required authorities to report all undocumented persons applying for public social services to the immigration authorities. Lisa Leff, Virginia Sets Aside Proposal on Illegal Immigrants, Wash. Post, Mar. 5, 1994, at B1.

/75/ See, e.g., Bureau of National Affairs Health Care Policy Report, May 16, 1994, citing S.J. Res. 185 designating Oct. 1994 as "National Breast Cancer Awareness Month."

/76/ Thomas Maugh II, Discovery of Breast Cancer Gene Called Major Advance, L.A. Times, Sept. 15, 1994, at A1.

/77/ Anna Lee-Feldstein et al., Treatment Differences and Other Prognostic Factors Related to Breast Cancer Survival, 271 JAMA 1163 -- 68 (1994), also finding that women treated at HMOs and small community hospitals were less likely to receive breast-conserving surgery than women treated at large community hospitals.

/78/ J. William Eley et al., Racial Differences in Survival from Breast Cancer, 272 JAMA 947 -- 54 (1994).

/79/ John Z. Azanian et al., The Relation Between Health Insurance Coverage and Clinical Outcomes Among Women with Breast Cancer, 329 New Eng. J. Med. 326 -- 31 (1993).

/80/ Shari Roan, 4600 Deaths That a Simple Yearly Test Might Prevent, L.A.Times, Oct. 4, 1994, at E1; Carolyn Runowicz, Women's Health Care: Prevention Is the Key, Vital Signs (National Black Women's Health Project, Atlanta, GA, Summer 1994), at 52.

/81/ Breast and Cervical Cancer Mortality Prevention Act of 1990, 42 U.S.C. Secs. 300k et seq.

/82/ Telephone interview with Dr. Liana Lianov, California Department of Health Services, Cancer Detection Section (Sept. 13, 1994).

/83/ AIDS Among Racial/Ethnic Minorities -- United States, 1993, 43 Morbidity & Mortality Wkly. Rep. 644 (CDC, Sept. 9, 1994).

/84/ Recommendations of the United States Public Health Service Task Force on the Use of Zidovudine to Reduce Perinatal Transmission of the Human Immunodeficiency Virus, 43 Morbidity & Mortality Wkly. Rep. 1 (CDC, Aug. 5, 1994). See also Lawrence Altman, High HIV Levels Raise Risk to Newborns, 2 Studies Show, N.Y. Times, Aug. 17, 1994, at C8, reporting later research showing that higher levels of HIV in a mother's blood closely correlates with the risk of infection of newborns; thus, slowing the course of a mother's infection may reduce the infant's odds of developing HIV.

/85/ Ruth Borelle, AZT During Pregnancy Backed, N.Y. Times, Aug. 10, 1994, at A1.

/86/ The New York Health Department routinely tests all babies born in the state for HIV infection in order to track the disease; results of the test are not given to mothers and doctors. Mireya Navarro, AIDS Panel Urges More Tests for Women, N.Y. Times, Feb. 2, 1994, at B14. See also David Bauder, Secrecy Under Fire for Hiding Baby's Infection from Mother, L.A. Times, Apr. 17, 1994, at A8, noting that 42 other states also screen newborns for HIV.

/87/ An HIV-positive test result at birth shows only that the child's mother is HIV positive and does not predict whether the child will develop HIV infection after the mother's positive antibodies are shed. Bauder, supra note 86.

/88/ Ruth Sorelle, AZT During Pregnancy Backed, N.Y. Times, Aug. 10, 1994, at A1.

/89/ Rosetti v. Shalala, 12 F.3d 1216 (3d Cir. 1993).

/90/ Ellis, No. S92-0529. NHeLP cocounseled this case with Southeast Mississippi Legal Services, Southern Mississippi Legal Services, Mississippi Legal Services, NAACP Legal Defense Fund, and the Sierra Club Legal Defense Fund.

/91/ California Paint Council v. Department of Health Servs., No. 533557 (Sacramento Co. Super. Ct 1994). Poor children intervened in the case and were represented by pro bono, legal services, civil rights, and environmental firms, including NHeLP.