

# Regulatory Takings and Emergency Medical Treatment

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## TABLE OF CONTENTS

I.	INTRODUCTION .....	146
II.	THE COUNTIES' OBLIGATION AS PROVIDERS "OF LAST RESORT" .....	147
	A. Bay General Community Hospital v. County of San Diego.....	147
	B. Bay General <i>Reconsidered: The Holdings in County</i> of San Diego v. State and Hunt v. Superior Court.....	154
	C. <i>Indeterminacy in the Level of Care Mandated by</i> Section 17000 .....	158
	D. <i>The Failure of the Counties To Fulfill Their</i> Obligation To Serve as the Provider "of Last Resort" .....	163
III.	STATUTORY OBLIGATIONS OF HOSPITALS TO PROVIDE EMERGENCY MEDICAL CARE TO INDIGENT PATIENTS .....	167
	A. <i>The Emergency Medical Treatment and Active Labor Act</i> .....	168
	B. <i>Section 1317 of the California Health and Safety Code</i> .....	170
	C. <i>Regulatory Takings Analysis</i> .....	170
IV.	CONCLUSION .....	184

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## I. INTRODUCTION

Americans have strongly held but inconsistent views regarding the provision of health services. Americans have traditionally endorsed a fee-for-service system, which is an application of the free market concept. The fee-for-service system is, however, fundamentally inconsistent with the concept of a right to receive health services. If one had a *right* to receive health services, then the lack of an ability to pay would be irrelevant.

The conflict between a fee-for-service system and the right to health care is manifested in the provision of emergency care. All states impose statutory or common law duties upon hospitals, public and private, to provide emergency care to patients in need thereof regardless of the ability to pay.<sup>1</sup> Once patients receive care, however, they must promise to pay for the care received.<sup>2</sup> Emergency care is thus a peculiar amalgam of a right and a mere service. Although persons in need of emergency care have an absolute right to the care, they must promise to pay after receiving it. In regard to other services, payment is a necessary condition for receiving the service.

An increasingly serious problem relating to the provision of emergency medical services in this country is the number of individuals who have no health insurance.<sup>3</sup> The economic burden upon states, counties, and hospitals is becoming insurmountable. The difficulties are especially significant in California, which has a peculiar system in which the obligation to support basic medical services for indigent persons is delegated to the counties, and yet the legal obligation to provide emergency medical services is imposed upon hospitals, most of which are private.<sup>4</sup> The relationship of the relative obligations of the counties and hospitals, and the failure of the former to fulfill their statutory obligations to support emergency medical services for indigent persons, has created a system of emergency care that is in continual crisis.<sup>5</sup>

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1. See, e.g., *St. Joseph's Hosp. & Med. Ctr. v. City of Phoenix*, 764 P.2d 25 (Ariz. Ct. App. 1988); *County of San Diego v. State*, 931 P.2d 312, 332-34 (Cal. 1997); *DeCicco v. Trinidad Area Health Ass'n*, 573 P.2d 559 (Colo. App. 1977); *Hunt v. Palm Springs Gen. Hosp.*, 352 So. 2d 582 (Fla. Dist. Ct. App. 1977); *People v. Flushing Hosp. & Med. Ctr.*, 471 N.Y.S.2d 745 (Crim. Ct. 1983); *Brownsville Med. Ctr. v. Gracia*, 704 S.W.2d 68, 76-77 (Tex. App. 1985); *Mercy Med. Ctr. of Oshkosh, Inc. v. Winnebago County*, 206 N.W.2d 198, 199 (Wis. 1973).

2. See, e.g., CAL. HEALTH & SAFETY CODE § 1317(d) (West 2008).

3. See, e.g., Michael A. Dowell, *The Nation's Emergency Care Crisis*, 11 WHITTIER L. REV. 45, 46, 48 (1989).

4. CAL. WELF. & INST. CODE § 17000 (West 2001 & Supp. 2009).

5. See Dowell, *supra* note 3, at 50-51.

In this Article, the legal obligations of the counties and of hospitals, respectively, will be examined. An argument will be proffered that the counties have failed to fulfill their statutory obligations to support emergency and other basic medical services for indigent persons. This argument, in conjunction with the fact that hospitals have an unfunded mandate to provide emergency and related medical services to all individuals in need thereof, provides a basis for an argument that the statutory requirement that private hospitals provide emergency and related medical services to indigent patients constitutes a taking of private property for a public purpose. Under this theory, the affected hospitals have a right to reimbursement for uncompensated care that they provide as a result of their statutory obligation.

## II. THE COUNTIES' OBLIGATION AS PROVIDERS "OF LAST RESORT"

Since 1855, California has imposed a legal obligation on the counties to provide medical care to indigents. This duty was codified in section 17000 of the California Welfare and Institutions Code in 1965.<sup>6</sup> Indeed, the duty imposed upon the counties is both remarkable and unique. No other jurisdiction has the responsibility for the overall health and welfare of its citizens. However, as *Bay General Community Hospital v. County of San Diego* indicates, California counties have successfully avoided fulfilling their obligations under section 17000 for many years.<sup>7</sup>

### A. *Bay General Community Hospital v. County of San Diego*

*Bay General* involved a class action suit by private hospitals against the county of San Diego.<sup>8</sup> The plaintiff hospitals, all of which were privately owned, sought reimbursement from the county for uncompensated care given to indigent patients.<sup>9</sup> Specifically, the action sought reconsideration and repeal of the county's 1972 decision to reimburse only University Hospital, a part of the University of California.<sup>10</sup>

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6. § 17000.

7. *Bay Gen. Cmty. Hosp. v. County of San Diego*, 203 Cal. Rptr. 184, 186–87 (Ct. App. 1984).

8. *Id.* at 185.

9. *Id.*

10. *Id.* at 186–87.

The plaintiff hospitals argued that section 17000 of the California Welfare and Institutions Code imposed upon the county a mandatory duty to render or at least pay for necessary health care administered by the hospitals to indigent patients.<sup>11</sup> Section 17000 provides:

Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions.<sup>12</sup>

Further, section 17001 places on the county a mandatory duty to implement section 17000 with compatible regulations.<sup>13</sup>

In addition to the above statutory authority, the hospitals based their argument on the Arizona case *St. Joseph's Hospital & Medical Center v. Maricopa County*.<sup>14</sup> In *St. Joseph's*, the appellate court interpreted an Arizona statute that mandated the reimbursement of private hospitals for the cost of emergency treatment of indigent patients.<sup>15</sup> The court stated that the necessary medical treatment of indigents was a public obligation, and that except for the emergency situation, the indigents would be cared for in a public hospital.<sup>16</sup>

The *Bay General* court, however, distinguished the holding in *St. Joseph's* on the basis that Arizona statutory law mandates that each county shall be liable for payment of costs for emergency treatment of indigents at private hospitals.<sup>17</sup> According to the *Bay General* court, the difference between Arizona statutory law and sections 17000 and 17001 of the California Welfare and Institutions Code is the discretion vested in each county's board of supervisors in implementing the mandatory duties imposed by sections 17000 and 17001.<sup>18</sup> The court concluded that there was no abuse of discretion on the part of the county in

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11. *Id.* at 187.

12. CAL. WELF. & INST. CODE § 17000 (West 2001 & Supp. 2009). Further, section 29606 of the California Government Code provides that “[t]he necessary expenses incurred in the support of the county hospitals, almshouses, and the indigent sick and otherwise dependent poor, whose support is chargeable to the county, are county charges.” CAL. GOV'T CODE § 29606 (West 2008). This section has remained unchanged since its adoption in 1947. *Id.*

13. CAL. WELF. & INST. CODE § 17001 (West 2001 & Supp. 2009); *Bay Gen.*, 203 Cal. Rptr. at 187.

14. 635 P.2d 527 (Ariz. Ct. App. 1981).

15. *Id.* at 531–32.

16. *Id.* at 531–33.

17. *Bay Gen.*, 203 Cal. Rptr. at 188–89.

18. *Id.*

selecting only one hospital, indeed a public hospital, for reimbursement for emergency care rendered to indigent patients.<sup>19</sup>

In regard to the county's obligation to support indigent patients under sections 17000 and 17001, the *Bay General* court referred to an opinion issued by the California attorney general, which stated in pertinent part:

It seems a reasonable requirement that indigents, in order to qualify for county medical care, must seek admission to either the county hospital or the private hospital with which the county has contracted to provide such care. Having taken reasonable measure to discharge its duty toward the indigent sick, the county does not become a guarantor to all other hospitals, public or private, for the care of those indigents who for one reason or another find their way into those hospitals.<sup>20</sup>

The attorney general concluded that it was within the discretion of the county's board of supervisors to determine if the county had indeed taken "reasonable steps" to discharge its duty pursuant to sections 17000 and 17001.<sup>21</sup> Based upon the fact that the decision to reimburse only one hospital was within the discretion of the county's board of supervisors, and that in any case the board itself had jurisdiction to determine if the county was fulfilling its statutory obligations, the *Bay General* court concluded that the hospitals' action had no merit.<sup>22</sup>

The *Bay General* court supported its conclusion by reference to five additional arguments. First, the court opined that hospitals that receive Hill-Burton funds are not really "private" in the relevant sense.<sup>23</sup> That is, hospitals that receive Hill-Burton funds for construction of the hospital facility must provide a "reasonable" amount of charity care as consideration for the low cost loans.<sup>24</sup> The court argued that if the plaintiff hospitals were already obligated by contract with the federal government to provide emergency care, and indeed had received a valuable consideration for undertaking the obligation, they may not be heard to demand additional reimbursement.<sup>25</sup>

Second, the *Bay General* court cited section 1317(a) of the California Health and Safety Code, which imposes a mandatory duty on all

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19. *Id.* at 189–90, 195.

20. *Id.* at 189 n.7 (emphasis omitted) (quoting 37 Op. Cal. Att'y Gen. 41, 43 (1961)).

21. *Id.* (quoting 37 Op. Cal. Att'y Gen. 41, 44 (1961)).

22. *Id.* at 188–89.

23. *Id.* at 191.

24. *Id.*

25. *Id.* at 190.

hospitals that have emergency rooms to render emergency care regardless of the patient's ability to pay.<sup>26</sup> The court concluded that because the plaintiff hospitals were required to provide emergency care to indigents in any case, they were not detrimented by the county's refusal to reimburse the hospitals for the uncompensated care.<sup>27</sup>

Third, the *Bay General* court proffered the argument that because hospitals provide "unique, or scarce, medical resources needed to preserve life," hospitals constitute a "public service enterprise" and may not withhold their services arbitrarily or without reasonable cause.<sup>28</sup>

Fourth, the court argued that hospitals actually possess the means to obtain payment for any care rendered to ostensibly indigent patients.<sup>29</sup> That is, if patients are impoverished, they qualify for Medicaid (Medi-Cal in California). If patients are not so impoverished as to qualify for Medi-Cal even if they are uninsured, they must have assets that may be liquidated to pay for services rendered.<sup>30</sup>

Finally, the court stated that hospitals may have other sources of funding for care given, and therefore do not suffer a net loss as a result of the county's failure to reimburse the hospitals for the services they provide.<sup>31</sup> Despite the fact that the county of San Diego prevailed in the *Bay General* case, each of the arguments proffered by the *Bay General* court is suspect. Specifically, each argument was not valid when proffered, or if valid in 1984, has been rendered inapposite due to significant changes in circumstances.

The *Bay General* court's argument that the county fulfilled its obligation under sections 17000 and 17001 of the California Welfare and Institutions Code to support indigent patients is suspect for the following reasons. First, it is doubtful that the county has fulfilled its obligations by electing to reimburse only University Hospital, a public hospital. The number of persons in San Diego who lack insurance has dramatically increased since 1984 and presently amounts to over 19% of the population under sixty-five.<sup>32</sup> This figure is a manifestation of the fact

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26. *Id.*

27. *Id.* at 190, 193.

28. *Id.* at 191 (citation omitted).

29. *Id.* at 193.

30. *Id.*

31. *Id.*

32. SAN DIEGO COUNTY GRAND JURY, *Holes in the Health Care Safety Net*, in SAN DIEGO GRAND JURY FINAL REPORT 1998–1999, at 178, 184 (1999). *See also* U.S. GEN. ACCOUNTING OFFICE, GAO/HEHS-97-122, PRIVATE HEALTH INSURANCE: CONTINUED EROSION OF COVERAGE LINKED TO COST PRESSURES 53 (1997); E. RICHARD BROWN ET AL., UCLA CTR. FOR HEALTH POLICY RESEARCH, THE STATE OF HEALTH INSURANCE IN CALIFORNIA 32 (2009), [http://www.healthpolicy.ucla.edu/pubs/files/SHIC\\_RT\\_82009](http://www.healthpolicy.ucla.edu/pubs/files/SHIC_RT_82009).

that there are 50,000 more people in California without insurance *each month*.<sup>33</sup>

Moreover, in 1995 alone, the twenty-one private hospitals in San Diego County furnished \$145 million in uncompensated care.<sup>34</sup> Insofar as private hospitals accounted for 76% of uncompensated care in the subject year,<sup>35</sup> the *Bay General* court's argument that the county has fulfilled its section 17000 obligation is prima facie invalid with respect to the provision of health care in recent years.<sup>36</sup>

The *Bay General* court's reference to the California attorney general's opinion regarding the county's section 17000 obligation is relevant at this juncture. The 1961 attorney general's opinion stated that (1) indigents must first seek to receive medical care at a public hospital or a private hospital with which the county has contracted to furnish care, and (2) if a county has taken "reasonable measures" to discharge its duty, it does not become a "guarantor" to all other hospitals for compensation for rendering care.<sup>37</sup> The following points may be made with respect to the first contention. The reference to a duty on the part of indigents to first seek services at a public hospital is clearly inapplicable to emergency care. Reasonable medical practice mandates that emergency medical personnel transport patients with emergency medical conditions to the nearest emergency room.<sup>38</sup> The comment of

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pdf; INTEGRATED HEALTH STRATEGIES, HOSPITAL CARE IN SAN DIEGO: A FRAGILE BALANCE 8 (1997); *A Report on California Hospitals and the Economy* (Cal. Hosp. Ass'n, Sacramento, Cal.), Jan. 2009, at 1, available at <http://www.calhospital.org/Download/CHASpecialReport.pdf>.

33. SAN DIEGO COUNTY GRAND JURY, *supra* note 32, at 183; HELEN HALPIN SCHAUFFLER ET AL., UNIV. OF CAL., BERKELEY CTR. FOR HEALTH & PUB. POLICY STUDIES, THE STATE OF HEALTH INSURANCE IN CALIFORNIA 7 (1998), <http://chpps.berkeley.edu/publications/hipp982.pdf>.

34. SAN DIEGO COUNTY GRAND JURY, *supra* note 32, at 186.

35. See ORANGE COUNTY GRAND JURY, HEALTH CARE FOR THE INDIGENT 5 (1999), <http://www.ocgrandjury.org/pdfs/GJHealth.pdf>; SAN DIEGO COUNTY GRAND JURY, *supra* note 32, at 186.

36. Indeed, in a 1998 study, the Urban Institute concluded that San Diego's safety net system is among the most vulnerable in the country. STEPHEN A. NORTON & DEBRA J. LIPSON, URBAN INST., PUBLIC POLICY, MARKET FORCES, AND THE VIABILITY OF SAFETY NET PROVIDERS 21 (1998), <http://urban.org/publications/308041.html>. See also PROJECT MGMT. COMM. ON OPTIONS FOR EXPANDING HEALTH COVERAGE TO UNINSURED SAN DIEGANS, IMPROVING ACCESS TO HEALTH COVERAGE 1-24 (1999) [hereinafter IMPROVING ACCESS TO HEALTH COVERAGE].

37. 37 Op. Cal. Att'y Gen. 41, 43-44 (1961).

38. See, e.g., *Bay Gen. Cmty. Hosp. v. County of San Diego*, 203 Cal. Rptr. 184, 186 n.2 (Ct. App. 1984).

the attorney general is relevant only to nonemergency situations and to informed and mobile indigent patients. Moreover, the second contention made in the opinion by its terms is applicable *only if* the county has taken “reasonable measures” to fulfill its section 17000 obligation. The 1995 statistics indicate that the county has not in fact taken reasonable measures to fulfill its section 17000 obligation.

The *Bay General* court’s reference to the Hill-Burton obligations of the plaintiff hospitals is moreover suspect. The court made no actual determination that *any* of the hospitals had current Hill-Burton obligations. Further, even if certain hospitals had outstanding Hill-Burton obligations, such obligations mandate only that hospitals furnish a “reasonable” amount of charity care.<sup>39</sup> The *Bay General* court made no determination as to the amount of care given to indigents by any of the plaintiff hospitals. As indicated above, the number of patients with no health insurance has steadily and greatly increased since 1984. Insofar as one in five patients in San Diego County has no health insurance, it is reasonable to infer that the burden of uncompensated care exceeds the quantum of “reasonable” amount of charity care mandated by Hill-Burton.<sup>40</sup> This inference is also justified by the extraordinary increase in the cost of emergency health care since 1984.<sup>41</sup> Moreover, the court’s argument is invalid with respect to the current situation in San Diego because *no* hospitals in San Diego County have Hill-Burton obligations.<sup>42</sup> Further, even if a hospital did have remaining Hill-Burton obligations in 1984, it may have been exempt from the requirement to provide charity care if to do so is “not feasible from a financial viewpoint.”<sup>43</sup> The *Bay General* court made no reference to the exemption with regard to any of the plaintiff hospitals.

Further, the hospitals’ obligation to furnish emergency medical treatment is an entirely distinct issue from the county’s obligation to provide or pay for emergency medical treatment for indigents. The *Bay General* court’s argument is therefore a false bifurcation. It may well be

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39. 42 C.F.R. § 124.503(a) (2008).

40. The amount of charity care recipient hospitals are required to furnish has, since 1972, been the lesser of either 3% of the operating cost of the hospital or 10% of the value of all federal assistance received by the hospital. *Id.*

41. Dowell, *supra* note 3, at 46; *see also* Mark A. Hall, *The Unlikely Case in Favor of Patient Dumping*, 28 JURIMETRICS J. 389, 394–95 (1988).

42. Indeed in San Diego County, only *one* facility, a neighborhood clinic that provides only outpatient services, has Hill-Burton obligations. *See* Health Res. & Servs. Admin., Hill-Burton Facilities Obligated To Provide Free or Reduced-Cost Health Care, <http://www.hrsa.gov/hillburton/hillburtonfacilities.htm> (last visited Jan. 30, 2010).

43. 42 U.S.C. § 291c(e) (2006).

that private hospitals are legitimately required to render emergency care to indigents *and* that the county is legitimately required to reimburse hospitals.

The argument that a hospital is a “public enterprise” insofar as it is the unique source of lifesaving services is subject to the same remarks as the argument regarding section 1317a of the California Health and Safety Code. That is, terming hospitals a “public enterprise” may entail that the public entity has a duty to fund the services that hospitals are mandated to provide.

The *Bay General* court’s argument that the plaintiff hospitals suffered no damage as they could obtain compensation from “other sources” may have had some validity in 1984. At that time, the federal government’s emendation of its payment schedule from a retrospective system to a prospective system had not yet manifested its effects.<sup>44</sup> The flat rate system of payments for Medicare and Medicaid based upon Diagnosis Related Groups (DRGs) ultimately resulted in reimbursements of portions of sums billed to the federal government by providers.<sup>45</sup> Further, soon after the federal government adopted the prospective payment scheme, the phenomenon of managed care emerged, especially in southern California. Managed care evolved into the private sector’s version of DRGs.<sup>46</sup> Due to the federal government’s and the private sector’s adoptions of prospective payment systems, the profit margins of hospitals were dramatically reduced.<sup>47</sup> As a result, hospitals’ traditional ability to “cost-shift” or obtain reimbursement for charity care from other sources of payment has been greatly constrained.<sup>48</sup> In addition, given the increase in the number of uninsured patients since 1984, it is

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44. See, e.g., Frank A. Sloan, *Commercialism in Nonprofit Hospitals*, in *TO PROFIT OR NOT TO PROFIT: THE COMMERCIAL TRANSFORMATION OF THE NONPROFIT SECTOR* 151, 154–55 (Burton A. Weisbrod ed., 1998).

45. *Id.* See also FRANK A. SLOAN & BRUCE STEINWALD, *INSURANCE, REGULATION, AND HOSPITAL COSTS* (1980); John J. Antel et al., *State Regulation and Hospital Costs*, 77 *REV. ECON. & STAT.* 416 (1995).

46. See MICHAEL M. MORRISEY, *COST SHIFTING IN HEALTH CARE: SEPARATING EVIDENCE FROM RHETORIC* 23–33 (1994); James C. Robinson, *Decline in Hospital Utilization and Cost Inflation Under Managed Care in California*, 276 *JAMA* 1060 (1996) [hereinafter Robinson, *Decline*]; James C. Robinson, *Health Care Purchasing and Market Changes in California*, *HEALTH AFF.*, Winter 1995, at 117; (1987); James C. Robinson & Harold S. Luft, *Competition and the Cost of Hospital Care, 1972 to 1982*, 257 *JAMA* 3241 (1987); Sloan, *supra* note 44, at 155–60.

47. See Robinson, *Decline*, *supra* note 46, at 1063.

48. See MORRISEY, *supra* note 46, at 71–73.

patent that the *Bay General* court's reliance upon "other sources" of payments in its decision is now inapposite.

Finally, the *Bay General* court's argument that indigent patients have assets that may be liquidated to pay for medical services that they receive is surely fanciful. The majority of uninsured persons are those who have low paying jobs without health benefits.<sup>49</sup> Such persons have few valuable assets and are effectively judgment proof. Uninsured persons use emergency rooms as providers of primary medical services because they often cannot afford to pay for medical care on a fee-for-service basis.<sup>50</sup> Emergency care is, in turn, mandatory and exceedingly expensive.<sup>51</sup> The working poor are in fact the class of persons least likely to have sufficient assets for a hospital to pursue through litigation. As a result, hospitals rarely pursue uninsured persons through the legal process.

The unbridled discretion exercised by the county of San Diego with respect to whether or not it has fulfilled its statutory duties pursuant to section 17000 of the California Welfare and Institutions Code has predictably led to the county's spending relatively little on indigent health care.<sup>52</sup> Based on the above discussion, therefore, it may be concluded that to the extent any of the arguments proffered by the *Bay General* court in support of its holding were valid in 1984, they are presently deserving of reconsideration.

*B. Bay General Reconsidered: The Holdings in County of San Diego v. State*<sup>53</sup> and *Hunt v. Superior Court*<sup>54</sup>

The concept of absolute discretion with respect to the decision by counties to fund the medical treatment of indigent persons articulated in *Bay General* remained in effect until 1997. On March 3, 1997, the California Supreme Court issued its decision in *County of San Diego v. State*.<sup>55</sup> In that case, San Diego County had attempted to obtain

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49. See SAN DIEGO COUNTY GRAND JURY, *supra* note 32, at 184.

50. CAL. ASS'N OF PUB. HOSPS. & HEALTH SYS., CAPH REPORT 1-2 (2009), [http://www.caph.org/newsreleases/EconomicImpactReport2\\_11\\_09.pdf](http://www.caph.org/newsreleases/EconomicImpactReport2_11_09.pdf).

51. SAN DIEGO COUNTY GRAND JURY, *supra* note 32, at 186.

52. *Id.* at 185-87. See also *County of San Diego v. State*, 931 P.2d 312, 316-17 (Cal. 1997); *Bay Gen. Cmty. Hosp. v. County of San Diego*, 203 Cal. Rptr. 184, 187-93 (Ct. App. 1984).

53. 931 P.2d. 312.

54. 987 P.2d 705 (Cal. 1999).

55. *County of San Diego*, 931 P.2d at 312.

reimbursement from the state for the costs of care furnished to adult indigents.<sup>56</sup>

In order to resolve the above issue, the supreme court first reviewed the history of the Medi-Cal program. Medi-Cal was established in 1966 in order to provide “basic and extended health care services for recipients of public assistance and for medically indigent persons.”<sup>57</sup> Eligibility for Medi-Cal was, however, initially limited to persons who qualified for a federal categorical aid program by age, blindness, disability, or membership in a family with dependent children.<sup>58</sup> Individuals not qualified in the requisite sense were ineligible for Medi-Cal, regardless of their means.<sup>59</sup> These individuals not covered by Medi-Cal and unable to afford medical care remained the responsibility of the counties.<sup>60</sup> In order to help defray the counties’ financial burden of providing health services for indigent persons who did not qualify for Medi-Cal, in 1971, the California legislature established the “county option” according to which the state would reimburse counties for the cost of furnishing medical care to indigent patients.<sup>61</sup>

In 1982, the legislature passed two Medi-Cal reform bills that had the effect of excluding from Medi-Cal coverage most adults who had been previously eligible for benefits.<sup>62</sup> At the same time, however, the state created the Medically Indigent Services Account as a mechanism for transferring state funds to the counties for the provision of medical services to indigent adults.<sup>63</sup>

Subsequent to the passage of the 1982 legislation, San Diego County established a County Medical Services (CMS) program to provide health services to indigent patients not covered by Medi-Cal.<sup>64</sup> In the litigation

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56. *Id.* at 314. It is ironic that the county vigorously pursued reimbursement for its relatively small expenditure for uncompensated care, in light of its refusal to reimburse private hospitals.

57. *Id.* at 315 (quoting *Morris v. Williams*, 433 P.2d 697, 700 (Cal. 1967)).

58. *Id.* at 316.

59. *Id.*

60. *Id.*

61. *Id.*

62. *Id.* at 317.

63. *Id.* at 318.

64. *Id.* In 1997 and 1998, only 21,000 of 645,000 uninsured persons were treated through the CMS program. SAN DIEGO COUNTY GRAND JURY, *supra* note 32, at 180. Further, the CMS reimbursement rate is less than 20% of actual cost. *Id.* at 187. As a result, even public hospitals in San Diego County have declined to participate in the CMS program. *Id.*

leading to the decision in *County of San Diego*, the county claimed that the state's reimbursements to the county for the provision of medical care to indigents through the CMS program from 1989 to 1990 were inadequate.<sup>65</sup> In February 1991, the San Diego Board of Supervisors voted to terminate the CMS program unless the state immediately agreed to provide full funding for the 1990 to 1991 fiscal year.<sup>66</sup> After the state had refused to provide additional funding, the county notified affected individuals and health care providers that it intended to terminate the CMS program, effective March 19, 1991.<sup>67</sup>

In addition to announcing its intention to terminate the CMS program, the county filed suit against the state on the basis that the 1982 legislation that imposed upon the counties the obligation to provide health services to indigent adults constituted an unfunded mandate in violation of article XIII B, section 6 of the California Constitution.<sup>68</sup> The supreme court agreed with the county: "[O]ur discussion demonstrates the Legislature excluded adult [medically indigent persons] from Medi-Cal *knowing* and *intending* that the 1982 legislation would trigger the counties' responsibility to provide medical care as providers of last resort under section 17000."<sup>69</sup> After holding that the exclusion of medically indigent adults from Medi-Cal constituted an unlawful unfunded mandate, the supreme court remanded the case to the trial court to determine the amount of reimbursement due to San Diego County by the state.<sup>70</sup>

Essential to the supreme court's decision, however, was the finding that the county was subject to a *mandate*.<sup>71</sup> That is, the supreme court held that the county was obligated to provide care for indigent adults because it had a duty to support *all* indigent persons pursuant to section 17000:

[S]ection 17000 requires Counties to relieve and support "*all indigent persons* lawfully resident therein, "when such persons are not supported and relieved by their relatives" or by some other means." Moreover, section 10000 declares that the statutory "purpose" of division 9 of the Welfare and Institutions Code, which includes section 17000, "is to provide for protection, care, and assistance to the people of the state in need thereof, and to promote the welfare and happiness of all of the people of the state by providing appropriate aid and services to *all* of its needy and distressed." (Italics added.) Thus Counties have no

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65. *County of San Diego*, 931 P.2d at 318.

66. *Id.*

67. *Id.*

68. *Id.*

69. *Id.* at 330.

70. *Id.* at 339.

71. *Id.* at 336.

discretion to refuse to provide medical care to “indigent persons” within the meaning of section 17000 who do not receive it from other sources.<sup>72</sup>

In a footnote attending the above passage, the supreme court stated:

We disapprove *Bay General* insofar as it (1) states that a county’s responsibility under section 17000 extends only to indigents as defined by the county’s board of supervisors, and (2) suggests that a county may refuse to provide medical care to persons who are “indigent” within the meaning of section 17000 but do not qualify for Medi-Cal.<sup>73</sup>

In its reference to the *Bay General* decision, the supreme court eviscerated the concept of absolute discretion on the part of the county to furnish medical care to indigents.<sup>74</sup> Instead, consistent with the plain meaning of section 17000, the court held that the county must provide health services to all indigents.<sup>75</sup> It would seem that the only discretion allowed the counties is to decide whether to reimburse other providers that furnish the medical care or to provide the services directly. The supreme court’s opinion is even more striking inasmuch as it nods approvingly toward lower courts’ holdings as well as statutory and legislative histories that interpret section 17000 obligations to encompass not only emergency care but also “medically necessary care.”<sup>76</sup> That is, section 17000 requires the provision of health services at a level that prevents “unnecessary suffering” or the endangerment of life and health.<sup>77</sup> Therefore, the section 17000 obligation, as broadly construed by the supreme court, could encompass therapies such as organ transplants and treatments for chronic conditions such as kidney dialysis and AIDS.<sup>78</sup>

In *Hunt v. Superior Court*, the California Supreme Court reiterated and explained its holding in *County of San Diego* that section 17000

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72. *Id.* at 332 (citation omitted).

73. *Id.* at 332 n.23.

74. *Id.*

75. *Id.* at 332–33.

76. *Id.* at 335–36 (quoting *County of Alameda v. State Bd. of Control*, 18 Cal. Rptr. 2d 487, 494 (Ct. App. 1993)).

77. *Id.* (quoting *Tailfeather v. Bd. of Supervisors*, 56 Cal. Rptr. 2d 255, 265 (Ct. App. 1996)). It is also important to note that after receiving emergency care, many patients with significant illnesses or injuries will be in need of “medically necessary” care, often for prolonged periods of time.

78. Indeed, nearly one-half of individuals served by San Diego’s CMS program have chronic medical conditions such as hypertension, diabetes, and AIDS. See IMPROVING ACCESS TO HEALTH COVERAGE, *supra* note 36, at 35.

subdivision (a) does not delineate the scope of health services that counties must provide to indigent persons.<sup>79</sup> The court held that the obligation was defined by section 17000, as outlined in its decision in *County of San Diego*.<sup>80</sup> In *County of San Diego*, the supreme court reiterated its disapproval of the holding in *Bay General*, stating that (1) “a county’s responsibility under section 17000 extends only to indigents as defined by the county’s board of supervisors,” and (2) “a county may refuse to provide medical care to persons who are ‘indigent’ within the meaning of section 17000 but do not qualify for Medi-Cal.”<sup>81</sup> The supreme court accordingly reasserted that counties are obligated to provide medical services to persons who do not qualify for receipt of medical services under any other specialized aid programs.<sup>82</sup> As in *County of San Diego*, the supreme court in *Hunt* defined an “indigent” patient as “one who has insufficient means to pay for his maintenance in a private hospital after providing for those who legally claim his support.”<sup>83</sup> The court also reiterated holdings that section 17000 requires the provision of services at a level that prevents “unnecessary suffering” or the “endanger[ment] of life and health,” and that is “humane” and “avoid[s] substantial pain and infection.”<sup>84</sup> The court concluded that counties have a duty to furnish “subsistence” health services, as previously defined, “promptly and humanely.”<sup>85</sup> Under the court’s holding, counties retain the discretion to determine how to meet the above standard, but meet it they must.<sup>86</sup> The scope of the obligation to support indigent patients must, however, also be established.

### C. Indeterminacy in the Level of Care Mandated by Section 17000

It may appear that after an extended period of time during which California counties were allowed to escape their statutory obligations to support indigent patients, the California Supreme Court’s decisions in *San Diego County* and *Hunt* should have at least theoretically brought an end to the counties’ irresponsibility. Several material issues remain to be resolved, however, before a coherent county health policy may be

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79. *Hunt v. Superior Court*, 987 P.2d 705, 718 (Cal. 1999).

80. *Id.* at 718.

81. *Id.* at 725.

82. *Id.* at 726.

83. *Id.* (quoting *County of San Diego v. State*, 931 P.2d 312, 334 (Cal. 1997)).

84. *Id.* (citations omitted).

85. *Id.* at 726–27.

86. *Id.* at 727.

formulated. For instance, the *level* of care mandated by section 17000 of the California Welfare and Institutions Code must be determined. In its concluding remarks in the *Hunt* case, the California Supreme Court stated:

[R]ecognizing such an obligation neither requires the County to satisfy all unmet needs nor mandates universal health care. . . . The Legislature has eliminated any requirement that counties provide the same quality of health care to residents who cannot afford to pay as that available to nonindigent individuals receiving health care services in private facilities. [Welfare and Institutions Code] [s]ection 10000 imposes a minimum standard of care—one requiring that subsistence medical services be provided promptly and humanely. Counties retain discretion to determine how to meet this standard, but they may not deny subsistence medical care to residents based upon criteria unrelated to individual residents’ financial ability to pay all or part of the actual cost of such care.<sup>87</sup>

The supreme court added that the “subsistence” standard articulated above includes medical services “necessary for the treatment of acute life-and-limb-threatening conditions and emergency medical services within the meaning of Health and Safety Code section 1317.”<sup>88</sup>

Further, the “subsistence” standard of health care referred to by the supreme court in *Hunt* is presumptively coextensive with the “medically necessary” standard that the supreme court articulated in *San Diego County*.<sup>89</sup> The standard articulated in *Hunt* was derived from the decision in *Tailfeather v. Board of Supervisors*.<sup>90</sup> *Tailfeather* involved an unsuccessful attempt by indigent residents of the county of Los Angeles to compel the county to adopt formal written standards regarding waiting time for medical care for indigents.<sup>91</sup> Although the *Tailfeather* court upheld the dismissal of the indigents’ action, it issued parameters regarding the level of care to be provided pursuant to section 17000 of the California Welfare and Institutions Code.<sup>92</sup> As precedent, the *Tailfeather* court referred to the decision in *Cooke v. Superior Court*, which determined the level of *dental* care mandated by section 17000.<sup>93</sup> The *Cooke* court held that section 17000 required that counties provide dental services “necessary to alleviate substantial pain, to treat infection,

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87. *Id.* at 726–27 (citations omitted).

88. *Id.* at 726.

89. *See supra* Part II.B.

90. *Tailfeather v. Bd. of Supervisors*, 56 Cal. Rptr. 2d 255, 262–63 (Ct. App. 1996).

91. *Id.* at 256.

92. *Id.* at 262–63.

93. *Id.* at 263; *Cooke v. Superior Court*, 261 Cal. Rptr. 706, 709 (Ct. App. 1989).

to maintain basic function, to maintain adequate nutrition, and to care for dental conditions which present a serious health risk.”<sup>94</sup> Services to be rendered included amalgam restorations, anterior root canals, and denture repair.<sup>95</sup>

It may be, however, that it is not feasible to create a suitable list of medical procedures that would be encompassed by the section 17000 obligation. That is, the number of possible medical procedures is relatively much greater than that of dental procedures. Therefore, even if an approximate designation of the former may be feasible, that fact does not imply that a manageable designation of medical procedures is possible. For instance, one of the dental procedures that the *Cooke* court validated was the treatment of infection.<sup>96</sup> In the context of dental procedures, this designation is properly interpreted as referring to oral bacteriological infection. In a medical context, however, infection can be the result of either bacteriological or viral causes. The treatment of infection could be taken to include not only simple treatment with antibiotics for an acute bacteriological infection but also prolonged and extensive treatment for chronic conditions such as HIV infection and AIDS.

The indeterminacy in the level of care that the counties must furnish indicates a more fundamental difficulty with the section 17000 mandate as articulated by the California Supreme Court. Insofar as the court interprets the section 17000 obligation to be less stringent than the prevailing standard of care, the court has abrogated any objective basis for evaluating whether or not counties have satisfied their section 17000 obligations. That is, the ordinary “community of physicians” standard has traditionally constituted the legal standard for adequate health care.<sup>97</sup> The proper level of care under this standard can be ascertained by reference to established medical practice. To the extent that the level of care mandated by section 17000 is not identical to the community standard, the former standard is nebulous. Because the proper care pursuant to section 17000 will, in the case of each treatment or category of treatment, not be determined by reference to the community standard, it presumably can only be established as a result of litigation. The level of care in any given case will moreover be the result of a quasi-legal criterion, as the prevailing medical practice will not be dispositive. One result may be expensive, inefficient, and protracted litigation, at least

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94. *Cooke*, 261 Cal. Rptr. at 709, 714.

95. *Id.* at 709.

96. *Id.* at 714–15.

97. See CALIFORNIA JURY INSTRUCTIONS: CIVIL, BAJI 6.00.1 (Spring ed. 2009).

until general judicial interpretations of section 17000 standards are established. Another result may be extreme divergence among the counties in terms of the level of medical care due to differences in interpretation of the scope of the section 17000 obligation.

Further, to the extent that the section 17000 standard of care differs from the community standard, persons who provide health services to indigents may feel compelled to distinguish between patients in terms of the level of care that they provide to patients. Finally, insofar as the section 17000 standard of care is below that mandated by the community standard, untoward long-term results may occur. For example, the funding of treatment only for “serious” health risks may lead to treatment for heart attacks and strokes but not high blood pressure, even if treatment for the latter were included in the community standard of care. The failure to intervene until the health risk is “substantial” may in the long-term be more expensive, be less efficient, and cause more suffering.

The uncertainty with respect to the mandated level of care may also be illustrated by a consideration of the result in *Payton v. Weaver*.<sup>98</sup> Brenda Payton was a thirty-five-year-old woman who suffered from end stage kidney disease and associated complications, as well as from psychological problems that made it difficult for her to conform to a treatment regimen.<sup>99</sup> To survive, Payton required kidney dialysis two or three times per week for a period of several hours.<sup>100</sup> Subsequent to receiving treatment for her disease from respondent’s physician and health care center for a period of three years, Payton attempted to legally compel continued treatment of her condition indefinitely.<sup>101</sup> Payton applied for a writ of mandate to compel treatment on the basis that her condition constituted an “emergency” pursuant to section 1317 of the California Health and Safety Code.<sup>102</sup> Payton argued that her illness was itself an emergency in that it required that she receive treatment every third day in order “to avoid death.”<sup>103</sup>

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98. 182 Cal. Rptr. 225 (Ct. App. 1982).

99. *Id.* at 226–27.

100. *Id.* at 226.

101. *Id.* at 227.

102. *Id.*

103. *Id.* at 229–30.

The trial court denied Payton's petition, holding that end stage renal disease is not itself an "emergency" pursuant to section 1317.<sup>104</sup> The court stated that if the patient obeys medical orders and receives regular medical attention, the condition will not result in an emergency situation.<sup>105</sup> Although the trial court denied Payton's petition, it stayed enforcement of its order pending Payton's appeal of the ruling.<sup>106</sup> The court of appeal affirmed the ruling of the trial court:

While end stage renal disease is an extremely serious and dangerous disease, which can create imminent danger of loss of life if not properly treated, the need for continuous treatment as such cannot reasonably be said to fall within the scope of section 1317. . . . If a patient suffering from such a disease or condition were to appear in the emergency room of a hospital in need of immediate life-saving treatment, section 1317 would presumably require that such treatment be provided. But it is unlikely that the Legislature intended to impose upon whatever health care facility such a patient chooses the unqualified obligation to provide continuing preventative care for the patient's lifetime.<sup>107</sup>

The *Payton* court based its conclusion upon the distinction between a dangerous condition that, with proper medical supervision and prudent conduct on the part of the patient, will not manifest its potential dangerous propensities and an emergency condition that will result in the absence of such preventative measures.<sup>108</sup> Thus, the *Payton* court appears to base its decision on the distinction between chronic and acute conditions. Section 1317 is intended to apply to acute conditions, which constitute immediate threats to life, and not to chronic conditions, which merely have the potential to manifest themselves as such threats.<sup>109</sup>

It is however unclear whether chronic conditions such as renal failure would be covered under the "subsistence" standard of health care articulated in *Tailfeather* and *San Diego County*. It could be argued that for the same reasons that the *Payton* court held that section 1317 of the California Health and Safety Code did not apply to renal failure, it would not be included in the subsistence standard. That is, properly treated renal failure does not constitute "endangerment" of health or basic function. On the other hand, it could be argued that renal failure *in and of itself* constitutes a serious threat to health and basic function. For example, the necessity of hemodialysis three days a week for several

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104. *Id.* at 229.

105. *Id.* at 230.

106. *Id.* at 231.

107. *Id.* at 230. To ensure continued treatment for Payton, the appellate court suggested placement in a private psychiatric facility. *Id.* at 231.

108. *Id.* at 230.

109. *Id.*

hours at a time is arguably a threat to and interferes with basic function. Indeed, if treatment for renal failure is not included in the subsistence standard, uninsured persons suffering from renal failure will not be able to adequately maintain treatment for their condition and will experience a crisis. Moreover, the distinction between chronic and acute conditions is less clear in regard to degenerative conditions such as diabetes and AIDS. Even with proper monitoring and medical care, many persons with such afflictions will experience deterioration of their conditions over time.

*D. The Failure of the Counties To Fulfill Their Obligation To Serve as the Provider “of Last Resort”*

The indeterminacy regarding the level of care that the counties are mandated to provide under section 17000 of the California Welfare and Institutions Code serves to compound the uncertainty that remains regarding California counties’ duty as the health care provider of last resort. After the decisions in the *San Diego County* and *Hunt* cases, however, it would seem that the counties have no discretion to avoid that function. Nonetheless, the rulings have had little or no effect on the problem of uncompensated care in California. In fact, in the decade following the decision in *San Diego County*, the number of hospital and emergency closures accelerated at an unprecedented rate. From 1998 through 2007, sixty-one hospitals closed, and fourteen hospitals remained in service only by closing their emergency departments.<sup>110</sup> That is, a total of seventy-five emergency departments closed in the years following the *San Diego County* and *Hunt* decisions.

In San Diego County alone, the setting for the seminal 1997 case *San Diego County*, eighteen emergency departments have closed since 2005.<sup>111</sup> Hospitals in the state as a whole provided more than \$10 billion in uncompensated care in 2008.<sup>112</sup>

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110. *Closed California Hospitals*, L.A. TIMES, <http://projects.latimes.com/hospitals/emergency-rooms/no/closed/list/> (last visited Jan. 30, 2010); *Open California Hospitals that Closed an Emergency Room Between 1998 and 2007*, L.A. TIMES, <http://projects.latimes.com/hospitals/emergency-rooms/no/open/list/> (last visited Jan. 30, 2010).

111. *Closed California Hospitals*, *supra* note 110; *Open California Hospitals*, *supra* note 110.

112. *A Report on California Hospitals and the Economy*, *supra* note 32, at 2.

Further, 33% of California hospitals reported an increase in the number of uninsured ER patients in 2008.<sup>113</sup> It has been estimated that currently in the United States only approximately 55% of emergency care is compensated.<sup>114</sup> As an inevitable result, access to emergency care in California has been rated as one of the worst in the country, receiving a grade of *F*.<sup>115</sup> The American College of Emergency Physicians has termed the system as one that is in crisis.<sup>116</sup> California emergency departments suffer from a serious deficiency in the number of specialists, registered nurses, and mental health providers.<sup>117</sup> The large number of emergency department closures has rendered California with a ratio of only 7.1 emergency departments per 1 million people, compared to an average of 19.9 among the states.<sup>118</sup> California also has a critical shortage of staffed inpatient and psychiatric beds.<sup>119</sup>

It is not surprising that the holdings in the *San Diego County* and *Hunt* cases have not prevented the crisis in access to emergency care. Although the California Supreme Court has declared that the counties are the health care provider of last resort for indigent patients,<sup>120</sup> the criteria for “indigence” nonetheless varies greatly from county to county, ranging from less than 100% to 300% of the federal poverty level.<sup>121</sup> In *Alford v. County of San Diego*, a California court of appeal struck down San Diego County’s rigid standard for assistance of \$1078 per month as violative of its duty to provide health services as a last resort.<sup>122</sup> The court held that the county must adopt standards that support the provision of medically necessary care and not just emergency services:

The County asserts that adoption of such a rule would require the County to “satisfy all unmet health care needs” or “provide universal health insurance.” Just such an argument was rejected by the Supreme Court in *Hunt*: “Contrary to [Sacramento County’s] assertion, recognizing such an obligation neither requires

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113. *Id.*

114. Am. Coll. of Emergency Physicians, *The Uninsured: Access to Medical Care*, <http://www.acep.org/patients.aspx?id=25932> (last visited Jan. 30, 2010).

115. AM. COLL. OF EMERGENCY PHYSICIANS, *THE NATIONAL REPORT CARD ON THE STATE OF EMERGENCY MEDICINE 25* (2009), available at <http://www.emreportcard.org/uploadedFiles/ACEP-ReportCard-10-22-08.pdf>.

116. *Id.*

117. *Id.*

118. *Id.*

119. *Id.*

120. *County of San Diego v. State*, 931 P.2d 312, 330 (Cal. 1997).

121. *County Programs for the Medically Indigent in California*, FACT SHEET (Cal. HealthCare Found., Oakland, Cal.), Aug. 2006, at 2–3, <http://www.chcf.org/documents/policy/CountyPrgmsMedicallyIndigentFactSheet.pdf>.

122. *Alford v. County of San Diego*, 59 Cal. Rptr. 3d 596, 605–06, 609 (Ct. App. 2007).

the County to satisfy all unmet needs, nor mandates universal health care. . . . The Legislature has eliminated any requirement that counties provide the same quality of health care to residents who cannot afford to pay as that available to nonindigent individuals receiving health care services in private facilities. . . . Section 10000 imposes a minimum standard of care—one requiring that subsistence medical services be provided promptly and humanely.” As stated above, “section 17000 requires provision of medical services to the poor at a level which does not lead to unnecessary suffering or endanger life and health.” Thus, section 17000 is designed to allow only necessary treatment for serious illness and injury, as the plaintiffs in this case have suffered. They are seeking treatment for such serious ailments as diabetes, serious lung infections, thyroid disease, high blood pressure, and malignant melanoma. They are not asking that *all* of the medical care of indigents, including the routine care enjoyed by nonindigents, be paid for by the County.<sup>123</sup>

As of June 2009, reflecting the holding in *Alford*, the upper limit for assistance for an indigent adult in San Diego County is 350% of the 2009 federal poverty level of \$10,830 for a single-family household.<sup>124</sup>

Nonetheless, despite the emendation of the upper limit for assistance, it is evident that many individuals with significant health needs are too “rich” to qualify for assistance. This fact illuminates why as of 2007 over 19% of residents of San Diego had no health coverage of any kind.<sup>125</sup> The “working poor,” employed persons with no health care insurance, often utilize emergency departments as their primary source of health services.<sup>126</sup> As a result, in 2008, the CMS program estimated that 44% of emergency room visits by its Standard Eligibility Users in San Diego County involved care that could have been rendered in other less costly facilities.<sup>127</sup> Moreover, due to the present untoward economy, California public hospitals can expect a significant increase in the volume of uninsured patients in their emergency departments.<sup>128</sup>

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123. *Id.* at 609 (citations omitted).

124. *See* COUNTY OF SAN DIEGO HEALTH & HUMAN SERVS. AGENCY, COUNTY OF SAN DIEGO MEDICAL SERVICES (CMS) PROGRAM: HOSPITAL HANDBOOK, at 2.2 (2009), <http://www.sdcountry.ca.gov/hhsa/programs/ssp/documents/HospitalHandbook.pdf>.

125. BROWN ET AL., *supra* note 32, at 32. The poverty line in San Diego County has been estimated to be \$53,426. The cost of living index in San Diego County is 186.95 compared to the national average of 100. *See* Numsum.com, Cost of Living—County of San Diego, California, <http://cf.numsum.com/spreadsheet/show/43147> (last visited Jan. 30, 2010). The cost of living in San Diego is 47% above the national average. Dean Calbreath, *San Diego County 11th Among Metro Areas in Cost of Living, Council Says*, SAN DIEGO UNION-TRIB., May 23, 2008, at C1.

126. CAL. ASS’N OF PUB. HOSPS. & HEALTH SYS., *supra* note 50, at 1.

127. IMPROVING ACCESS TO HEALTH COVERAGE, *supra* note 36, at 23, 35.

128. CAL. ASS’N OF PUB. HOSPS. & HEALTH SYS., *supra* note 50, at 1–2.

Another issue is that the burden of pursuing reimbursement is placed upon the hospital, not the county. The *Alford* court held that when setting standards for reimbursement for the cost of care for indigent persons, counties are not required to perform individual needs assessments, but rather may utilize cost-of-living statistics coupled with mechanisms to ensure that deserving individuals qualify for assistance:

[T]here are several alternative methods of providing care to those with a limited ability to pay. The County could institute a sliding scale fee system, in which health care services are priced based upon ability to pay. It could enact an income limit for free care, supplemented by provisions permitting those over the limit to apply for medical and financial hardship exceptions. The County could set an income cap that is sufficiently high that those exceeding the limit will have the means to obtain health care. Because of the discretion vested in the County to select standards for subsistence medical care to indigents under section 17000, this court will not mandate a particular vehicle to achieve that result. However, counties “have no discretion to refuse to provide medical care to ‘indigent persons’ within the meaning of section 17000 who do not receive it from other sources.” Because the current income cap results in a denial of subsistence medical care to such individuals, it is void.<sup>129</sup>

There are, however, several difficulties with the *Alford* holding. First, from the standpoint of the private hospitals, which must provide care to indigent patients, the process of qualification may fail at various points. Certain individuals may simply refuse or otherwise fail to follow procedures relating to qualification, or even if they qualify, they could fail to pay for services received. Indeed, the reference to the reception based upon the “ability to pay” is irrelevant in regard to the reception of emergency and associated care, which hospitals must provide *regardless* of the ability to pay.

As noted, private hospitals are declaring bankruptcy at an alarming rate due to the large amount of charity care and bad debt. Hospitals simply become creditors for individuals who receive necessary services but cannot pay. If the takings argument is valid, then at the very least the public entity—the state, the county, or both—should assume the risk of the bad debt resulting from the involuntary provision of emergency care and related services. If so, the hospitals should be reimbursed for rendering such care. The public entities, which are in a much stronger position to recover the costs of treatment, should assume the risk of obtaining funds from individuals receiving such care.

Second, as noted in *Tailfeather*, section 17000 does not require counties to fund the same level of care for indigent patients as is

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129. *Alford v. County of San Diego*, 59 Cal. Rptr. 3d 596, 611 (Ct. App. 2007) (citations omitted) (quoting *County of San Diego v. State*, 931 P.2d 312, 332 (Cal. 1997)).

provided to those patients with medical insurance.<sup>130</sup> The legal standard of care required of hospitals, however, makes no allowance for inadequate reimbursement. Physicians at hospitals are required to provide the same level of care to all patients.<sup>131</sup>

Third, section 17000 only provides support for California residents and legal aliens.<sup>132</sup> Pursuant to federal and state law, emergency departments are required to provide emergency care to all patients in need thereof, regardless of their citizenship.<sup>133</sup>

It is apparent that the requirement that California counties serve as the provider of medical services of last resort has not alleviated the problem of uncompensated emergency and related medical treatment. An alarming number of emergency departments and a smaller number of hospitals have in the last decade become insolvent. To fully resolve the issue of uncompensated emergency care, the statutory duties relating to emergency departments must be examined.

### III. STATUTORY OBLIGATIONS OF HOSPITALS TO PROVIDE EMERGENCY MEDICAL CARE TO INDIGENT PATIENTS

Despite several judicial decisions over the last two decades that purport to ensure that all individuals have access to basic medical care, a substantial and growing percentage of the population has no medical insurance.<sup>134</sup> The failure to remedy the problem by placing the responsibility for indigent health care on the counties indicates that the responsibility may be better placed elsewhere. Indeed, in giving the emergency services system in California an *F*, the American College of Emergency Physicians noted California's "unique public health structure," pursuant to which "counties have been charged with many of the responsibilities other states maintain at the state level."<sup>135</sup> It is therefore

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130. Tailfeather v. Bd. of Supervisors, 56 Cal. Rptr. 2d 255, 262 (Ct. App. 1996).

131. See CALIFORNIA JURY INSTRUCTIONS: CIVIL, BAJI 6.00.1 (Spring ed. 2009).

132. CAL. WELF. & INST. CODE § 17100 (West 2001 & Supp. 2009).

133. 42 U.S.C. § 1395dd(a) (2006); CAL. HEALTH & SAFETY CODE § 1317(a)–(b) (West 2008).

134. Jackson v. E. Bay Hosp., 246 F.3d 1248, 1254 (9th Cir. 2001); Marshall v. E. Carroll Parish Hosp. Dist., 134 F.3d 319, 323 (5th Cir. 1998); Power v. Arlington Hosp. Ass'n, 42 F.3d 851, 859 (4th Cir. 1994); Guzman v. Mem'l Hermann Hosp. Sys., 637 F. Supp. 2d 464, 481 (S.D. Tex. 2009); Magruder v. Jasper County Hosp., 243 F. Supp. 2d 886, 890 (N.D. Ind. 2003).

135. AM. COLL. OF EMERGENCY PHYSICIANS, *supra* note 115, at 25.

imperative to examine the other statutory requirements regarding the provision of emergency health services.

*A. The Emergency Medical Treatment and Active Labor Act*

In response to the national crisis in emergency care, in 1984 a new section was appended to Medicare regulations. The legislation containing the new section was entitled the Emergency Medical Treatment and Active Labor Act (EMTALA).<sup>136</sup> EMTALA applies to all hospitals with emergency facilities participating in the Medicare program.<sup>137</sup> The statute protects all individuals who present themselves at emergency rooms, regardless of whether the person is eligible for Medicare benefits.<sup>138</sup> The law requires that the hospital examine each individual entering its emergency room to determine if an emergency situation exists or if the individual is in active labor.<sup>139</sup> If either condition exists, the hospital must render emergency care, provide treatment for labor, or provide for an “appropriate transfer” to another medical facility.<sup>140</sup> This duty is not conditioned upon the patient’s ability to pay for services rendered and is not accompanied by any guarantee of reimbursement by the federal government.<sup>141</sup>

A hospital that negligently violates the above duty is subject to a civil money penalty of not more than \$50,000.<sup>142</sup> Further, hospitals and physicians are liable for civil fines of up to \$50,000 for each negligent violation of the statute.<sup>143</sup> Perhaps most importantly, however, EMTALA provides that any individual who suffers personal harm or any receiving facility that suffers a financial loss due to a violation may bring a civil action for damages and equitable relief.<sup>144</sup>

From the standpoint of the present argument, the most serious difficulty with EMTALA is that it imposes a substantial duty upon hospitals without also providing funds to assist the hospitals in fulfilling their duty. This duty is imposed upon facilities that have already entered into Medicare contracts with the federal government. Ironically, the specification of the remedies for violations of the statute will only make

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136. 42 U.S.C. § 1395dd (2006).

137. *Id.* § 1395dd(a).

138. *Id.*

139. *Id.*

140. *Id.* § 1395dd(b)(1), (c)(2).

141. *Id.* § 1395dd.

142. *Id.* § 1395dd(d)(1)(A).

143. *Id.* § 1395dd(d)(1)(B).

144. *Id.* § 1395dd(d)(2).

the financial burden greater. The imposition of the duties under EMTALA without the provision of funding is in a significant sense hypocritical. The federal government is properly concerned that all citizens receive emergency care regardless of ability to pay, but the government is not willing to defray the immense cost associated with the endeavor. The result will likely be more closing of emergency facilities as well as a reduction in the number of hospitals willing to enter into Medicare and Medicaid contracts with the federal government. A reduction in the number of hospitals willing to take Medicare and Medicaid patients could in turn cause chronic shortfalls in care in certain areas for patients who are eligible for Medicare benefits and who have no other coverage.

Despite the fact that EMTALA causes hospitals to incur significant losses due to the requirement to provide uncompensated care, the statutory scheme is not constitutionally infirm. In *Whitney v. Heckler*, a group of physicians alleged that a temporary freeze in reimbursement rates under Medicare constituted a taking of the physicians' services due to the fact that they could not charge their patients an additional amount to make up for the shortfall.<sup>145</sup> The court held that no taking had occurred because participation in the Medicare program was voluntary.<sup>146</sup> Similarly, in *Minnesota Ass'n of Health Care Facilities v. Minnesota Department of Public Welfare*, a regulation setting rates that a nursing home could charge residents who were participants in the Medicaid program was held not to be a taking because the nursing homes were voluntary parties to the Medicaid contract.<sup>147</sup> More recently, the court in *Franklin Memorial Hospital v. Harvey* held that low reimbursement rates in Maine's Medicaid program did not constitute a taking because the hospital's participation in the program was voluntary.<sup>148</sup>

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145. *Whitney v. Heckler*, 780 F.2d 963, 972 (11th Cir. 1986).

146. *Id.*

147. *Minn. Ass'n of Health Care Facilities v. Minn. Dep't of Pub. Welfare*, 742 F.2d 442, 445-46 (8th Cir. 1984).

148. *Franklin Mem'l Hosp. v. Harvey*, No. 07-125-B-S, 2008 WL 4416412, at \*7-8, \*11 (D. Me. Sept. 24, 2008), *aff'd*, 575 F.3d 121 (1st Cir. 2009).

*B. Section 1317 of the California Health and Safety Code*

Section 1317 of the California Health and Safety Code, adopted in 1973, requires facilities that have emergency departments to provide emergency health care to persons in need thereof without regard to the ability of the recipient to pay for such services.<sup>149</sup> In this regard, the statute embodies a right to health care. After receipt of the care, however, the recipient must pay for or make an agreement to pay for the services.<sup>150</sup> In this sense, the statute implies that emergency health care is a service for which the recipient must pay. However, payment is not a necessary condition of the receipt of these services, as it is with other services.<sup>151</sup> Further, failure to pay for emergency health care previously received would not be a bar to the receipt of future emergency health care, as would be the case with any ordinary service.<sup>152</sup>

The statutory attempt to mandate universal access to emergency care as manifested in section 1317 is noble in one sense and hypocritical in another. It is laudable to provide for an enforceable right to health care, but it is shortsighted and inequitable not to provide funding as well. Indeed, section 1317 may be legally questionable precisely because of the failure to provide funding together with the imposition of the duty to provide care. The *Bay General* court's reference to the fact that emergency departments are "public service enterprise[s]" merely begs the question as to the legitimacy of section 1317.<sup>153</sup>

*C. Regulatory Takings Analysis*

The issue of a regulatory taking is raised when a public entity imposes regulations upon the use of private property for a public purpose. In regard to a regulatory taking that does not involve a physical invasion or occupation of real property, the courts apply the ad hoc balancing test as articulated in *Penn Central Transportation Co. v. City of New York*.<sup>154</sup>

There are three published cases that have involved litigation regarding the issue of whether or not the duty to provide emergency care to indigents constitutes a taking, all of which involved the application of

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149. CAL. HEALTH & SAFETY CODE § 1317(d) (West 2008).

150. *Id.*

151. *Id.* § 1317(b).

152. *See id.*

153. *Bay Gen. Cmty. Hosp. v. County of San Diego*, 203 Cal. Rptr. 184, 191 (Ct. App. 1984).

154. *Penn Cent. Transp. Co. v. City of New York*, 438 U.S. 104, 124 (1978).

the ad hoc balancing test.<sup>155</sup> The earliest is *St. Joseph's Hospital & Medical Center v. Maricopa County*, in which the plaintiff, a private hospital, sued Maricopa County for the cost of rendering emergency care required by a statute similar to section 1317 of the California Health and Safety Code.<sup>156</sup> In rejecting the takings argument, the court stated:

Traditional eminent domain cases shed some light on the question. The typical eminent domain case involves the taking or regulation of real property which diminishes or destroys the value of that property to the owner and provides a direct benefit to the state. This case is atypical because the benefit—emergency health care—inures to the patient directly. The only fiscal benefit the state enjoys is that it does not have to pay for the patient's care, unless the patient qualifies as indigent. There is some authority for the proposition that the government must pay for an unconstitutional taking of property, even if it is another who derives the benefit. In any event, the eminent domain analysis provided in property-use-regulation cases will be our guide.

....

There are no set formulas for determining at which point a regulation effects a taking of property. . . . Rather a two step process is required. First, we must determine *whether a legitimate state interest is substantially advanced* by the ordinance at issue. . . . Second, we focus on *whether the ordinance denies the owner the economically viable use of the land* . . . . Ultimately the issue is whether the public at large, rather than a few landowners should bear the burden of an exercise of police power.

....

. . . We think it is beyond discussion that this requirement advances a legitimate state interest . . . . As our supreme court stated in *Thompson*:

"If a person, seriously hurt, applies for . . . aid at an emergency ward . . . a refusal might well result in worsening the condition of the injured person, because of the time lost in a useless attempt to obtain medical aid."<sup>157</sup>

With respect to the second criterion, the court stated:

Obviously, these regulations are not tantamount to a complete condemnation of the hospital. The questions for the court then is whether the regulation is so severe as to deny the owner a reasonable economic use of the property and whether, in justice and fairness, the burden should fall on the hospital or on the public as a whole.

The *Penn Central* Court, noting that this determination is essentially an ad hoc factual inquiry, identified several significant factors. The first factor mentioned in *Penn Central* is the economic impact of the regulation on the plaintiff,

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155. *Franklin Mem'l Hosp. v. Harvey*, No. 07-125-B-S, 2008 WL 4416412, at \*7 (D. Me. Sept. 24, 2008), *aff'd*, 575 F.3d 121 (1st Cir. 2009); *St. Joseph's Hosp. & Med. Ctr. v. Maricopa County*, 786 P.2d 983 (Ariz. Ct. App. 1989).

156. *St. Joseph's*, 786 P.2d at 987.

157. *Id.* at 987–88 (citations omitted).

particularly the extent that the regulation has interfered with the plaintiff's "investment-backed expectations." We have absolutely nothing in the record to indicate the extent to which these regulations have [a]ffected St. Joseph's profitability. We know that St. Joseph's is unable to collect on the Neu account, totaling \$50,006.45. We do not know what percentage of that figure is expected profit, nor do we know the impact these regulations have had on the hospital's overall profitability. Presumably, these "bad debts" are absorbed by the hospital as a cost of doing business and are ultimately passed on to the consumer. St. Joseph's has not provided us with adequate information upon which we could determine that it has suffered economic hardship tantamount to an unconstitutional taking.<sup>158</sup>

The court found in that case that there was no unconstitutional taking.<sup>159</sup>

Several aspects of the *St. Joseph's* court's reasoning, however, are patently questionable or of less relevance twenty years after the decision. First, the court found that in principle a takings argument could be made, but that in this particular case, there was insufficient evidence of economic hardship resulting from the provision of care to the single indigent patient.<sup>160</sup> Second, since 1989, the number of uninsured in this country has increased by approximately 30%.<sup>161</sup> Third, since managed care and fixed reimbursement rates became widespread in the 1990s, the ability of hospitals to shift the burden of uncompensated care to those with insurance coverage has been seriously curtailed.

With respect to the first criterion articulated in the *Penn Central* decision, it is indisputable that the requirement that hospitals treat all those with medical emergencies promotes an important state interest for all patients. The material issue, however, is whether an unfunded mandate that all hospitals be required to promote the public good is in the public interest, given the long-term consequences thereof. The alarming data regarding the number of emergency department and hospital closures indicate that a policy that only considers the value of the requirement of rendering care to all in need is shortsighted and does not promote the state interest overall.

Further, given the issue in *St. Joseph's Hospital*, it is clear that the case has no precedential value with respect to whether laws requiring hospitals with emergency departments constitute takings in general. In *St. Joseph's*, the issue before the court was whether the hospital's duty to provide uncompensated treatment to *one individual* constituted a taking

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158. *Id.* at 988 (citations omitted).

159. *Id.* at 988–89.

160. *Id.* at 988.

161. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, PUB. NO. P60-236, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2008, at 22, 59 (2009), available at <http://www.census.gov/prod/2009pubs/p60-236.pdf>.

under the *Penn Central* analysis.<sup>162</sup> Clearly, however, the cost of treating one individual would not deprive the hospital of the economically viable use of the land or would interfere with investment-backed expectations. The larger issue is whether the duty to provide uncompensated care to all in need thereof constitutes a taking. That is, the material issue in the context of a taking is not, as the *St. Joseph's* court held, the impact of the debt of one indigent patient, but rather the entire burden of uncompensated care that a particular hospital must bear.

It is important to note that nonprofit hospitals are dissimilar from ordinary commercial properties in several respects. They are rightfully considered to be communal assets, whose continued existence is an important consideration, not just their profitability. Indeed, the reference by the *St. Joseph's* court to the necessity of access to emergency care for all those in need indicates that hospital property is not akin to ordinary private equity investments.<sup>163</sup> Unlike a typical investment relationship, hospitals, the majority of which are not for profit, are financed through bond measures rather than equity investments such as stock.<sup>164</sup> That is, purchasers of bonds issued by nonprofit hospitals do not own any equity interest in the facility, but rather are creditors thereof. Moreover, it is not clear that the interests of equity investors and creditors are identical. Equity investors are interested in return on investment, which requires a risk-benefit analysis. A creditor, on the other hand, is more likely to be concerned with long-term stability rather than the profitability of the facility, insofar as he will not benefit from any accrual in value. Thus, emphasis in *Penn Central* on the interests of investors may not be the appropriate standard for assessing whether a taking has occurred in the context of required emergency treatment for indigent patients at nonprofit entities such as hospitals.

Even if the *Penn Central* criterion were relevant, however, it is important to note that nonprofit hospitals experienced a severe degradation of their investment positions beginning in 2008.<sup>165</sup> It was

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162. *St. Joseph's*, 786 P.2d at 987.

163. *Id.* at 988.

164. See Tammy Lundstrom, Note, *Under-Reimbursement of Medicaid and Medicare Hospitalizations as an Unconstitutional Taking of Hospital Services*, 50 WAYNE L. REV. 1243, 1254–55 (2004).

165. See Claire Cowart Haltom, *Factors Indicate Not-for-Profit Hospital Downgrades Will Likely Continue Through 2009*, AHLA BUS. L. UPDATE (Am. Health Lawyers Ass'n, Wash., D.C.), Feb. 2009.

reported that in 2008 an alarming increase in the downgrading of nonprofit hospitals took place.<sup>166</sup> By a ratio of eighteen to one, nonprofit hospitals experienced a downgrading in their bond ratings, resulting in higher costs for loans.<sup>167</sup> The deterioration in the bond ratings of several major hospitals in the United States was attributed to several factors, including: (1) “softening” clinical revenue caused by patients deferring elective procedures due to cost concerns; (2) intensifying competition for a dwindling supply of insured patients; (3) increasing bad debt and charity care due to rising rates of unemployment and costs of medical services for indigent patients, as mandated by provisions; and (4) falling reimbursement rates by third-party payers, including higher patient deductibles.<sup>168</sup>

Thus, even on the assumption that the *Penn Central* analysis is correct, data exist demonstrating that investors in nonprofit hospitals have recently experienced degradation of the value of their investments, and the degradation will likely accelerate through 2009 due to the collapse of the economy. As one commentator has recently stated:

Not-for-profit hospitals heavily rely on bond debt to finance their projects. In the past, the health care industry has been viewed as well-insulated from the volatility of economic cycles, in part because of bond market security. This recession, however, has wreaked more havoc on the bond markets than any other recession in recent history.<sup>169</sup>

In addition, the *Penn Central* Court held that only a deprivation of all economically viable uses of the property was actionable. Since the decision in *St. Joseph’s*, however, courts have recognized that even partial deprivations of economically viable uses of property may be actionable. In *Palazzolo v. Rhode Island*, the Supreme Court restated the *Penn Central* criteria but allowed that:

Where a regulation places limitations on land that fall short of eliminating all economically beneficial use, a taking nonetheless may have occurred, depending on a complex of factors including the regulation’s economic effect on the landowner, the extent to which the regulation interferes with reasonable investment-backed expectations, and the character of the government action. These inquiries are informed by the purpose of the Takings Clause, which is to prevent the government from “forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole.”<sup>170</sup>

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166. *Id.*

167. *Id.*

168. *Id.*

169. *Id.*

170. *Palazzolo v. Rhode Island*, 533 U.S. 606, 618–19 (2001) (citations omitted).

Reflecting the holding in *Palazzolo*, the court in *Cwynar v. City & County of San Francisco*<sup>171</sup> stated the rule as follows:

[A] regulation may effect a taking even though it “leaves the property owner some economically beneficial use of his property.” Such an owner simply loses the benefit of the per se analysis. Indeed, the United States Supreme Court acknowledged this fact in its recent decision in *Palazzolo v. Rhode Island*.<sup>172</sup>

The amendment to the *Penn Central* requirement that to be actionable a regulation must deprive the owner of all economically viable use of his property is significant in regard to the requirement that emergency departments render uncompensated emergency and related care. First, the amendment permits hospitals to prove a taking has occurred if the losses suffered from providing uncompensated care have caused the hospital itself to be insolvent. Second, it allows hospitals to seek redress for the closing of their emergency departments even if the remainder of the hospital remains viable.

The second case in which the takings issue was litigated is *Methodist Hospital v. Indiana Family & Social Services Administration*, in which the hospital and physicians filed a motion to enjoin the state agencies from implementing new Medicaid regulations that included extremely low reimbursement rates.<sup>173</sup> One of the theories promulgated by the plaintiffs was that the low Medicaid reimbursement rates constituted a regulatory taking.<sup>174</sup> The plaintiffs alleged that insofar as EMTALA required the hospital and physicians to treat all indigent patients, the regulations constituted a taking inasmuch as the rates were too low to cover costs associated with the treatment.<sup>175</sup>

The court recognized that although property may be regulated to a certain extent, “if regulation goes too far it will be recognized as a taking.”<sup>176</sup> The court stated that this principle applied with equal force to regulatory takings.<sup>177</sup> However, when a service provider voluntarily

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171. *Cwynar v. City & County of San Francisco*, 109 Cal. Rptr. 2d 233, 254–55 (Ct. App. 2001).

172. *Id.* at 244 (citations omitted) (quoting *Kavanau v. Santa Monica Rent Control Bd.*, 941 P.2d 851, 859 (Cal. 1997)).

173. *Methodist Hosp. v. Ind. Family & Soc. Servs. Admin.*, 860 F. Supp. 1309, 1314 (N.D. Ind. 1994).

174. *Id.* at 1317.

175. *Id.*

176. *Id.* at 1334 (quoting *Pa. Coal Co. v. Mahon*, 260 U.S. 393, 415 (1922)).

177. *Id.* (citing *Garelick v. Sullivan*, 987 F.2d 913, 916 (2d Cir. 1993)).

participates in a regulated program or activity, there is no legal compulsion to provide services and thus there can be no taking.<sup>178</sup> The court noted that the plaintiff physicians claimed that they were “mandated by federal law to examine and medically stabilize any individual” who came to the hospital emergency department and requested examination or treatment.<sup>179</sup> The court held however that the plaintiff physicians “do not argue, nor can they,” that individual physicians were compelled to provide mandatory service because the physicians were not obligated by law to practice medicine at Methodist Hospital, nor were they obligated to serve Medicaid patients.<sup>180</sup>

The court noted however that whether or not the reimbursement rates constituted taking the hospital’s property without due process of law was a “more interesting question.”<sup>181</sup> The court noted that “[t]here is no set formula for determining when regulation of private property constitutes a compensable taking.”<sup>182</sup> Whether or not a particular restriction will be rendered invalid by the government’s failure to pay for any losses caused by the regulation depends largely “upon the particular circumstances [in that] case.”<sup>183</sup> Nonetheless, the court noted that the U.S. Supreme Court has identified several factors that have significance relative to this inquiry.<sup>184</sup> The first of which is the economic impact of the regulation.<sup>185</sup> In particular, “the extent to which the regulation has interfered with distinct investment-backed expectations.”<sup>186</sup>

The *Methodist Hospital* court denied the State’s motion for summary judgment on the grounds that several questions of fact remained in dispute with respect to its takings argument. Specifically, the court pointed to whether or not compensation paid to the hospital for rendering emergency care constitutes a taking of the hospital’s property pursuant to the criteria set forth in *Penn Central*.<sup>187</sup>

The distinction the *Methodist Hospital* court made between the manner in which physicians and hospitals are reimbursed is reasonable. There are differences in the formulas used to determine reimbursement

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178. *Id.* at 1335 (citing *Garelick*, 987 F.2d at 916).

179. *Id.* (citing 42 U.S.C.A. § 1395dd (West 1992)).

180. *Id.*

181. *Id.*

182. *Id.* (internal quotation marks omitted).

183. *Id.* (alteration in original) (quoting *Penn Cent. Transp. Co. v. City of New York*, 438 U.S. 104, 124 (1978)).

184. *Id.*

185. *Id.*

186. *Id.* (quoting *Penn Cent.*, 438 U.S. at 124).

187. *Id.* at 1335–36.

rates for the two types of providers. The reimbursement rate for physicians reflects the fact that physicians do not have fixed assets such as expensive facilities, and that they are able to relocate to other geographical areas if it is in their best interest to do so.<sup>188</sup> Hospitals, on the other hand, may only provide services pursuant to Certificates of Need, which are issued in a manner that ensures that the allocation of hospital services is controlled by the needs of the community rather than the market. As a result, hospitals are at a distinct disadvantage in terms of responding to unfavorable market conditions, such as the number of uninsured. They may not relocate in any realistic sense, and they are subject to the reimbursement rates set by Congress.<sup>189</sup>

Hospitals are thus extremely vulnerable to adverse results from reimbursement rates that do not allow the hospital to remain viable. Further, most of the 5815 hospitals in this country<sup>190</sup> contract with the federal Medicaid or Medicare programs, or both, because the sheer volume of patients who qualify for coverage under one or both of the programs renders participation in the programs necessary for hospitals.<sup>191</sup> As such, participation in the Medicare and Medicaid programs is “voluntary” in only a technical sense.<sup>192</sup>

Nonetheless, the fact that hospitals participate in Medicare and Medicaid programs by contract renders the hospital’s argument in *Methodist Hospital* vulnerable to the response that it assumed the risk of unfavorable reimbursement rates by virtue of entering into the contract with the federal government and could refuse to participate in the

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188. Compare 42 C.F.R. §§ 414.20, .22, .26, .28 (2008) (setting reimbursement rates for physicians based on the cost of the procedure with no reimbursement for capital-related costs), with 42 C.F.R. §§ 412.116, 413.130 (2008) (allowing hospitals to be reimbursed for capital-related costs). See also, e.g., *Methodist Hosp. v. Ind. Family & Soc. Servs. Admin.*, 860 F. Supp. 1309, 1316–17, 1335 (N.D. Ind. 1994) (discussing Medicaid reimbursement rates for physicians in Indiana as being based on a per procedure payment rate and holding that these rates did not constitute a taking because physicians are free to relocate).

189. See Medicaid Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates, 68 Fed. Reg. 45,346 (Aug. 1, 2003) (to be codified at 42 C.F.R. pts. 412, 413).

190. AM. HOSP. ASS’N, FAST FACTS ON US HOSPITALS (2009), [http://www.aha.org/aha/resource-center/Statistics-and-Studies/Fast\\_Facts\\_Nov\\_11\\_2009.pdf](http://www.aha.org/aha/resource-center/Statistics-and-Studies/Fast_Facts_Nov_11_2009.pdf).

191. AM. HOSP. ASS’N, UNDERPAYMENT BY MEDICARE AND MEDICAID FACT SHEET (2008), <http://www.ihatoday.org/issues/payment/charity/underpymt.pdf>.

192. See William S. Brewbaker III, *Health Care Pricing Controls and the Takings Clause*, 21 HASTINGS CONST. L.Q. 669, 672–76 (1994); Thomas Merrill, *Constitutional Limits on Physician Price Controls*, 21 HASTINGS CONST. L.Q. 635, 642 (1994).

program in the future. Indeed, the argument that participation in the Medicare and Medicaid programs is voluntary has been successfully used as a defense in every case in which it has been asserted.<sup>193</sup>

The third and most recent case in which the requirement to provide emergency care to indigents on the part of emergency departments was litigated is *Franklin Memorial Hospital v. Harvey*.<sup>194</sup> In *Franklin*, the hospital sought a declaratory judgment that Maine’s “free care law”—which requires hospitals to provide free health care to certain low-income individuals—constitutes a regulatory taking.<sup>195</sup> In denying the plaintiff’s motion, the court held that pursuant to the *Penn Central* criteria, no regulatory taking had occurred.<sup>196</sup> The court based its conclusion on examination of the “investment-backed expectations” criterion, affirming the lower court.<sup>197</sup> In holding that there were no reasonable investment-backed expectations that were frustrated by the free care law, the trial court stated:

[T]he existence of the Free Care Laws necessarily informs the expectations that Franklin Memorial must have when it prospectively “invests” in medical supplies or in its staff. The undisputed facts demonstrate that Franklin Memorial understands that a portion of the medical supplies it purchases and a portion of time the staff spends on patients simply will not produce a return on investment. This understanding grows out of Franklin Memorial’s knowledge of the Free Care Laws and out of its own non-profit health care mission. In other words, viewed prospectively, Franklin Memorial restocks supplies and retains staff knowing that a portion of the supplies and labor will be subject to the regulatory obligation of the Free Care Laws. It is not a simple matter of having owned a stockpile of supplies and labor capacity, all previously paid for, that suddenly, out of the blue, were confiscated by operation of the Free Care Laws. Franklin Memorial has been operating for years under this regulatory regime.<sup>198</sup>

As a result, the *Franklin Memorial* court held that because participation in the state’s medical program is voluntary, there is no taking.<sup>199</sup>

The holdings in *St. Joseph’s, Methodist Hospital*, and *Franklin Hospital* are all questionable because in each case the court assumed that the regulations involved did not involve a physical invasion that was countenanced by the state. In *Nollan v. California Coastal Commission*, the U.S. Supreme Court held that a California statute requiring owners

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193. See, e.g., *Garelick v. Sullivan*, 987 F.2d 913, 916–17 (2d Cir. 1993); *Whitney v. Heckler*, 780 F.2d 963, 972 (11th Cir. 1986).

194. *Franklin Mem’l Hosp. v. Harvey*, 575 F.3d 121 (1st Cir. 2009).

195. *Id.* at 123.

196. *Id.* at 126.

197. *Id.*

198. *Franklin Mem’l Hosp. v. Harvey*, No. 07-125-B-S, 2008 WL 4416412, at \*4 (D. Me. Sept. 24, 2008), *aff’d*, 575 F.3d 121 (1st Cir. 2009).

199. *Id.*

of beachfront property to allow access to the beach by the public constituted a “physical occupation” for purposes of regulatory takings analysis:

We have repeatedly held that, as to property reserved by its owner for private use, “the right to exclude [others is] ‘one of the most essential sticks in the bundle of rights that are commonly characterized as property.’” In *Loretto* we observed that where governmental action results in “[a] permanent physical occupation” of the property, by the government itself or by others, “our cases uniformly have found a taking to the extent of the occupation, without regard to whether the action achieves an important public benefit or has only minimal economic impact on the owner.” We think a “permanent physical occupation” has occurred, for purposes of that rule, where individuals are given a permanent and continuous right to pass to and fro, so that the real property may continuously be traversed, even though no particular individual is permitted to station himself permanently upon the premises.<sup>200</sup>

The *Nollan* Court restated the rule regarding mandated physical occupations as articulated in *Loretto v. Teleprompter Manhattan CATV Corp.*, which held that physical occupations were not subject to the balancing test contained in *Penn Central*:

Although this Court’s most recent cases have not addressed the precise issue before us, they have emphasized that physical *invasion* cases are special and have not repudiated the rule that any permanent physical *occupation* is a taking. The cases state or imply that a physical invasion is subject to a balancing process, but they do not suggest that a permanent physical occupation would ever be exempt from the Takings Clause.

*Penn Central Transportation Co. v. New York City*, as noted above, contains one of the most complete discussions of the Takings Clause. The Court explained that resolving whether public action works a taking is ordinarily an ad hoc inquiry in which several factors are particularly significant—the economic impact of the regulation, the extent to which it interferes with investment-backed expectations, and the character of the governmental action. The opinion does not repudiate the rule that a permanent physical occupation is a government action of such a unique character that it is a taking without regard to other factors that a court might ordinarily examine.<sup>201</sup>

The *Nollan* Court’s holding that mandated public access on a continued basis constitutes a physical occupation even if no one person has a right to remain on the premises is crucial in the context of emergency medical treatment. Section 1317 of the California Health

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200. *Nollan v. Cal. Coastal Comm’n*, 483 U.S. 825, 831–32 (1987) (alterations in original) (citations omitted) (quoting *Loretto v. Teleprompter Manhattan CATV Corp.*, 458 U.S. 419, 433 (1982)).

201. *Loretto*, 458 U.S. at 432–33 (citation omitted) (citing *Penn Cent. Transp. Co. v. City of New York*, 438 U.S. 104, 124 (1977)).

and Safety Code mandates public access, but no individual has a right to remain on the premises or to receive medical treatment on a continuing basis.<sup>202</sup> Nonetheless, the ongoing access by the public in the event of medical need constitutes a permanent occupation. Consequently, as the *Loretto* Court noted:

[W]hen the “character of the governmental action,” is a permanent physical occupation of property, our cases uniformly have found a taking to the extent of the occupation, without regard to whether the action achieves an important public benefit or has only minimal economic impact on the owner.

...  
... [S]uch an occupation is qualitatively more severe than a regulation of the use of property, even a regulation that imposes affirmative duties on the owner, since the owner may have no control over the timing, extent, or nature of the invasion.<sup>203</sup>

The *Loretto* Court’s observation that a mandated occupation is “qualitatively more severe” than a regulation of the use of the property is particularly relevant in the context of the requirement to provide emergency medical treatment. Hospitals have no control over the social conditions that have resulted in an increasing number of uninsured patients, they have no control over the expense of the treatment rendered, and they have no control over the extent of the injuries suffered by patients who are present at emergency departments. Hospitals and medical personnel must render treatment consistent with the applicable standard of care regardless of whether the patient has the means to pay for the treatment. Any deviation from the standard of care may result in civil liability, administrative penalties, or both. Finally, hospitals have little or no control over the escalating costs of providing such care. In short, hospitals have virtually no control over the factors that result in the burden of uncompensated and undercompensated care that they must provide.

To be actionable as a taking, however, the physical invasion by third persons must be without the owner’s consent. The U.S. Supreme Court in *Yee v. City of Escondido* held that owners of land had no takings claim because they had initially consented to the occupation of their property by the third parties prior to a rent control ordinance taking effect.<sup>204</sup> The *Yee* Court restated the rule articulated in *FCC v. Florida Power Corp.*<sup>205</sup> that once consent to occupation is given, any subsequent

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202. CAL. HEALTH & SAFETY CODE § 1317 (West 2008).

203. *Loretto*, 458 U.S. at 434–36 (citation omitted) (quoting *Penn Cent.*, 438 U.S. at 124).

204. *Yee v. City of Escondido*, 503 U.S. 519, 538–39 (1992).

205. *FCC v. Fla. Power Corp.*, 480 U.S. 245, 252–53 (1987).

disagreement over the terms of payment for the access is not a takings issue but rather one of ordinary commercial litigation.<sup>206</sup> Similarly, the court in *Adamson Cos. v. Malibu* rejected a landowner's takings argument that the requirement to continue to furnish rental space to a mobile home tenant at reduced rent control rates constituted a taking "[b]ecause the park owners invited the tenants onto their land."<sup>207</sup> The issue of initial consent is crucial. As the *Yee* Court stated: "A different case would be presented were the statute, on its face or as applied, to compel a landowner over objection to rent his property or to refrain in perpetuity from terminating a tenancy."<sup>208</sup> Therefore, if there is no initial consent to occupation by third persons, a takings claim is tenable.

It is crucial to note that prior to the passage of section 1317 of the California Health and Safety Code, there was no common law duty for private hospitals to accept patients who had emergencies and with whom there was no privity.<sup>209</sup> Section 1317 requires all hospitals with emergency departments to treat any person who is in need of emergency care, the issue of privity notwithstanding.<sup>210</sup> That is, section 1317 created a new statutory obligation on the part of all hospitals, including private hospitals.<sup>211</sup> This section was adopted for the express purpose of providing a significant benefit for the public at large.<sup>212</sup> Therefore, there is no prior consent required for medical care access by any third person who has an emergency condition; access is mandated, thus satisfying the requirements for a taking set forth in *Loretto* and *Yee*.

Also, the owner must suffer damages as a result of the occupation by third parties. In *Pruneyard Shopping Center v. Robins*, the U.S. Supreme Court held that the owners of a large shopping center had not stated a claim for a regulatory taking.<sup>213</sup> The owners had argued that mandated

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206. *Yee*, 503 U.S. at 527.

207. *Adamson Cos. v. City of Malibu*, 854 F. Supp. 1476, 1499–500 (C.D. Cal. 1994).

208. *Yee*, 503 U.S. at 528 (emphasis added).

209. See *Williams v. United States*, 242 F.3d 169, 177 (4th Cir. 2001); *Childs v. Weis*, 440 S.W.2d 104, 106–07 (Tex. Civ. App. 1969); Karen H. Rothenberg, *Who Cares?: The Evolution of the Legal Duty To Provide Emergency Care*, 26 HOUS. L. REV. 21, 25 (1989); Denise H. Field & Colleen M. Margiotta, Comment, *To Treat or Not To Treat: A Hospital's Duty To Provide Emergency Care*, 15 U.C. DAVIS L. REV. 1047, 1048 (1982).

210. CAL. HEALTH & SAFETY CODE § 1317 (West 2008).

211. *Id.*

212. 1987 Cal. Stat. ch. 1240, § 1(a).

213. *Pruneyard Shopping Ctr. v. Robins*, 447 U.S. 74, 88 (1980).

access to the commercial premises by a group of high school students who wished to distribute political materials constituted a physical invasion of their premises.<sup>214</sup> The students wished to set up a table to distribute informational pamphlets and other materials.<sup>215</sup> The Court held that no claim was stated because the owners could not prove that the presence of the students was permanent and affected the ability of the shopping center to conduct its commercial activities. The Court distinguished the case from a factual situation in which adverse economic impact from the occupation constituted a taking:

This case is quite different from *Kaiser Aetna v. United States*. *Kaiser Aetna* was a case in which owners of a private pond had invested substantial amounts of money in dredging the pond, developing it into an exclusive marina, and building a surrounding marina community. The marina was open only to fee-paying members, and the fees were paid in part to “maintain the privacy and security of the pond.” The Federal Government sought to compel free public use of the private marina on the ground that the marina became subject to the federal navigational servitude because the owners had dredged a channel connecting it to “navigable water.”<sup>216</sup>

In the case of mandated access to emergency services, however, pursuant to the holding in *Nollan*, the serial occupation of the premises by third persons on a permanent basis seems to constitute a physical “invasion” in the requisite sense. Further, in *Nollan*, the Court held that a permanent occupation was actionable as a taking even if the economic impact was minimal:

In *Loretto* we observed that where governmental action results in “[a] permanent physical occupation” of the property, by the government itself or by others, “our cases uniformly have found a taking to the extent of the occupation, without regard to whether the action achieves an important public benefit or has only minimal economic impact on the owner.”<sup>217</sup>

It is clear that under section 1317 unlimited mandated access to the premises and services of private emergency departments constitutes a “permanent physical invasion” as defined in *Nollan* and *Yee*. Further, as in *Kaiser* and unlike the facts of *Pruneyard*, the right to access by third parties conferred by section 1317 has had and will continue to have disastrous economic consequences for private hospitals. The adverse consequences begin even before indigent patients are present at

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214. *Id.* at 77–78.

215. *Id.* at 77.

216. *Id.* at 85 (citations omitted) (quoting *Kaiser Aetna v. United States*, 444 U.S. 164, 168 (1979)).

217. *Nollan v. Cal. Coastal Comm’n*, 483 U.S. 825, 831–32 (1987) (alteration in original) (citation omitted).

emergency departments. Due in large part to the high number of uninsured patients, emergency departments are overloaded.<sup>218</sup> Patients with emergency conditions, including many with medical insurance who could have paid for services rendered, must be taken by ambulance to emergency facilities that are not in close proximity, causing increased expense and danger to the patients.<sup>219</sup> Further, patients at many emergency departments experience delays in treatment of several hours due to the number of uninsured patients, who have delayed seeking needed care and have arrived with emergency conditions.

Finally, the California Supreme Court has recently held that providers of emergency medical services may not bill patients who have medical insurance for the balance due after payment by the patient's insurance carrier. In *Prospect Medical Group, Inc. v. Northridge Medical Group*, the court held that section 1317 of the California Health and Safety Code and associated statutes express a legislative intent to "ensure the best possible health care for the public at the lowest cost by transferring the financial risk of health care from patients to providers."<sup>220</sup> Thus, emergency departments must confront the greatly increasing burdens of both uncompensated and undercompensated care.

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218. For example, on average, Los Angeles County hospitals spend one out of every four hours on "diversion," in which case patients with emergency conditions must be taken to other hospitals. NATASHA MIHAL & RENEE MOILANEN, UCLA SCH. OF PUB. AFFAIRS, WHEN EMERGENCY ROOMS CLOSE: AMBULANCE DIVERSION IN THE WEST SAN FERNANDO VALLEY 1 (2005).

219. See Linda R. Brewster et al., *Emergency Room Diversions: A Symptom of Hospitals Under Stress*, ISSUE BRIEF: FINDINGS FROM HSC (Ctr. for Studying Health Sys. Change, Wash., D.C.), May 2001, at 1, <http://www.hschange.com/CONTENT/312>; Kerry McKean Kelly, *Healthcare's Woes Converge in Overcrowded Emergency Rooms*, HEALTHCARE N.J. (N.J. Hosp. Ass'n, Princeton, N.J.), Feb. 2001, at 1 available at <http://www.njha.com/publications/HCNJ/HCNJV10No2.pdf>.

220. *Prospect Med. Group, Inc. v. Northridge Med. Group*, 198 P.3d 86, 92 (Cal. 2009). The *Prospect Medical Group* decision has been seen as yet another factor in reducing the amount of reimbursement that providers of emergency services receive. It implies that providers will be required to file suit against third-party payers for inadequate reimbursement. In many, if not most cases, it will not be feasible to do so because of the cost of litigation. See Jeffrey Reeves et al., *California Supreme Court Deals a Blow to Healthcare Providers in Prospect Medical Group Decision*, ORANGE COUNTY BUS. J., Feb. 2, 2009, at 8.

#### IV. CONCLUSION

Despite the fact that the rulings in cases such as *San Diego County*, *Hunt*, and *Alford* have theoretically ensured that indigent persons receive public funding for emergency and medically necessary care, private emergency departments and hospitals in California have not received the benefit of such coverage. They continue to fail in record numbers. A basis for a takings argument on the part of private emergency departments and hospitals for recovery of costs incurred in providing uncompensated and undercompensated care to indigents now exists. As the U.S. Supreme Court has held, the state may not “forc[e] some people . . . to bear . . . burdens which, in all fairness and justice, should be borne by the public as a whole.”<sup>221</sup> As the Court held in *Nollan*, if the public requires private hospitals to treat all persons in need of emergency care, the public “must pay for it.”<sup>222</sup>

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221. *Armstrong v. United States*, 364 U.S. 40, 49 (1960).

222. *Nollan v. Cal. Coastal Comm’n*, 483 U.S. 825, 842 (1987).