

California

I. Government Funded Indigent Care

Over the past two decades, California's financing of indigent health care has been the subject of extraordinary controversy. California's counties have a longstanding obligation to provide health care to those indigent residents who lack other health care coverage. County general assistance obligations date from 1855.¹ The counties' statutory obligation to provide health care to indigents has not undergone any meaningful change since 1931.²

In 1971, the California legislature assumed responsibility for the health care of indigent adults under Medi-Cal, the state's version of the federal Medicaid program. Under former Welfare and Institutions Code §§ 14005.1, California used state funds to provide Medi-Cal benefits to Medically Indigent Adults (MIAs) ineligible for federal assistance under the Medicaid program.

In 1983, the state terminated Medi-Cal coverage for the MIAs, returning the obligation for their care to the counties.³ Under Welfare and Institutions Code § 16700 *et seq.*, the state apportioned some funds to the counties to assist them in meeting their health care obligations to the poor, but these funds were not sufficient to pay for the full costs of county indigent care obligations.

Article XIII B of the California Constitution requires the state legislature to reimburse local governments whenever the state mandates a new program or a higher level of services. In the years following the state's turnover of responsibility for the MIAs to the counties, various counties filed administrative claims and lawsuits against the state under Article XIII B, requesting reimbursement for the full cost of providing care to the MIA population.⁴

In 1991, the state legislature resolved these disputes through enactment of realignment legislation.⁵ Under realignment, the state shifted billions in state revenues to the counties, including vehicle license fees and state sales taxes. In return, the counties assumed full financial responsibility for a range of health care programs, including mental health and substance abuse services and indigent health

¹*Mooney v. Pickett*, 4 Cal.3d 669, 677-78, 94 Cal.Rptr. 279 (1971).

²*Id.*

³*Cooke v. Superior Court*, 213 Cal.App.3d 401, 411, 261 Cal.Rptr. 706 (1989).

⁴*See Kinlaw v. State*, 54 Cal.3d 326, 329 n.2, 285 Cal.Rptr. 66 (1991) (describing efforts by Los Angeles and San Bernardino Counties to obtain mandate relief before the State Commission on Mandates and in state court).

⁵A.B. 1288, codified at Welfare and Institutions Code § 17600 *et seq.*

care.⁶ The realignment bill contains a powerful incentive for counties to abstain from further challenges to state financing of local health care obligations. In the event any part of the realignment package is finally determined to be a state mandate, all of the provisions of the realignment bill will become inoperative.⁷

To receive state funds under realignment, cities and counties must devote specified amounts of their own general funds to the provision of health care.⁸

A. County Poor Laws

Under Welfare and Institutions Code § 17000, California's counties have a duty to "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." Under this statute, counties must set general assistance standards for aid and care that provide benefits necessary for basic survival.⁹ Counties must provide an appropriate allowance for each of the necessities of life, including food, clothing, shelter and medical care.¹⁰

The existence of the Medi-Cal program and other health care programs does not supplant the counties obligations to their indigent residents under Section 17000. Section 17000 creates a county obligation to provide medical care for the poor that must be satisfied with county funds.¹¹

While counties have a duty to provide for the health care needs of the poor, this duty does not require counties to reimburse private providers for expenses incurred in treating indigent residents, because the duty only arises when the poor are not supported or relieved by others.¹² Counties cannot escape this obligation by refusing to accept the transfer of indigent patients from private facilities.¹³

⁶Kathryn Saenz Duke, *Indigent Medical Care in California: Still Invisible?*, 25 PAC.L.J. 21, 24-28 (1993).

⁷Stats. 1991, c. 89 as amended by Stats. 1993, c. 728, § 6, codified as Historical and Statutory Note to Former Health and Safety Code § 209.

⁸Welfare and Institutions Code § 17608.10.

⁹*Boehm v. Superior Court*, 176 Cal.App.3d 494, 501, 223 Cal.Rptr. 716, 720 (1986).

¹⁰*Id.* at 502.

¹¹*Madera Community Hospital v. Madera County*, 155 Cal.App.3d 136, 151, 201 Cal.Rptr. 139 (1984).

¹²*Union of American Physicians & Dentists v. County of Santa Clara*, 149 Cal.App.3d 45, 50 n.10, 196 Cal.Rptr. 603 (1983).

¹³*Bay General Community Hospital v. San Diego County*, 156 Cal.App.3d 944, 956-58, 203 Cal.Rptr. 184 (1984).

In discharging their duties to the poor, counties have broad discretion in determining eligibility for, the type and amount of, and the conditions to be attached to, indigent aid.¹⁴ In *Bay General Community Hospital v. San Diego County*, the court permitted San Diego County to limit reimbursement to individuals who would meet Medi-Cal income and resource standards, notwithstanding plaintiff's argument that this definition excluded the working poor, who lacked the resources to pay for their care, based upon the county's "broad discretion" to set eligibility standards under Welfare and Institutions Code § 17001.¹⁵

Section 17000 does not mandate any particular form of relief, leaving counties free to choose the means by which they will discharge their duties to the poor.¹⁶ Counties may discharge their health care obligations to indigent residents through the direct delivery of health care services at county facilities or through contracts with private providers.¹⁷

California's courts have been extremely reluctant to intervene in the internal workings of county indigent health care systems. In *Tailfeather v. Board of Supervisors*,¹⁸ plaintiffs complained of long delays in receiving essential health care services from county facilities under Welfare and Institutions Code § 17000. Plaintiffs requested that the court order Los Angeles County to adopt formal written standards governing waiting times for medical procedures and adhere to them. The court acknowledged that the county had an obligation to provide "medical services to the poor at a level which does not lead to unnecessary suffering or endanger life or health."¹⁹ The court nevertheless refused to order the county to adopt formal standards on wait times, based upon the county's assertion that it had informal procedures in place to deal with this problem and upon the county's broad "discretion in determining how best to meet the medical needs of its indigent residents in light of the limited resources available."²⁰

While the counties have broad discretion in providing medical care to the poor, this discretion is not limitless. In administering aid, the county is acting as the agent of the state and its regulations must be consistent with state law and reasonably necessary to effectuate its purpose. State statutes require aid to all indigents lawfully resident in the county, with specified exceptions.

Accordingly, regulations that exclude whole classes of individuals without individualized determinations of need have been held to conflict with Section 17000, absent specific statutory

¹⁴*Clay v. Tryk*, 177 Cal.App.3d 121, 124, 222 Cal.Rptr. 729 (1988).

¹⁵156 Cal.App.3d at 958-60

¹⁶*Scates v. Rydingsword*, 229 Cal.App.3d 1085, 1098, 280 Cal.Rptr. 544 (1990) (county may use in kind support or cash aid to discharge its 17000 obligation).

¹⁷Health and Safety Code § 1442.5(a).

¹⁸__ Cal.App.4th __ (1996).

¹⁹Slip Opn. at 20.

²⁰*Id.* at 28

authorizations for such limits. In *Bernhardt v. Alameda County Board of Supervisors*,²¹ the court struck down a county rule that restricted cash assistance for indigents between the ages of 18 and 21, based upon the theoretical availability of assistance from their parents. California's courts have also rejected county efforts to deny aid to individuals who can work based upon their alleged lack of need for aid.²²

In recent years, the legislature has attempted to alleviate county burdens under state general assistance statutes by allowing counties limit monthly grants to the poor.²³ Courts have concluded that these limits apply only to financial aid for the poor, not to medical care. In *Gardner v. County of Los Angeles*,²⁴ the court rejected county efforts to reduce monthly grants to the indigent based upon the value of medical care provided to the poor. The court noted that the county's obligation to provide medical care is separate and distinct from its obligation to provide financial aid to the poor. While the legislature intended to allow counties to limit financial aid to the poor, there was no evidence that the legislature intended to allow similar limits on county funded medical care.²⁵

County obligations to the indigent extend only to lawful residents. Under Welfare and Institutions Code § 17003, counties may choose to provide aid to non-residents, including undocumented aliens, but they have no obligation to do so.²⁶ While it is clear that permanent residents are eligible for benefits, other aliens, whose status is more indeterminate, may be excluded from benefits. In *Khasminskaya v. Lum*,²⁷ the court concluded that an alien granted asylum was ineligible for benefits during the years before the INS finally acted on her application, because the INS had merely tolerated, rather than authorized her residence in the United States for this period. In determining the eligibility of lawful immigrants for county aid during the first three years following their entry to the United States, counties may consider the income and assets of their sponsors.²⁸ However, immigrants are exempt from this provision if they can show that their sponsor has abandoned their duty to support them.²⁹

²¹58 Cal.App.3d 806, 130 Cal.Rptr. 189 (1976)

²²*Washington v. Board of Supervisors of San Diego County*, 18 Cal.App.4th 981, 22 Cal.Rptr.2d 852 (1993); *Mooney v. Pickett*, 4 Cal.3d 669, 679, 94 Cal.Rptr. 279 (1971). In 1996, the state legislature authorized counties to limit cash assistance to employable recipients to three months in any twelve month period. Welfare and Institutions Code § 17____. However, the counties' obligation to provide medical care is not similarly limited.

²³Welfare and Institutions Code § 17000.5.

²⁴34 Cal.App.4th 200, 40 Cal.Rptr.2d, 261 (1995),

²⁵*Id.* at 223. *See also Tailfeather v. Board of Supervisors*, ___ Cal.App. 4th at ___, (rejecting county arguments that medical care obligations had been limited by various statutes).

²⁶*Bay General Community Hospital v. San Diego County*, 156 Cal.App.3d at 960-61.

²⁷96 Daily Journal D.A.R. 8669 (July 18, 1996),

²⁸Welfare and Institutions Code § 17001.7.

²⁹Welfare and Institutions Code § 17001.7(c).

The legislature has authorized the counties to limit aid in a number of other ways. Counties may impose 15 day residence requirements as a condition of receiving aid.³⁰ However, this requirement does not permit counties to deny assistance to homeless residents based upon their lack of an address.³¹ At one time, California's courts held that counties could require recipients to furnish a dwelling address as a condition of receiving benefits as a fraud control measure.³² More recent case law has rejected this decision, noting that a county's denial of benefits to homeless individuals lawfully resident within its jurisdiction "appears to be inconsistent with and in open conflict with section 17000's mandate."³³

In calculating the financial eligibility of aliens for county aid, state law permits counties to consider the income and assets of their sponsors for a period of three years from their admission to the United States.³⁴ In addition, counties may sanction able bodied, mentally competent general assistance recipients for failure to comply with county job training or work requirements by disqualifying them from benefits for periods of up to 180 days.³⁵

Under Welfare and Institutions Code § 17403, counties may seek funds from the after-acquired property of former recipients for the costs of their care. However, this obligation is limited to the extent of a former recipient's ability to pay. Counties may only seek repayment from the wages of former recipients from surpluses retained after they have met the support needs of themselves and their families.³⁶

The scope of the county's health care obligation has been defined by case law. In *Cooke v. Superior Court*,³⁷ the California Court of Appeal concluded that medically indigent adults must be provided with dental services necessary to remedy pain and infection. In enacting California's public assistance statutes, the legislature stated its intent "that aid shall be provided and services provided promptly and humanely...as to encourage self-respect, self-reliance, and the desire to be a good citizen, useful to society."³⁸ The *Cooke* court relied upon this statement as a substantive legal standard for judging the adequacy of county services, noting that "[i]n section 10000 the legislature has decreed that

³⁰Welfare and Institutions Code § 17001.5(a)(1).

³¹Welfare and Institutions Code § 17001.5(a)(2).

³²*Adkins v. Leach*, 17 Cal.App.3d 771, 95 Cal.Rptr. 61 (1971).

³³*Nelson v. San Diego County Bd. of Supervisors*, 190 Cal.App.3d 32, 31, 235 Cal.Rptr. 305, 308 (1987).

³⁴Welfare and Institutions Code § 17001.7.

³⁵ Welfare and Institutions Code § 17001.5(a)(2).

³⁶*County of San Diego v. Muniz*, 22 Cal.3d 29, 148 Cal.Rptr. 584 (1978).

³⁷213 Cal.App.3d 413, 261 Cal.Rptr. 706 (1989).

³⁸Welfare and Institutions Code § 10000.

counties must provide care 'humanely' and it is this court's duty to give that declaration meaning."³⁹

The court held that counties do not have an obligation to provide the same level of care to medically indigent adults as that available to private patients or to Medicaid recipients.⁴⁰ However, county obligations to the poor extend beyond the provision of emergency services, to cover services needed to remedy pain and infection.⁴¹ In *Tailfeather v. Board of Supervisors*, the court reiterated this obligation, noting that counties have a duty to provide "medical services to the poor at a level which does not lead to unnecessary suffering or endanger life or health."⁴²

B. County Hospitals

Health and Safety Code § 1440 *et seq.* authorizes the counties to establish and maintain county hospitals. Before a county may close or change ownership of a medical facility or reduce services to the indigent, the county must publish a notice listing the proposed changes and reductions in services at least fourteen days in advance of a public hearing on the change.⁴³ Counties that choose to eliminate or reduce county services must continue to fulfill their statutory obligations to provide medical care to indigent patients. Counties that close or sell facilities must also maintain a 24 hour a day information service to inform indigent patients on how they can obtain services.

The notice requirements under Health and Safety Code § 1442.5 have loosened over time. At one time, the statute required counties to provide a *detailed* list of proposed changes in services. Based upon San Francisco's failure to provide details of a proposal to reduce services at its county hospital, an appellate court enjoined the county's proposed reductions in *Smith v. Board of Supervisors*,⁴⁴ A year later, the legislature amended the statute to delete the requirement that the list of changes be a detailed one.

C. Proposition 99 Programs

In the late 1980s, the State of California began distributing funds raised through a tax on tobacco products enacted by the voters as part of Proposition 99 for a variety of health care purposes.⁴⁵ As a result of litigation by anti-tobacco groups unhappy with the state's funding of tobacco education efforts, the state has been enjoined from spending funds raised by the tobacco tax for health care purposes. In recent years, these programs have remained as tobacco tax revenues have been replaced by the state's

³⁹213 Cal.App.3d at 414.

⁴⁰*Id.* at 409-11.

⁴¹*Id.* at 414.

⁴²Slip Opn. at 20.

⁴³ Health and Safety Code § 1442.5.

⁴⁴216 Cal.App.3d 862, 265 Rptr. 446 (1989).

⁴⁵ Welfare and Institutions Code § 16940 *et seq.* and Health and Safety Code § 104350 *et seq.*

general revenues. The Proposition 99 programs remain a valuable source of health care for indigent patients throughout California.

Proposition 99 established the California Healthcare for Indigents Program (CHIP), which distributes funds to counties to reimburse uncompensated care by hospitals and physicians and to provide other health services for indigent patients.⁴⁶

The state also used these revenues to expand services under the Child Health and Disability Prevention (CHDP) Program, California's version of the Medicaid Early Periodic Screening Diagnosis and Treatment (EPSDT) Program, to provide regular screening, diagnosis and treatment to all children between birth and the first 90 days after their admission to first grade and to all children who are under 19 years of age and have family incomes of less than 200 percent of the federal poverty level.⁴⁷ As a condition of receiving funds under CHIP and Proposition 99's expansion of the CHDP program, counties must expend specified amounts of their own funds for health services.⁴⁸ In addition, the state has used Proposition 99 funds to support school-based health services for pregnant minors and minor parents.⁴⁹

Tobacco tax funds also helped establish the Access for Infants and Mothers (AIM) Program.⁵⁰ The AIM Program, which is administered by California's Major Risk Medical Insurance Board, provides insurance coverage for women during their first pregnancy and for sixty days postpartum.⁵¹ It also covers the children of women enrolled in the AIM Program from birth up to age two. To qualify, an individual must reside in the State of California for at least six months and have an income of between 200 and 250 percent of the federal poverty level. Enrollees must pay an enrollment fee of \$50. MediCal and Medicare beneficiaries and individuals who are eligible for private insurance are ineligible for the AIM Program. California statutes mandate that the AIM plan must cover physician services, inpatient services, outpatient services, laboratory and x-ray services, short-term rehabilitation and physical therapy, twenty mental health outpatient visits per year, substance abuse treatment, home health services, family planning services, services for infertility, eye and ear exams for children, well-child care, and pediatric and adult immunizations.⁵²

D. Mental Health Services

The Short-Doyle Act (recently renamed the Broznan-McCorquada Act), provides funding for

⁴⁶Welfare and Institutions Code §§ 16943 and 16952.

⁴⁷Health and Safety Code § 104395 and Welfare and Institutions Code § 16970.

⁴⁸Welfare and Institutions Code § 16990(a).

⁴⁹Welfare and Institutions Code § 104460.

⁵⁰Cal. Ins. Code § 12695 et seq.

⁵¹Cal. Ins. Code § 12698.30 (at a minimum, AIM must provide coverage to these groups).

⁵²Cal. Ins. Code § 12698.30 (at a minimum, services provided to AIM participants must include services required of federally qualified Health Maintenance Organizations under 42 C.F.R. § 417.101).

county mental health programs.⁵³ To receive state realignment funds for mental health care, states must contribute specified amounts in county funds to county mental health services.⁵⁴ The counties' funding obligations under the Act are limited to the contribution of this sum.⁵⁵

In *Board of Supervisors v. Superior Court (Comer)*,⁵⁶ indigent patients argued that the county had an additional, residual obligation to provide needed mental health services to the poor under Welfare and Institutions Code § 17000. The court rejected this contention, concluding that the legislature's adoption of the Short-Doyle Act in 1968 modified any pre-existing obligation that the counties may have had to provide mental health services under Welfare and Institutions Code § 17000.⁵⁷ Since the *Comer* decision, the funding cap on county mental health services has been a continuing source of frustration for mentally ill patients and their advocates. As a result of the *Comer* decision, mental health services continue to be unavailable to many California residents who need them.

Counties are required to charge for the costs of mental health services based upon a sliding scale determined by the extent of the patients' ability to pay.⁵⁸ Patients, their spouses and the parents of minor patients are liable for the costs of these services.⁵⁹

E. California Children's Services

California has also established a program for the care of disabled children who are not eligible for Medicaid benefits. The California Children's Services (CCS) program provides a wide range of medical services to children who suffer from physical defects or handicaps.⁶⁰ Eligibility for services is based upon financial need.⁶¹ The families of CCS children pay an annual enrollment fee, based upon a sliding scale.⁶² This fee is waived for families with incomes of less than 200 percent of the federal poverty level.

F. State Only Medi-Cal Benefits

⁵³Cal. Welf. and Inst. Code § 5600 et seq.

⁵⁴Cal. Welf. and Inst. Code §§ 5702 and 17608.05.

⁵⁵Cal. Welf. and Inst. Code § 5703.

⁵⁶207 Cal.App.3d 552, 254 Cal.Rptr. 905 (1989).

⁵⁷*Id.* at 559-61.

⁵⁸Cal. Health and Safety Code §§ 5709 and 5710.

⁵⁹Cal. Health and Safety Code § 5710.

⁶⁰Cal. Health and Safety Code § 123800 et seq.

⁶¹Cal. Health and Safety Code § 123870.

⁶²Cal. Health and Safety Code § 123900.

California has elected to provide Medi-Cal benefits with state funds alone to two categories of recipients: individuals over the age of 21 who reside in nursing homes and intermediate care facilities for the developmentally disabled,⁶³ and pregnancy related services for undocumented aliens.⁶⁴

G. Other Programs

California funds a wide range of other programs, including subsidized drug programs for individuals with HIV,⁶⁵ treatment for tuberculosis, sexually transmitted diseases and other infectious diseases,⁶⁶ immunization programs,⁶⁷ genetic disease and prevention services,⁶⁸ perinatal services,⁶⁹ primary care services for underserved populations⁷⁰ and renal dialysis services.⁷¹ The appropriations for these purposes are finite and they create no entitlement to services on the part of recipients. However, these funds do serve to bolster safety net services that indigent patients depend upon for health care.

II. State Efforts to Extend Coverage or Care for the Uninsured

A. High Risk Pools

The state has also established a major risk medical insurance program to provide coverage to individuals and their dependents who have been rejected for private insurance coverage by at least one plan.⁷² Individuals who are eligible for Part A and Part B Medicare coverage may not purchase coverage under this program.⁷³ Copayments under the plan are limited to 20% of health care costs and annual deductibles are limited to \$500. Total copayments and deductibles are limited to \$2,000 per individual and \$3,000 per family.⁷⁴

⁶³Cal. Welf. and Inst. Code §§ 14005.4 and 14052.

⁶⁴Cal. Welf. and Inst. Code § 14007.5(d).

⁶⁵Cal. Health and Safety Code § 120775 et seq.

⁶⁶Cal. Health and Safety Code §§ 121350 et seq., 120500 et seq. and 120100 et seq.

⁶⁷Cal. Health and Safety Code § 120325

⁶⁸Cal. Health and Safety Code § 124795 et seq.

⁶⁹Cal. Health and Safety Code § 123475 et seq.

⁷⁰Cal. Health and Safety Code § 124400 et seq.

⁷¹Health and Safety Code § 125500 et seq.

⁷²Insurance Code § 12700 et seq.

⁷³Insurance Code § 12733.

⁷⁴Insurance Code § 12718.

B. Emergency Treatment

Under state law, private hospitals that have emergency facilities are required to provide emergency care for any condition in which a patient "is in danger of loss of life, or serious injury or illness."⁷⁵ Patients remain liable for the cost of this care.

⁷⁵Health and Safety Code § 1317.