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> Medical indigence is a silent, largely invisible epidemic. . . . Occasionally medical indigence roars into public consciousness, usually in the case of a needy young transplant candidate or a patient who has been dumped by a hospital. But for the most part, it does not happen under the noses of those who provide health care or who formulate its policy.[1]

INTRODUCTION

Amidst growing public concern about health care, and particularly about the twenty-two and one-half percent of California's population who are without insurance to pay for their health care,[2] California counties have struggled to meet the health care needs of indigent people who are without other access to medical services. Our counties have a long history of legal responsibility for meeting the core elements of subsistence[3] (food, shelter and medical care) for indigent people, although this obligation has recently undergone statutory changes of great potential significance.[4] This Article reviews California law[5] concerning section 17000 of the Welfare and Institutions Code and the legal obligations of counties to cover the medical care needs of their indigent residents.[6] The Article also provides a brief overview of state and county indigent medical care programs for the last three decades.[7] The closing section suggests a conceptual framework for consideration of past, current and potential legal standards for levels of health care that are provided to indigent people.[8]

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1. Emily Friedman, *The Torturer's Horse*, 261 JAMA 1481 (1989).

2. *Health Care Costs and Health Insurance Coverage in California: Hearings on Health Care Reform: Current Trends in Health Care Costs and Health Insurance Coverage*, 103d Cong., 1st Sess. 1-2 (1993) (testimony of E. Richard Brown, Ph.D.) (copy on file with the *Pacific Law Journal*). The estimates of health insurance coverage are based on the authors' analyses of the March 1990 Current Population Survey.

3. Poverty Resistance Ctr. v. Hart, 213 Cal. App. 3d 295, 307, 271 Cal. Rptr. 214, 222 (1989); *see* Boehm v. Superior Court, 178 Cal. App. 3d 494, 503, 223 Cal. Rptr. 716, 722 (1986) (listing the "most basic needs . . . food, shelter, utilities, clothing, medical care, transportation").

4. *See infra* notes 112-125 (discussing the recent statutory changes made to § 17000 of the California Welfare and Institutions Code and other laws affecting the level of medical care services that must be provided to indigent people).

5. Although this Article concentrates on legal obligations of counties in California, many of the 3,000 counties in the United States also provide health care for the poor. *See generally* PATRICIA BUTLER, TOO POOR TO BE SICK: ACCESS TO MEDICAL CARE FOR THE UNINSURED 40 (1988).

6. *See infra* notes 9-73 and accompanying text.

7. *See infra* notes 74-240 and accompanying text.

8. *See infra* notes 241-292 and accompanying text.

I. BACKGROUND AND OVERVIEW

A. A Brief History of County Medical Assistance

California counties have a long history of responsibility for caring for their indigent residents' needs under Welfare and Institutions Code section 17000.[9] Although the medical care aspect of counties' responsibility is well established,[10] counties can choose whether to deliver this medical care through county hospitals, county clinics, a purchased-care system, a managed care system, or some combination of these delivery components.[11] County medical care programs operate as a complement to federal or state health care programs, providing a "safety net" for low income people who are not eligible or otherwise have no access to federal and state financed health care. The largest, most significant federal-state indigent health care program in California is Medi-Cal.

After Congress enacted the Medicaid program in 1965 to provide health care for specific categories of indigent people,[12] California enacted a basic health care program (now called Medi-Cal)[13] for categorically needy people whose eligibility was linked to federal financial aid categories.[14] Medi-Cal also covered "medically needy" people incapable of meeting their medical expenses, but ineligible for federal financial aid due to income or resources above the statutory maximums.[15] Until the reforms of 1982, the Medi-Cal Reform Program of 1971 was the most important change in the scope and direction of Medi-Cal.[16] One part of

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9. *See generally* Jacobus tenBroek, *California's Welfare Law—Origins and Development*, 45 CAL. L. REV. 241 (1957).

10. Simone Workman, *County Hospitals in Crisis: Legislative Response to Assure Indigent Health Care*, 10 U.C. DAVIS L. REV. 331, 333 (1977).

11. *See* Randall R. Bovberg & William G. Kopit, *Coverage and Care for the Medically Indigent: Public and Private Options*, 19 IND. L. REV. 857, 881-84 (1986) (describing four different delivery models for local indigent health programs throughout the country).

12. 42 U.S.C. §§ 1396-1396(u) (1989 & Supp. II 1991). This subchapter is usually referred to as Medicaid.

13. CAL. WELF. & INST. CODE § 14000.4 (West 1991).

14. *Id.* § 14005.1 (West 1991).

15. *Id.* §§ 14005.7, 14051 (West 1991); *see also* 1974 Cal. Stat. ch. 1240, sec. 9, at 2688 (enacting CAL. WELF. & INST. CODE § 14050.1) (defining a categorically needy persons as those falling within federal regulations); CAL. WELF. & INST. CODE § 14051.5 (West Supp. 1993) (defining a medically needy person as anyone who receives in-home supportive services and whose income resources are insufficient to provide for health care or coverage).

16. *See generally* CALIFORNIA CENTER FOR HEALTH STATISTICS, THE MEDI-CAL PROGRAM: A BRIEF SUMMARY OF MAJOR EVENTS, DATA MATTERS TOPICAL REPORTS, CALIFORNIA DEPARTMENT OF HEALTH SERVICES, Report No. 0656-001 (Sept. 1979) (revised) [hereinafter THE MEDI-CAL PROGRAM: A BRIEF SUMMARY OF MAJOR EVENTS].

the 1971 reforms expanded Medi-Cal eligibility to include county medically needy children and adults under age sixty-five not otherwise Medi-Cal eligible.[17] It was assumed that this new, "medically indigent" category of Medi-Cal eligibles[18] would cover most of the county medical indigents,[19] thereby bringing state and federal funds to the county hospital systems that had been treating an estimated 800,000 "working poor" people not previously eligible for Medi-Cal.[20] In fact, some counties made this total Medi-Cal coverage assumption a self-fulfilling reality by adopting the position that any person not qualifying for Medi-Cal under the expanded eligibility criteria was assumed to be capable of paying for his or her health care.[21] In June 1978, voter approval of Proposition 13 sharply restricted counties' ability to raise revenues, bringing increased budget competition to all county-funded programs.[22] The next year, Assembly Bill (AB) 8 was enacted to provide fiscal relief to counties coping with greatly reduced tax revenues.[23] AB 8's health-related provisions helped to protect spending for county public health and medical care programs, by adopting a distribution formula for state funds that included a state share that had to be matched by county funds.[24]

In 1982, responsibility for the Medically Indigent Adults (MIAs) traveled almost full circle when these people were eliminated from the

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17. 1971 Cal. Stat. ch. 577, sec. 12, at 1110 (enacting CAL. WELF. & INST. CODE §§ 14000-14029).

18. *Id.*; 1971 Cal. Stat. ch. 577, sec. 23, at 1115 (enacting CAL. WELF. & INST. CODE § 14052). These statutes designated anyone covered by the new eligibility expansion as a "noncategorically related needy person," but the more commonly used phrase is "medically indigent." *See* 1982 Cal. Stat. ch. 328, sec. 8.3, at 1575 (referring to the repeal of California Welfare and Institutions Code § 14005.13 as the elimination of medically indigent adults from the Medi-Cal program); THE MEDI-CAL PROGRAM: A BRIEF SUMMARY OF MAJOR EVENTS, *supra* note 16, at 10.

19. REPORT OF THE LEGISLATIVE ANALYST TO THE JOINT LEGISLATIVE BUDGET COMMITTEE, ANALYSIS OF THE BUDGET BILL OF THE STATE OF CALIFORNIA, at 628 (Fiscal Year 1974-75) [hereinafter ANALYSIS OF THE 1974-75 BUDGET].

20. THE MEDI-CAL PROGRAM: A BRIEF SUMMARY OF MAJOR EVENTS, *supra* note 16, at 10-11.

21. There is some question as to what persons, if any, outside of the Medi-Cal medically indigent eligibles, are the county's responsibility under § 17000 of the Welfare and Institutions Code. ANALYSIS OF THE 1974-75 BUDGET, *supra* note 19, at 629.

22. This ballot initiative was officially titled "Tax Limitation" by the Attorney General's office, but is popularly referred to as "Proposition 13," after the number assigned to it on the ballot. This ballot initiative limited a county's tax assessments on property within its boundaries. Proposition 13 of June 1978 was added to the California Constitution at Article XIIIA. CAL. CONST. Art. XIIIA (implementing legislation codified at CAL. REV. & TAX CODE §§ 50-100.5 (West 1987)).

23. *See* 1979 Cal. Stat. ch. 282, sec. 87, at 1047-51 (enacting CAL. WELF. & INST. CODE §§ 16700-16718).

24. Another part of the health care funding formula included a per capita allocation based on each county's population. Both parts of this formula were adjusted annually to reflect changes in population and cost of living. For a brief description of the AB 8 program, see THE 1991-92 BUDGET: PERSPECTIVES AND ISSUES, REPORT FROM THE LEGISLATIVE ANALYST'S OFFICE TO THE JOINT LEGISLATIVE BUDGET COMMITTEE at 180.

Medi-Cal program and were transferred back to the counties.[25] Twenty-four of California's fifty-eight counties assumed responsibility for the MIAs, while the other thirty-four counties chose the County Medical Services Program (CMSP) option of contracting back with the state for their MIA program.[26] Although the CMSP option provided counties with administrative convenience and to some extent shifted financial risk back to the state, it did not relieve participating counties of their section 17000 responsibility for health care.[27] The 1982 MIA transfer saved the state about $110 million for that year, but also resulted in fragmentation of medical benefits, eligibility criteria, and access to medical care as many counties developed their own programs for the medically indigent.[28] Some counties tried to provide the former MIAs with the same care they would have received under Medi-Cal, while other counties applied more restrictive eligibility standards and minimum benefits.[29]

In 1988, a decade after creation of the AB 8 program, voters approved a cigarette tax ballot initiative that had important effects on indigent medical care. Proposition 99, the Tobacco Tax and Health Protection Act of 1988,[30] raised cigarette taxes by 25 cents per pack, directing approximately two-thirds[31] of the revenue raised by this new tax[32] to

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25. 1982 Cal. Stat. ch. 328, sec. 8, at 1575 (repealing CAL. WELF. & INST. CODE § 14005.13); 1982 Cal. Stat. ch. 328, sec. 8.3, at 1575-76 (declaring the legislative intent to transfer funds to counties to be consolidated with the existing county health services funds to provide health services to low income persons and other persons not eligible for Medi-Cal); 1982 Cal. Stat. ch. 328, sec. 8.5, at 1576 (enacting CAL. WELF & INST. CODE § 14005.16). For a description of the 1982 changes to Medi-Cal and their impact on California's poor people, see Christopher Bellavita, *California's Health Policy Reform and the Poor*, 24 PUB. AFF. REP. No. 5, 1-10 (University of California, Berkeley, October 1983).

26. Fifteen of these twenty-four counties were required to assume responsibility for MIAs because they had a population of more than 300,000. The other nine counties that took responsibility for operating their own MIA program were smaller counties that chose to do so. This group of large and small counties is often referred to as the "MISP" group of counties because they operate under the Medically Indigent Services Program (MISP). The remaining counties, all of them with less than 300,000 residents, are considered "CMSP counties" because they choose to contract back to the state through the County Medical Services Program (CMSP). Bellavita, *supra* note 25, at 5; *see* CAL. WELF. & INST. CODE § 16905 (West Supp. 1993) (stating that a MISP county is own which administers, either directly or through contracts with selected providers, its own indigent health services program); *id.* § 16901 (West 1991) (defining a CMSP county as a county which contracts with the department for the administration of health services).

27. CAL. WELF. & INST. CODE § 16709(c) (West 1991).

28. Bellavita, *supra* note 25, at 5.

29. *Id.*

30. *See* CAL. REV. & TAX. CODE §§ 30121-30130 (West Supp. 1993) (codifying Proposition 99).

31. Forty-five percent of the revenues raised by Proposition 99 are required to be deposited in the Hospital Services Account and Physician Services Account. CAL. REV. & TAX. CODE § 30124(b) (West 1992). Another 25 percent of the revenues is deposited in the Unallocated Account. *Id.* § 30124(b) (West 1992). Subsequent legislation has allocated most of the Unallocated Account to the same medical care-related purposes as the funds from the Hospital and Physician Services Accounts. *See* 1989 Cal. Stat. ch. 1331, sec. 10, at 4696-4700 (uncodified) (containing allocations from the Cigarette and Tobacco Products Surtax Fund for the 1989-

pay hospitals and physicians for treatment of people who lack private coverage or federal funding and who cannot afford to pay for those services.[33] To implement the requirement that Proposition 99 funds be used to supplement rather than to fund existing levels of service,[34] the legislation that initially allocated Proposition 99 funds for health and medical care activities set forth several specific maintenance of effort requirements for counties to continue current levels of indigent care funding and service.[35]

In 1991 and 1992, California lawmakers struggled to craft a state budget and other statutes in light of massive budget gaps. The 1991-92 budget adopted in July 1991 was designed to resolve a gap between revenues and expenditures that had grown from $7 billion in January 1991 to $14.3 billion in May 1991.[36] While the State grappled with its budget problems, many of California's counties also faced increasing financial stress. In fact, Butte County threatened to declare bankruptcy.[37]

With this bleak financial backdrop, in January 1991, Governor Wilson proposed a realignment of state and local programs that included a transfer of responsibility for the AB 8 county health services program. This realignment,[38] characterized as a major component of the state plan to

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1990 fiscal year); 1991 Cal. Stat. ch. 278, secs. 24-43, at 1536-46 (uncodified) (containing allocations from the Cigarette and Tobacco Products Surtax Fund for the next three fiscal years, 1990-91, 1991-92, 1992-93).

32. Letter from Kristi Anderson, Associate Budget Analyst, Department of Finance, State of California, Unpublished figures (Jan. 29, 1993) (copy on file with the *Pacific Law Journal*) (stating that the total Proposition 99 revenues have fallen from a high of $569 million for fiscal year 1989-90 to an estimated $512 million for fiscal year 1992-93).

33. CAL. REV. & TAX CODE § 30122(a)(3) (West Supp. 1993).

34. *Id.* § 30125 (West Supp. 1993).

35. Counties were required to maintain a funding match based on their 1988-89 expenditures and the same number of indigent medical care outpatient visits as in 1988-89. 1989 Cal. Stat. ch. 1331, sec. 9, at 5427, 5431 (enacting CAL. WELF. & INST. CODE §§ 16990, 16995). Counties were also prohibited from imposing more stringent eligibility standards or reducing the scope of benefits, using November 1988 as the basis of comparison. CAL. WELF. & INST. CODE § 16995 (West 1991).

36. THE 1992-93 BUDGET: PERSPECTIVES AND ISSUES, REPORT FROM THE LEGISLATIVE ANALYST'S OFFICE TO THE JOINT LEGISLATIVE BUDGET COMMITTEE, 7-8 [hereinafter 1992-93 BUDGET: PERSPECTIVES AND ISSUES].

37. *Id.* at 160. *See generally,* RICHARD P. SIMPSON & CARY S. JUNG, CALIFORNIA COUNTIES FOUNDATION, CALIFORNIA COUNTIES ON THE FISCAL FAULT LINE: A STUDY OF THE FINANCIAL CONDITION OF CALIFORNIA COUNTIES (November 1990).

38. The 1991-92 realignment was implemented through several pieces of legislation developed by a legislative administrative task force. *See generally* 1991 Cal. Legis. Serv. ch. 87, sec. 1, 3, at 232 (enacting CAL. REV & TAX CODE § 10753.1) (repealing CAL. REV. & TAX CODE § 6276, enacting CAL. REV. & TAX CODE §§ 10753.1, 10753.7, 11001.5 and amending CAL. REV. & TAX CODE §§ 10753, 10753.2) (providing for the allocation of vehicle license fees); 1991 Cal. Legis. Serv. ch. 91, sec. 2-3, at 396 (repealing and reenacting CAL. HEALTH & SAFETY CODE § 257) (requiring counties to collect enrollment fees under the California Children's Services Act). These bills affected a total of 16 programs in the health and welfare area. 1992-93 BUDGET: PERSPECTIVES AND ISSUES, *supra* note 36, at 105.

address its "significant funding gap" for 1991-92, proposed to eliminate a total of approximately $900 million in state funding for local mental health, public health, and indigent medical care programs. Such a realignment would also provide counties with equivalent additional revenues from increased taxes on alcohol and vehicle licenses.[39] As it was finally enacted, the package of realignment measures accounted for a total of $2.2 billion of projected increases in county revenues to offset an equivalent amount of state General Fund savings and increased county sharing costs.[40] The statutes for AB 8 County Health Services and for the Medically Indigent Services Program (MISP) were eliminated, resulting in cost shifts of $503 million and $348 million, respectively, from the state to the counties.[41]

The budget years following realignment have continued to reflect substantial decline in the state's fiscal fortunes.[42] The impact of this fiscal decline on county medical care obligations was made clear by the 1993 enactment of legislation that allowed counties to dramatically reduce their general indigent assistance aid levels.[43] This same legislation also appeared to anticipate current and future reductions in the Medi-Cal program by stating that a county shall not be required to fund or provide indigent medical care services that have been reduced or eliminated from the Medi-Cal program.[44]

B. Who Receives County Medical Care?

The history of Medi-Cal and of county-only indigent medical care illustrates how closely these two programs have interacted with each other on a practical, program and fiscal basis. Even now, with legal responsibility for medical care to non-categorically linked indigents clearly transferred to the counties, Medi-Cal reimbursement is a vital thread in the fabric of county health care systems. Many providers who serve large numbers of Medi-Cal patients also care for medically indigent people, providing continuity of care for individuals and families who may move

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39. 1992-93 BUDGET: PERSPECTIVES AND ISSUES, *supra* note 36, at 104.
40. *Id.*
41. *Id.* at 105, 112.
42. *Id.* at 5.
43. CAL. WELF. & INST. CODE § 17000.6(a) (West Supp. 1993) (allowing a county that demonstrates "significant financial distress" to reduce its general assistance aid levels to 40 percent of the federal poverty level).
44. *Id.* § 17030 (West Supp. 1993).

into and out of Medi-Cal eligibility.[45] Medi-Cal revenues also serve an important role as fiscal support and even subsidies for providers who serve medically indigent people not eligible for Medi-Cal.[46] Although the federal-state funded Medi-Cal program and the county-funded section 17000 programs are closely related in many practical and financial aspects, they are governed by different legal requirements. The remainder of this Article concentrates only on the legal requirements for county indigent health care programs, particularly the requirements for the minimum standards of care that these programs must meet.

Who are the indigent people served by county medical assistance? A recent survey of all California counties indicates that unemployed, non-working, or seasonally employed adults were most frequently identified by county respondents as the largest group of medically indigent people.[47] Working adults comprised a smaller but still sizable portion of county medical indigents, while undocumented people and mothers and infants made up still smaller proportions of this patient population.[48] The categories representing the smallest number of county indigent care users were homeless and children and adolescents.[49] The first category of under-employed or unemployed adults, which was identified as the largest proportion of the medically indigent, was also reported to be both the fastest growing group and one of the two groups with the highest levels of unmet medical needs.[50] The other group with high unmet need levels was undocumented people, particularly for the larger counties.[51]

C. Constitutional Rights and County Assistance

Federal constitutional provisions allow government health care programs for the medically indigent, but clearly do not require them.[52]

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45. THE DEPARTMENT OF HEALTH SERVICES PLAN FOR EXPANDING MEDI-CAL MANAGED CARE: PROTECTING VULNERABLE POPULATIONS 51 (March 31, 1993).

46. Letter to Molly Coye, Director, Department of Health Services, from Mary Pittman, President and CEO, California Association of Public Hospitals 6 (January 27, 1993) (copy on file with the *Pacific Law Journal*).

47. David Carrell, et al., Indigent Medical Care in California: Views From the Bottom (July 1993) (unpublished paper presented to the Association for Health Studies Research (AHSR)) (copy on file with the author).

48. *Id.*

49. *Id.*

50. *Id.*

51. *Id.*

52. *See* Bovberg & Kopit, *supra* note 11, at 872; Michael A. Dowell, *State and Local Government Legal Responsibilities to Provide Medical Care for the Poor*, 3 J.L. & HEALTH 1, 3 (1988-89).

However, courts have found Fourteenth Amendment rights for people in federally-funded indigent assistance programs.[53] These rights even include indigent people who are not eligible for these nationally established programs, but who live in a state such as California with local indigent assistance programs.[54]

The legal framework for California's county-level indigent assistance programs allows much more local discretion than the framework for federally established indigent aid programs. For example, California's Medi-Cal program is governed by more than 550 pages of statutory language[55] while this state's local medical assistance programs for indigents operate under a broad state statutory mandate contained in just a handful of pages.[56] One legal commentary that addressed California's general assistance programs for indigents pointed out the practical difference between federal assistance programs, with their detailed laws governing all recipients, and local assistance programs, which can vary widely from county to county.[57] Although this commentary suggested a possible constitutional requirement to minimize county-by-county variations in general assistance programs, it acknowledged that "the constitutional question is most difficult where, as in California, general assistance programs are totally funded and administered by local governments."[58]

The local control and county-by-county variability of California's general relief programs was also a focus of *Griffeth v. Detrich*,[59] a federal trial court decision that emphasized the "diverse and variable nature" of general relief in California and each county's considerable discretion in establishing eligibility criteria for relief.[60] When that decision was appealed to the Ninth Circuit Court of Appeals, the appellate court took a

53. The landmark case is Goldberg v. Kelly, 397 U.S. 254 (1970), which held that due process required a hearing prior to terminating a person's benefits in the Aid to Families with Dependent Children (AFDC) program. For a discussion that contrasts the jurisprudence of welfare entitlement first developed by social workers with that developed later by lawyers, see generally William H. Simon, *The Invention and Reinvention of Welfare Rights*, 44 MD. L. REV. 1 (1985).

54. Griffeth v. Detrich, 603 F.2d 118, 122 (9th Cir. 1979), *cert. denied*, 445 U.S. 970 (1980).

55. *See* CAL. WELF. & INST. CODE §§ 14000.4-14029 (West 1991).

56. *See id.* §§ 17000, 17000.5, 17001 (West 1991 and West Supp. 1992).

57. Harold W. Horowitz & Diana L. Neitring, *Equal Protection Aspects of Inequalities in Public Education and Public Assistance Programs From Place to Place Within a State*, 15 UCLA L. REV. 787, 815 (1968).

58. *Id.* at 815.

59. 448 F. Supp. 1137 (S.D. Cal. 1978).

60. Griffeth v. Detrich, 448 F. Supp. 1137, 1140-41 (S.D. Cal. 1978).

different view of inter-county variability in local assistance programs.[61] In *Griffeth*, the appellate court found that people applying for general assistance benefits had a constitutional right to eligibility determination procedures that meet due process requirements.[62] The plaintiff had applied to the San Diego County Department of Public Welfare on August 18, 1976 for general relief after she was fired as a waitress because her employer claimed that she dressed improperly.[63] Although the plaintiff disputed the alleged impropriety, her application was denied because she had apparently been fired for cause.[64] The plaintiff requested and received administrative review, but the supervisor denied her application after trying once, unsuccessfully, to reach her former employer.[65] After the district court granted summary judgment in favor of the county,[66] the Ninth Circuit reversed, agreeing with the plaintiff's assertion that the interest in general relief benefits is an interest protected by the Fourteenth Amendment.[67] The case was remanded to the district court for determination of the process due to protect the plaintiffs' interest in general relief benefits.[68]

In its decision, the Ninth Circuit emphasized the mandatory nature of general relief, which required each county to provide this assistance, and the detailed regulations adopted by San Diego county that set forth specific objective eligibility criteria for receiving this assistance.[69] The court relied heavily on a then recent Supreme Court ruling, *Greenholtz v. Nebraska Penal Inmates*, which had found a protectible entitlement in parole applications by inmates in Nebraska state prisons.[70] The Ninth Circuit found that the *Griffeth* case, like *Greenholtz*, involved statutory entitlement and stated that the authorizing statute coupled with the implementing regulations of the county creates a legitimate claim of entitlement and

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61. *Griffeth*, 603 F.2d at 118 (9th Cir. 1979).

62. Griffeth v. Detrich, 455 U.S. 970 (1980), *cert. denied* (Rehnquist, J., dissenting). *But cf.* Bernhardt v. Alameda County Bd. of Supervisors, 58 Cal. App. 3d 806, 809, 130 Cal. Rptr. 189, 192 (1976) (holding that Alameda County's general assistance eligibility regulations were invalid without reaching the constitutional issues raised by plaintiffs).

63. *Griffeth*, 603 F.2d at 120.

64. *Id.*

65. *Id.*

66. *Id.* at 119.

67. *Id.*

68. *Id.* at 122.

69. *Id.* at 121.

70. *Id.* at 120 (citing Greenholtz v. Nebraska Penal Inmates, 442 U.S. 1 (1979)).

expectancy of benefits in persons who claim to meet the eligibility requirements.[71]

An absence of post-*Griffeth* case law regarding federal constitutional issues in California's local assistance programs contrasts sharply with the large number and broad scope of cases interpreting the state law governing these programs.[72] The remainder of this Article discusses the legislative history and recent case law developments for the state statutes most relevant to setting standards for counties' indigent assistance programs, particularly focusing on the level of medical care required for these programs.[73]

II. LEGISLATIVE HISTORY OF STATUTES CONCERNING STANDARDS FOR COUNTY SERVICES TO INDIGENTS

The California laws that are most relevant to setting minimum standards for a county's medical assistance obligations to its indigent residents are the Beilenson Act, Welfare and Institutions Code section 17000, and Welfare and Institutions Code section 10000. The legislative history of each of these laws reveals that most of their amendments have been relatively minor compared to the statutory changes made in 1991, 1992, and 1993. The real impact of these amendments will not be known

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71. *Id.* at 121.

72. *See infra* notes 149-210 and accompanying text (discussing the cases pertaining to state law governing county indigent care programs).

73. In addition to constitutional questions regarding California's general assistance programs, one court recently considered tort claims based on the § 17000 mandate. Benjamin v. County of Lake, 235 Cal. App. 3d 1574, 1 Cal. Rptr. 2d 604 (1991), *withdrawn*, Feb. 27, 1992. In that case, medically indigent adults who were denied dental treatment sued Lake County for damages, claiming that the county had breached a mandatory duty to provide dental treatment. *Id.* The Court of Appeals affirmed the trial court's finding that there was no basis for a cause of action for damages under § 17000. *Id.* Plaintiffs claimed that the county had a mandatory duty to provide them with dental care, based on California Welfare and Institutions Code §§ 17000 and 10000. *Id* at 607. The court rejected this claim, finding that the county was required to adopt some sort of standards and that these standards needed to be "humane," but that there was "no specific statutory mandate . . . [to] adopt standards providing dental care or, indeed, any particular care at all." *Id.* The court also considered whether § 17000 protected against the kind of risk of injury suffered by plaintiffs. *Id.* at 608. Here, the court looked to public policy issues in deciding whether the county owed plaintiffs a duty of care and could therefore be negligent toward them. *Id.* These general policy issues included the social utility of the county's activities, the workability of a rule of care, parties' relative ability to bear financial burden of injury and to spread loss, the statutes and judicial precedents which color the parties' relationship, and the legal role and budget limitations of a public agency defendant. *Id.* The court seemed especially persuaded by two other observations it made about the county role in providing and financing indigent medical care: that counties encounter difficulty establishing a workable rule of care because they are "given very little guidance", presumably by the state statutes, and the court's reluctance to "exercise . . . judicial hindsight," thereby exposing counties to the "excessive liability" of potential tort damages. *Id.*

until enough time has passed for evaluation of any changes in county programs and the corresponding case law has developed. Even so, it is clear that the statutory framework for county assistance programs, and particularly for indigent medical care, looks quite different now than it did only a few years ago.

A. The Beilenson Act

A decade after Medicaid's enactment, a law was added to the California Health and Safety Code that specifically governed procedures and standards for the medical care portion of a county's larger indigent care responsibilities. The stated purpose of this law, commonly referred to as the "Beilenson Act,"[74] was to "insure that the duty of counties to provide health care to indigents is properly and continuously fulfilled."[75] Any county planning to change the management of county medical facilities or otherwise reduce the level of health care services provided to indigents was required to give prior notice to the State Department of Health.[76] The County Board of Supervisors was additionally required to hold public hearings prior to proposed service cuts and to "make findings based on these hearings that their proposed action will not have a detrimental impact" on indigent health care in the county.[77] Prior to its partial repeal in 1992, the Beilenson Act's "community standard" language was twice affected by legislative actions. In 1978, concern about county budgets following voter approval of Proposition 13[78] prompted the state to suspend the Beilenson Act for the 1978-79 fiscal year.[79] The drafters of this suspension chose to limit their action to the current budget year and to use budget language instead of directly changing the language of the Beilenson Act.[80] Reports made after the Beilenson Act requirements

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74. 1974 Cal. Stat. ch. 810, sec. 1, at 1764 (enacting CAL. HEALTH & SAFETY CODE § 1442), *repealed by* 1992 Cal. Legis. Serv. ch. 719, sec. 1., at 2880. The author of the legislation creating these new statutes was California State Senator Anthony Beilenson. Workman, *supra* note 10, at 353 n.148.

75. 1974 Cal. Stat. ch. 810, sec. 1, at 1764 (enacting CAL. HEALTH & SAFETY CODE § 1442), *repealed by* 1992 Cal. Legis. Serv. ch. 719, sec. 1., at 2880.

76. 1992 Cal. Stat. ch. 719, sec. 1, at 2881 (repealing CAL. HEALTH & SAFETY CODE § 1442).

77. 1992 Cal. Legis. Serv. ch. 719, sec. 2, at 2881 (amending CAL. HEALTH & SAFETY CODE § 1442.5). These hearings were commonly referred to as "Beilenson hearings."

78. The Initiative Constitutional Amendment - Property Tax Limitation, Prop., §§ 1-6 (codified at CAL. CONST. art. XIIIA, §§ 1-6 (implementing legislation codified at CAL. REV. & TAX CODE §§ 50-100.5). This ballot initiative limited a county's tax assessments on property within its boundaries. *Id.*

79. 1978 Cal. Stat. ch. 292, sec. 20(c), at 604 (repealing CAL. HEALTH & SAFETY CODE §§ 1442, 1442.5) (uncodified) (stating that the statute was suspended for one year).

80. *Id.*

resumed effect indicated that only one of California's fifty-eight counties closed, sold, leased, or transferred its county hospital during 1978.[81] Thus, one can assume that the one-year absence of a "Beilenson" hearing and reporting requirement did not greatly affect county hospital closures that year.[82]

More than a decade later, more changes were made to the Beilenson Act as part of state budget negotiations and limited to one fiscal year. This time, the changes were aimed at the standard of care for services provided in county programs of indigent medical care. One of the 1990 budget legislation provisions stated that the Beilenson Act's requirements should not require counties to exceed the Medi-Cal standard of care, nor to increase eligibility or expand the scope of their health services.[83]

The summer of 1992 brought unprecedented delays in adopting a final state budget[84] due in large part to the difficulties presented by a record level state budget deficit.[85] Although 1992 amendments to the Act made several changes to the advance notice and procedural requirements for a

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81. Tehama County closed its hospital sometime in 1978, but now operates a skilled nursing facility. PETER ABBOTT, COUNTY HEALTH SERVICES BRANCH, HEALTH & WELFARE AGENCY, A REPORT TO THE CALIFORNIA STATE LEGISLATURE ON COUNTY MEDICAL FACILITIES FOR FISCAL YEAR 1985-86 Appendix C (copy on file with the *Pacific Law Journal*). This document contains a list of twenty-one counties that closed a county hospital any time from 1965 to 1986, plus ten other counties that sold, leased, or transferred their county hospitals during that same time period. *Id.* Information on county hospital closures or other county health service changes or reductions was annually reported from the counties to the state pursuant to California Health and Safety Code § 1442(c). *Id.* The state then published a report to the Legislature containing this information. *Id.*

82. The actual impact of Proposition 13 and suspension of the Beilenson Act during the following year was probably softened by state "bailout" programs such as AB 8. For a summary of the AB 8 program to help fund county medical care for indigents, see *supra* notes 9-44 and accompanying text (discussing the history of county indigent medical care programs).

83. Chapter 457 provided that, "[f]or the 1990-91 fiscal year, nothing in subdivision (c) of Section 1442.5 of the Health and Safety Code shall require any county to exceed the standard of care provided by the state Medi-Cal program. Notwithstanding any other provision of law, counties shall not be required to increase eligibility or expand the scope of services in the 1990-91 fiscal year for their programs." 1990 Cal. Stat. ch. 457, sec. 23(b), at 1674 (uncodified). It is interesting to note the contrast between the "ceiling" (maximum) standard used in the 1990 budget language and the "floor" (minimum) standard used in the 1989 legislation for counties receiving Proposition 99 funds. The Proposition 99-related legislation required counties to *maintain* the same eligibility requirements and scope of services for indigent health care as had been in effect in 1988. *See supra* notes 30-35 and accompanying text (discussing Proposition 99).

84. Although California's fiscal year began on July 1, 1992, the main budget bill was not signed into law until September 2, 1992. 1992 Cal. Legis. Serv. ch. 587, sec. 1, at 1852 (enacting the California Budget for the 1992 fiscal year).

85. The Governor and Legislature were seeking to eliminate a budget deficit of $7.9 billion. Telephone interview with Jim Miller, Assistant Program Budget Manager for Health and Welfare, California Department of Finance (Oct. 8, 1992). Total state expenditures for that fiscal year were projected to be approximately $60 billion. GOVERNOR'S BUDGET SUMMARY 1992-93: FROM ADVERSITY TO OPPORTUNITY 7 (Jan. 1993) (copy on file with the *Pacific Law Journal*).

county's "Beilenson hearings,"[86] the change with greatest potential impact on standards of indigent health care was the complete elimination of section 1442.5(c), typically called the "community standard of care" provision.[87] The language of section 1442.5(c) provided that people who cannot afford to pay for their health care should receive the same availability of services and quality of treatment as non-indigent people receiving health care services in private facilities within that county.[88]

The repeal of the Beilenson Act's community standard provision eliminated California's only statutory language that speaks directly to standards for counties meeting their indigent health care responsibilities.[89] Although this appears to have been a significant change in statutory law, its precise impact cannot be known until counties, health care advocates, and courts have time to operate under and interpret the new statutory framework created by the Beilenson Act's repeal. As discussed below, this interpretive process is complicated by the fact that section 17000, the statute that defines a county's larger indigent care responsibilities, was also recently amended.[90]

B. Welfare and Institutions Code Section 17000

Section 17000 of the Welfare and Institutions Code is the anchor for any discussion of California counties' legal responsibility to care for their indigent residents. This law speaks broadly of the counties' obligation to relieve and support indigent people not receiving assistance from other

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86. The most notable of the procedural modifications was the elimination of the requirement that the supervisors holding the hearing make findings as to whether their proposed actions will be detrimental. 1992 Cal. Legis. Serv. ch. 719, sec. 2, at 2881-82 (amending CAL. HEALTH & SAFETY CODE § 1442.5).

87. Although the statute never used those precise words, counties often used that phrase to refer to that part of the Beilenson Act. *See, e.g.*, CALIFORNIA STATE ASSOCIATION OF COUNTIES, 29 LEGIS. BULL. 32 (1992).

88. 1992 Cal. Legis. Serv. ch. 719, sec. 2, at 2881-82 (amending CAL. HEALTH & SAFETY CODE § 1442.5).

89. As discussed *infra* at notes 91-125 and accompanying text, this language provided a more specific and probably higher standard for indigent health care than California Welfare and Institutions Code § 17000. Curiously, there have been remarkably few appellate court decisions that discuss the meaning and application of California Health and Safety Code § 1442.5(c). *See* Cooke v. Superior Court, 213 Cal. App. 3d 401, 261 Cal. Rptr. 706 (1989); Board of Supervisors v. Superior Court, 207 Cal. App. 3d 552, 254 Cal. Rptr. 905 (1989). One could hypothesize several reasons for the scarcity of published case law for the Beilenson Act's "community standard" when compared to case law regarding § 17000. Perhaps the Beilenson Act's statutory standards are so much clearer that litigation seems less necessary; perhaps there have been many suits brought with § 1442.5(c) claims, but these claims have been settled before trial or decided at the district court level without appeal; perhaps counties' medical care services for indigents have been better than their general assistance programs and therefore a less likely subject of law suits.

90. *See supra* notes 112-125 and accompanying text (discussing the recent amendments to § 17000).

private or public sources. Although the statute does not speak specifically of food, housing, medical care, or any other specific means of relief or support, there has never been any question that medical care is part of the county obligation.[91] Any determination of legal standards for the health care provided by counties to indigent people must rely heavily on interpretation of what is commonly referred to as the counties' "[s]ection 17000 responsibility."

Historically, California counties have had general assistance programs since the middle of the nineteenth century, and for many years these programs provided the only available relief for indigents.[92] The Pauper Act of 1901 provided:

> Every county and every city and county shall relieve and support all *pauper*, 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, *or* by their own means, or by state hospitals or other state or private institutions [emphasis added].[93]

Except for the two italicized words, the language from 1901 is identical to the current version of Welfare and Institutions Code section 17000, although there have been a few statutory changes over the years.

In 1933, the California Legislature replaced the Pauper Act language with a new section that referred to "all able-bodied indigent persons" and to the possibility of work requirements.[94] These additions only remained in the statute until 1937, when the Legislature established the Welfare and Institutions Code, thereby consolidating and revising the law relating to and providing for protection, care, and assistance to children, aged persons, and others specially in need.[95] The 1937 changes to what is now section 17000 brought the statute back closer to the original Pauper Act, except

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91. *See, e.g., infra* note 93 and accompanying text (showing that "state hospitals" have always been part of the statutory language).

92. The California Supreme Court reviewed § 17000's early legislative history in Mooney v. Pickett, 4 Cal. 3d 669, 675, 94 Cal. Rptr. 279, 283, 483 P.2d 1231, 1235-36 (1971).

93. 1901 Cal. Stat. ch. CCX, sec. 1, at 636.

94. 1933 Cal. Stat. ch 761, sec. 1, at 2005 (explaining the purpose of the work requirement as follows: "[s]uch work shall be created for the purpose of keeping the indigent from idleness and assisting in his rehabilitation and the preservation of his self-respect.").

95. 1937 Cal. Stat. ch. 369, sec. 1, at 1005 (enacting CAL. WELF. & INST. CODE); *see id.* (reciting the preamble to the California Welfare and Institutions Code).

that the word "pauper" was deleted.[96] Other changes included reinsertion of the reference to "lawful" county residents and removal of references to "able-bodied" people and possible work requirements.[97]

In 1965, California extensively revised the Welfare and Institutions Code.[98] Included in these revisions were general provisions[99] and a renumbering of what is now section 17000.[100] This section has remained essentially unchanged from the 1937 changes to the present.[101] Section 17000 reads as follows:

> 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.[102]

In addition to section 17000's mandate, the Welfare and Institutions Code contains section 17001, which requires counties to adopt standards of indigent aid and care.[103] This section originally required that such standards shall be open to public inspection, but that requirement was deleted in 1969.[104]

Although the language of section 17000 itself has not been changed since 1937, its effect on the standard for county indigent assistance was potentially modified by a new law added during the state's 1991 realignment of state and county responsibility for health and social service programs.[105] Then section 17000.5[106] expressly declared that a general

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96. *Id.* at 1097.

97. *Id.*

98. 1965 Cal. Stat. ch. 1784, sec. 1, at 3977 (amending CAL. WELF & INST. CODE § 19).

99. 1965 Cal. Stat. ch. 1784, sec. 5, at 3978 (enacting CAL. WELF. & INST. CODE § 10000). The importance of this statute is discussed *infra* at notes 126-131 and accompanying text.

100. 1965 Cal. Stat. ch. 1784, sec. 5, at 4090 (enacting CAL. WELF & INST. CODE §§ 17000-17409).

101. Although the actual language remained unchanged, "State" in § 2500 became "state" when § 17000 was given its current number. The chaptered legislation contains no intent language or other indication that this change from upper to lower case "s" was more than a stylistic one. *Id.*

102. CAL. WELF. & INST. CODE § 17000 (West 1992).

103. *Id.* § 17001 (West 1991). Section 17001 was a renumbering of the former California Welfare and Institutions Code § 200.1, which was added to the Code in 1937. 1957 Cal. Stat. ch. 1323, sec. 1, at 2656 (enacting CAL. WELF. & INST. CODE § 200.1).

104. 1969 Cal. Stat. ch. 371, sec. 55, at 907 (amending CAL. WELF. & INST CODE § 17001).

105. 1991 Cal. Legis. Serv. ch. 89, sec. 1-212 at 243-341 (realigning CAL. WELF. & INST. CODE). *See supra* notes 9-104 and accompanying text (providing a brief history of county medical assistance); *infra* notes 106-131 and accompanying text (summarizing the realignment provisions).

assistance payment set at sixty-two percent of the official federal poverty line[107] was legally sufficient.[108] In the following year, protracted state budget negotiations[109] again reflected the politically painful challenges of a depressed state economy and unexpectedly low state revenues.[110] Counties' growing frustration with insufficiently funded but state mandated activities caused increased mention of mandate relief for the counties, particularly in the area of health and welfare requirements imposed by the state.[111] Many statutory and budget changes contained in the 1992-93 budget legislation reflect the gravity of the state's fiscal situation and its willingness to reduce the burden of its mandates on the counties.

The 1992 changes related to section 17000 provided more specific guidance for counties choosing to link their general assistance payments to another standard.[112] These amendments also increased the likelihood

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106. 1991 Cal. Legis. Serv. ch. 91, sec. 34, at 410 (enacting CAL. WELF. & INST. CODE § 17000.5).

107. The official federal "poverty line" is defined by the Office of Management and Budget based on Bureau of the Census data. It is revised annually by multiplying the official poverty line by the percentage change in the Consumer Price Index For All Urban Consumers. 42 U.S.C. 9902(2) (Supp. 1993). § 9902 subsection (2). The payment level specified in § 17000.5 as originally enacted was also the level of benefits for people receiving Aid to Families with Dependent Children [hereinafter AFDC] at that time. In the 1992 amendments to § 17000.5, this implicit linkage to AFDC levels was stated directly. *See infra* note 111 (citing the 1992 text of § 17000.5 of the California Welfare and Institutions Act).

108. CAL. WELF. & INST. CODE § 17000.5(b) (West 1992). At the time § 17000.5 was enacted, twenty-eight of California's fifty-eight counties had general assistance levels at or above this guideline, many of them pursuant to a court order. Telephone Conversation with Karen Coker, Legislative Representative for Health and Welfare, California State Association of Counties (Oct. 29, 1992) (copy on file with the author).

109. *See* note 36 and accompanying text (stating that the budget gap has grown from $7 billion in January 1991 to $14.3 billion in May 1991).

110. *See supra* note 42 and accompanying text (citing the state's fiscal decline).

111. In its summary of 1992 budget provisions, the California State Association of Counties speaks of "significant mandate relief in health and welfare." CALIFORNIA STATE ASSOCIATION OF COUNTIES, 29 LEGIS. BULL. 32 (1992).

112. The statutory language included, in pertinent part, the following:

> (a) The board of supervisors in any county may adopt a general assistance standard of aid, including the value of in-kind aid, that is 62 percent of a guideline that is equal to the 1991 federal official poverty line and may annually adjust that guideline in an amount equal to any adjustment provided under Chapter 2 [containing the statutes regarding the Aid to Families with Dependent Children (AFDC) program]. . . .
>
> (b) The adoption of a standard of aid pursuant to this section shall constitute a sufficient standard of aid. . . .
>
> (d) For purposes of this section, "any adjustment" includes . . . statutory increases, decreases, or reductions in the maximum aid level in the county under the Aid to Families with Dependent Children program.
>
> (e) In the event that adjustments pursuant to Section 11450.02 are not made, the amounts established pursuant to subdivision (a) may be adjusted to reflect the relative cost of housing in various counties as follows: [all counties are put into one of three groups, with one group allowed a reduction of 1.5 percent, another group allowed a reduction of 3 percent, and the last group a reduction of 4.5 percent]. . . .

of lower payment levels being judged sufficient in three ways: First, by expressly allowing downward adjustments to the federally-linked county guideline;[113] second, by expressly allowing the value of in-kind aid to be included in the county's general assistance standards;[114] and third, by specifying additional payment reductions that could be made according to the county's "relative cost of housing."[115] Lastly, the Legislature stated its intent to abrogate existing county agreements, including court-ordered stipulated judgments, concerning payment of general assistance grants above specified levels.[116] The reason given by the Legislature for this abrogation of county agreements was an unanticipated fiscal emergency in California affecting counties' ability to provide welfare services.[117]

During the summer of 1993, the Legislature and Governor again struggled with painful realities while trying to fashion a budget for the 1993-94 fiscal year.[118] One of the techniques the State used to balance

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1992 Cal. Legis. Serv. ch. 719, sec. 13, at 2887 (amending CAL. WELF. & INST. CODE § 17000.5); 1992 Cal. Legis. Serv. ch. 721, sec. 1, at 2896 (amending CAL. WELF. & INST. CODE § 17000.5); 1992 Cal. Stat. ch. 722, sec. 139, at 3011 (amending CAL. WELF. & INST. CODE § 17000.5).

113. CAL. WELF. & INST. CODE § 17000.5 (d) (West 1992). The adjustments are linked to statutory changes in the maximum aid level in the Aid to Families with Dependent Children (AFDC), a federal-state program whose maximum payment levels were decreased by 4.5% by the 1992-93 budget legislation, effective October 1, 1992. Memorandum from F. Patrick Sutherland, Chief, AFDC Policy Implementation Bureau, to All County Welfare Directors 1 (Sept. 2, 1992) (copy on file with the *Pacific Law Journal*).

114. CAL. WELF. & INST. CODE § 17000.5 (a) (West 1992). This allows a county that provides, for example, soup kitchens or homeless shelters to deduct the value of those services from a participant's general assistance payments. Although the value of medical care provided to indigents could, theoretically, be treated as aid whose in-kind value can be deducted from general assistance payments, the official staff analysis of this legislation makes no mention of this possibility, and the parties negotiating this language never spoke of including the value of medical care as an "in-kind aid" deduction. ASSEMBLY STAFF, ANALYSIS OF CONCURRENCE IN SENATE AMENDMENTS TO AB 1012, AS AMENDED August 19, 1992, File Number 029390; Telephone Interview with Frank Mecca, Executive Director, County Welfare Directors Association of California (Oct. 27, 1992) (copy on file with the author).

115. CAL. WELF. & INST. CODE § 17000.5(e) (West 1992).

116. *Id.* § 17000(a) (West 1992). The Legislature finds and declares that there is a fiscal emergency in the State of California, which was not anticipated and that affects the ability of counties to provide welfare services in the state. *Id.* Counties that have entered into agreements, including court-ordered stipulated judgments, which require the payment of general assistance grants above the amounts provided under [the California law governing AFDC payments] will suffer serious consequences if forced to maintain those levels. *Id.* Therefore, it is the intent of the Legislature to abrogate the provisions of existing agreements, including court-ordered stipulated judgments, that require counties to provide general assistance grants above the current [AFDC] levels. . . . *Id.* § 17000(b) states that the provisions of any agreement, including a court-ordered stipulated judgment, that requires a county to provide a monthly general assistance grant greater than the [AFDC] amount . . . are null and void. 1992 Cal. Legis. Serv. ch. 721, sec. 2, at 2896 (declaring legislative intent).

117. 1992 Cal. Legis. Serv. ch. 721, sec. 2, at 2896 (amending CAL. WELF. & INST. CODE § 17000.5).

118. According to projections from the California Commission on State Finance, there was an $11.3 billion gap between expected revenues and what it would cost to fully fund government services at the prior year's level. CALIFORNIA SENATE OFFICE OF RESEARCH, AN OVERVIEW OF THE BUDGET SOLUTION FOR 1993-94 1 (July 1, 1993) (copy on file with the *Pacific Law Journal*).

the budget was to shift $2.6 billion in tax revenues from local governments to schools.[119] At the same time, a number of state mandates on local government were suspended, eliminated, or reduced in scope.[120] During this time, legislation was drafted that, if enacted, will, for the third consecutive year, adversely affect the minimum standards for county relief imposed by section 17000.[121] This pending legislation will add yet another section to the Welfare and Institutions Code,[122] this one allowing a county in significant financial distress to reduce its level of general assistance aid to forty percent of the federal poverty level.[123] To show significant distress, a county must make a compelling case that it would not be able to maintain basic county services, including public safety, if aid levels were set at a higher level.[124] The pending law would also make an explicit link between section 17000 and outside standards of indigent medical care by expressly stating that Welfare and Institutions Code sections 10000, 17000, and 17001 do not require a county to provide or pay for a service not offered by Medi-Cal.[125]

C. Welfare and Institutions Code "General Provisions": Section 10000

Section 10000 first appeared in the Welfare and Institutions Code when the code was extensively revised in 1965.[126] The two amendments made since that time both occurred in 1975, when "sex"[127] and "marital status"[128] were added to that statute's anti-discrimination provisions. Section 10000 also contains codified legislative intent that county assistance be provided "promptly and humanely."[129] As discussed

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119. *Id.*

120. For an overview of 1993-94 state budget "mandate relief" for local government, see CALIFORNIA SENATE OFFICE OF RESEARCH, AN OVERVIEW OF THE BUDGET SOLUTION FOR 1993-94 11-16 (July 1, 1993) (copy on file with the *Pacific Law Journal*).

121. 1993 Cal. Legis. Serv. ch. 72, sec. 1, at 905-06 (enacting CAL. WELF. & INST. CODE §§ 17000.6).

122. *Id.*

123. *Id.*

124. *Id.*

125. *Id.* (enacting CAL. WELF. & INST. CODE § 17030.1).

126. *See* 1965 Cal. Stat. ch. 1784, sec. 5, at 3978.

127. *See* 1975 Cal. Stat. ch. 442, sec. 1, at 938 (amending CAL. WELF & INST. CODE §§ 10000, 18907).

128. *See* 1975 Cal. Stat. ch. 1129, sec. 8, at 2775 (amending CAL. WELF & INST. CODE § 1760.4).

129. *See* CAL. WELF. & INST. CODE § 10000 (West 1992). The entire text of § 10000 reads as follows:

> The purpose of this division 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. It is the legislative intent that aid shall be administered and services provided promptly and humanely, with due regard for the

below,[130] the "humane" standard has been used in several court decisions to determine the minimum standard for a county's medical care and other assistance to its indigents.[131]

III. SECTION 17000 AND STANDARDS FOR COUNTY INDIGENT AID PROGRAMS

After reviewing the history and current text of the three most important statutes concerning standards for county indigent care—the Beilenson Act, section 17000, and section 10000—we now turn to the court decisions that have interpreted and applied these statutes. This Article concentrates on those decisions regarding legal standards for county assistance to indigents, particularly decisions that were made within the last two decades and involve standards for access to and availability of medical care.

A. A General View of County Discretion

How much discretion do counties have in their design and administration of indigent aid programs? Although counties traditionally have been seen as agents of the state without a clearly independent political existence,[132] courts have also recognized that the local general assistance program allows counties "unique" discretion because its funding and administration largely comes from the individual counties.[133] One clear legal requirement, however minimal, is based on the section 17001 mandate that counties adopt *some* standards of indigent aid and care.[134]

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preservation of family life, and without discrimination on account of race, national origin or ancestry, religion, sex, marital status, or political affiliation; and that aid shall be so administered and services so provided as to encourage self-respect, self-reliance, and the desire to be a good citizen, useful to society.

Id.

130. *See infra* note 215-231 and accompanying text (discussing basic human needs and the *Cooke* case).

131. Section 10000 also includes a phrase that appeared and then disappeared in the legislative history of § 17000, then reappeared later when § 10000 entered the California Welfare and Institutions Code. This phrase, requiring that county aid be provided as to "encourage self respect," has always been part of § 10000. This language had also existed in the 1933 predecessor to California Welfare and Institutions Code § 17000. 1933 Cal. Stat. ch. 761, sec. 1, at 2005. This language was removed when the California Welfare and Institutions Code was established in 1937. 1937 Cal. Stat. ch. 464, sec. 1, at 1406 (enacting CAL. WELF. & INST. CODE §§ 2500-2615).

132. Jacobus tenBroek & Richard B. Wilson, *County of Los Angeles v. State Social Welfare Department —A Criticism*, 41 CAL. L. REV. 499, 503 (1953).

133. Boehm v. Superior Court, 178 Cal. App. 3d 494, 499, 223 Cal. Rptr. 716, 719 (1986).

134. CAL. WELF. & INST. CODE § 17001 (West 1991).

In *City & County of San Francisco v. Superior Court*,[135] the court held that section 17001's requirements invalidated a county's assistance program only when the county in question had not adopted any discernible aid standards at all.[136] This lack of standards forced the Department of Social Services to "divide among the indigent and dependent poor such sums as the mayor and the Board of Supervisors had deigned to appropriate."[137] Even when the *City & County of San Francisco* court found an absence of any standards adopted by the Board of Supervisors, this seems to have been only part of the reasoning behind the ruling against the county.[138] There were three other facts that the court thought worth mentioning in its opinion.[139] First, the county had much lower general assistance grant levels than surrounding counties. Second, the county's Department of Social Services had reduced monthly assistance grants from $110 to $83. Third, the board of supervisors of the county—in this case, San Francisco—may have acted from improper motives because they were "besieged at the time by rumors of a mass 'hippie' invasion of the city."[140]

However, it is clear that counties must adopt some guidelines for indigent assistance, the counties do have considerable discretion in the manner in which they develop program standards and the content of those standards. The general direction of California case law has been one of decreasing judicial deference to county decisions concerning their indigent assistance programs.[141] At least until the 1991, 1992, and 1993, statutory changes affecting section 17000 and the Beilenson Act spoke specifically to questions previously addressed only in case law.[142]

The following discussion of recent case law is organized around several questions regarding the legal sufficiency of a county's standards for meeting its indigent assistance obligations, particularly those involving

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135. 57 Cal. App. 3d 44, 128 Cal. Rptr. 712 (1976).

136. City & County of San Francisco v. Superior Court, 57 Cal. App. 3d 44, 47, 128 Cal. Rptr. 712, 715 (1976).

137. *Id.* at 49, 128 Cal. Rptr. at 717.

138. *Id.*

139. *Id.*

140. *Id.*

141. *See* Los Angeles County v. Department of Social Welfare, 41 Cal. 2d 455, 458, 260 P.2d 41, 44 (1953); Los Angeles County v. Frisbie, 19 Cal. 2d, 634, 639, 122 P.2d 526, 529 (1942); Patten v. San Diego County, 106 Cal. 2d 467, 470, 235 P.2d 217, 219 (1951); Madison v. City and County of San Francisco, 106 Cal. 2d 232, 243, 234 P.2d 995, 1003 (1951). *See generally* Kerry R. Bensinger, *From Public Charity to Social Justice: The Role of the Court in California's General Relief Program*, 21 LOY. L.A. L. REV. 497, 509-10 (1988) (explaining that modern courts are far from deferential to county judgments).

142. *See supra* note 92-125 and accompanying text (providing a summary of these statutory changes).

health care. These questions analyze eligibility requirements for county assistance, whether there is a minimum procedural requirement for counties to assess their indigent residents' needs before adopting assistance standards, the extent to which a county's budget problems can be part of the decision about standards for assisting that county's indigent residents and what the minimum standards are for services or assistance provided by the county.

B. Eligibility Requirements for County Assistance

Before considering the type and amount of indigent support that counties must provide, there must be consideration of the county's process of determining people's eligibility to receive that support.[143] First, it is important to determine who the incompetent, poor, and indigent people are who benefit from section 17000's mandate. This Article concentrates on the "indigent" part of that descriptive triad,[144] focusing on those indigent people in California who must rely on the county for food, shelter, and medical care because they do not receive services under AFDC, Medi-Cal, or other federally-funded programs. These are the people who are truly members of a "silent, largely invisible" class,[145] the people who rely on section 17000's mandate that local government provide for their subsistence needs. One legal commentary defines "medically indigent" to mean "the class of people who cannot afford necessary medical care from their own resources or from health insurance coverage, if any."[146] This commentary, however, noted the difficulty of agreeing on the elements of medical indigence such as necessary care and poverty.[147] The Beilenson Act's former "community standard" language contained the closest to a

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143. AVEDIAS DONABEDIAN, BENEFITS IN MEDICAL CARE PROGRAMS 3 (Harv. Univ. Press 1976); *see id.* (stating that, "[i]n considering any medical care program . . . the scope of benefits and the conditions governing eligibility are so intimately related that it is difficult to speak of one feature without becoming involved, to some extent, in the other").

144. This follows the practice of most case law and legal commentary. *See, e.g.*, Boehm v. Superior Court, 178 Cal. App. 3d 494, 497, 223 Cal. Rptr. 716, 717 (1986) (describing the counties determination of needs of its "indigent residents"); Guidotti v. County of Yolo, 214 Cal. App. 3d 1552, 1555, 271 Cal. Rptr. 858, 859 (1989) (describing plaintiffs as "indigent residents of County"); Cooke v. Superior Court, 213 Cal. App. 3d 401, 404, 261 Cal. Rptr. 706, 707 (1989) (stating that "[i]n this case we consider the level of dental care counties must furnish to indigent residents in order to comply with Welfare and Institutions Code §§ 10000 and 17000").

145. *See supra* note 1 and accompanying text (quoting from Emily Friedman, *The Torturer's Horse*, 261 JAMA 1481 (March 1989)).

146. Bovberg & Kopit, *supra* note 11, at 859.

147. *Id.* at 859 n.9. "Opinions vary greatly on how much medical care is truly needed, on how poor one must be to be truly needy, and on what constitutes inadequacy in insurance." *Id.*

statutory definition of medical indigence in California. Even this language, however, implied rather than stated a definition of "indigent" by referring to "people who cannot afford to pay for their health care," and then contrasting them to "non-indigent people."[148] Although it is difficult to find case law speaking to the definition of indigent, one court has addressed that word's relationship to the other two words used by section 17000: "incompetent" and "poor."[149] The court asked whether these three words should each represent separate eligibility requirements for county assistance, or whether an applicant could qualify by meeting only one of these descriptors.[150] The court took the latter view.[151] It rejected the county's "strained" interpretation of section 17000 that read the statute in the conjunctive—i.e., that to receive aid an applicant must be "poor, indigent *and* incompetent . . . [emphasis in original]."[152] The court did not permit the county to exclude from aid people not considered incompetent.[153]

Even though section 17000 does not define indigence, poverty, or incompetence, it does make clear that the category of aid recipients it defines is a residual one, consisting of people not otherwise receiving private or public assistance.[154] The residual character of section 17000 aid was discussed in *Guimbellot v. Caulk*,[155] a 1992 trial court decision concerning Sacramento County's proposed restrictions on eligibility for county medical assistance. One of the ways in which the county proposed to limit access to its medical assistance program was to exclude people eligible for Medi-Cal.[156] Although the court did not dispute that some Medi-Cal eligibles may not be able to obtain medical care if insufficient numbers of private providers accept Medi-Cal reimbursement,[157] the

148. 1992 Cal. Legis. Serv. ch. 719, sec. 2, at 2881-82 (amending CAL. HEALTH & SAFETY CODE § 1442.5).

149. Mooney v. Pickett, 4 Cal. 3d 669, 676, 483 P.2d 1231, 1235 (1971).

150. *Id.*

151. *Id.*

152. *Id.* The county had further interpreted "incompetent" to mean "unemployable" and disqualified employable people. *Id.*

153. *Id.* "[T]hese sections [of California law] contemplate that General Assistance will be given to recipients who are neither unemployable nor legally incompetent." *Id.* (citing California Welfare and Institutions Code § 11000).

154. CAL. WELF. & INST. CODE § 17000 (West 1992). Counties are required to assist people "not supported and relieved by their relatives or friends, by their own means, or by state hospitals or other state or private institutions." *Id.*

155. Guimbellot v. Caulk, No. 530286 (Sup. Ct. Sac. County 1992) (memorandum and order granting preliminary injunction) (copy on file with the *Pacific Law Journal*).

156. *Id.* at 8.

157. *Id.* at 8.

court found that Medi-Cal alleviates the county's section 17000 obligation to people eligible for that federal-state program.[158]

In the same trial court decision, another eligibility question spoke directly to the relationship between a county's responsibility to meet its indigents' medical needs and its responsibility for other basic needs. On November 1, 1992, Sacramento County used the newly enacted statutory formula for general assistance payment levels[159] to redefine financial eligibility for its indigent medical care program.[160] These new eligibility criteria excluded people with monthly incomes that exceeded approximately sixty-two percent of the federal poverty level.[161] The trial court enjoined the county from using these new guidelines, rejecting the county's claim that the statutory formula for setting a standard of indigent assistance includes medical services.[162] The court noted that the county addresses indigents' medical needs through a separate program, thereby demonstrating county intent that the general assistance standard not be deemed a sufficient standard of aid for medical assistance.[163] Although the court did not explicitly call for a factual assessment of medical needs as the basis for the new eligibility guidelines,[164] it criticized the county's presumption "on the basis of speculation rather than facts" that any person with income beyond the general assistance standard is able to meet his or her subsistence medical needs.[165]

C. Needs Assessment

Until enactment of section 17000.5's formula option, the substantive question of what constitutes a minimum standard of county assistance often became intertwined with, or even secondary, to the procedural

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158. *Id.* at 9. The court also noted that even if the county has no legal obligation to Medi-Cal eligibles unable to find providers, the county may have "public policy" obligations to try to increase the number of providers accepting Medi-Cal patients. *Id.*

159. *See* CAL. WELF. & INST. CODE § 17000.5 (West Supp. 1993).

160. *Guimbellot*, No. 530286, at 5.

161. Sixty-two percent of the federal poverty level translates into $298 of monthly income for a person living alone. Sacramento County's formula, like that of California Welfare and Institutions Code § 17000.5, adjusted this base figure (62%) for reductions in AFDC benefit levels and for a regional housing differential. *Id.* at 5.

162. *Id.* at 6 n.1.

163. *Id.* at 6.

164. *See infra* notes 178-191 and accompanying text (discussing of the case law requirement that counties make a factual study of indigents' needs prior to adopting general assistance standards).

165. Guimbellot v. Caulk, No. 530286 (Sup. Ct. Sac. County 1992) (memorandum and order granting preliminary injunction) (copy on file with the *Pacific Law Journal*).

question of *how* counties arrive at a standard. The body of case law developed around indigent needs assessment requirements now seems less relevant for counties that choose to use the statutory formula to set general assistance standards. However, this body of law remains applicable to counties that choose not to use the statutory formula. In addition, important questions remain concerning the indigent medical care component of the section 17000 mandate,[166] especially after partial repeal of the Beilenson Act's procedural requirements for counties proposing to reduce health services or close health facilities.[167] The key case concerning county needs assessments is *Boehm v. County of Merced*,[168] the first decision to require expressly that counties conduct a factual assessment of indigents' needs prior to reducing county assistance.[169]

Boehm, published in 1985, involved Merced County's 1983 reduction in monthly general assistance grant levels from $198 to $175 per person.[170] There was no dispute that the Board of Supervisors had no factual study of subsistence needs of Merced County's indigents on which to base its reduced grant levels. Thus, the court concluded that the Board could not have determined whether its reductions were the "fat trimming" that they claimed them to be or were instead a "chiseling of the indigents' bones."[171] The essential components of such a factual study were spelled out more clearly when the same parties appeared in court the following year, after the county had completed the required study of minimum subsistence needs.[172] This time, the court criticized the county's study because it had included only food and housing costs, while the court found

166. *See supra* notes 155-165 and accompanying text (discussing *Guimbellot v. Caulk*).

167. Although neither case nor statutory law speak directly to the relationship between the procedural requirements implied by § 17000 and those stated in the Beilenson Act, counties whose health cutbacks triggered Beilenson requirements presumably fulfilled the indigent needs assessment implied by § 17000 when those counties following Beilenson procedures for advance notice and prior public hearing. *See generally* CAL. HEALTH & SAFETY CODE § 1442.5 (West Supp. 1993) (describing the procedure required for closing a public health care facility).

168. 163 Cal. App. 3d 447, 452, 209 Cal. Rptr. 530, 532 (1985). The needs assessment requirement articulated in this decision has been so closely associated with the *Boehm* decision that some later courts referred to a needs assessment as a "*Boehm* study." *See also* Scates v. Rydingsword, 229 Cal. App. 3d 1085, 1088, 280 Cal. Rptr. 544, 545 (1991); Oberlander v. County of Contra Costa, 11 Cal. App. 4th 535, 541, 15 Cal. Rptr. 2d 182, 185 (1992).

169. "[O]ur primary concern in this case is whether the [county] board [of supervisors] acted arbitrarily in reducing the general assistance payments without having made a factual determination of the minimum subsistence needs of its indigent residents." Boehm v. County of Merced, 163 Cal. App. 3d 447, 452, 209 Cal. Rptr. 530, 532 (1985).

170. *Id.* at 449, 209 Cal. Rptr. at 531.

171. *Id.* at 452, 209 Cal. Rptr. at 533.

172. Boehm v. Superior Court, 178 Cal. App. 3d 497, 223 Cal. Rptr. 716 (1986).

that general assistance grants should cover other items such as utilities, clothing, transportation, and medical care.[173] Any grant levels that do not account for all of these needs must be based on a study showing how other programs could meet the omitted need.[174]

Subsequent cases from other appellate courts further refined the methodological standards for county assessments of indigent assistance needs. One case criticized a county housing study that grouped together housing costs for people in different living situations.[175] The court was specifically troubled that the county's methodology implied that general assistance recipients must share housing because the study methodology failed to distinguish between people who lived alone and those who shared housing.[176] Another case involved a challenge to general assistance payment levels based on surveys of food and shelter costs that used assumptions that county critics alleged to be faulty. Here, the court found that the county had not met its obligation to determine *actual* costs of subsistence.[177]

Two court cases involving application of section 17000 in Northern California counties were published only months before enactment of a new statute, Welfare and Institutions Code section 17000.5, added specifics to the broad mandate of section 17000.[178] One of these cases raised the question of whether Contra Costa County was required to perform an indigent needs assessment before it could discontinue its emergency assistance program for homeless people.[179] The appellate court held that this program was not one intended by the county to address its section 17000 responsibilities, but was instead a discretionary supplement to

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173. *Id.* at 501-02, 223 Cal. Rptr. at 721.

174. *Id.* Note how this foreshadows the 1992 amendments to California Welfare and Institutions Code § 17000.5 regarding the value of in-kind aid.

175. Guidotti v. County of Yolo, 214 Cal. App. 3d 1522, 1565, 271 Cal. Rptr. 858, 866 (1989).

176. *Id.* at 1564, 271 Cal. Rptr. at 866.

177. Poverty Resistance Ctr. v. Hart, 213 Cal. App. 3d 295, 303, 271 Cal. Rptr. 214, 219 (1989). "When the general assistance grant level standard is challenged as insufficient by comparison with other government indices of poverty the standard must be justified by an identified factual predicate concerning the *actual* costs of subsistence within the county [emphasis in original]." *Id.* Note that the court's comparison between general assistance standards and "other government indices of poverty" foreshadowed the linkage to federal poverty levels made by California Welfare and Institutions Code § 17000.5.

178. Whitfield v. Board of Supervisors, 227 Cal. App. 3d 451, 277 Cal. Rptr. 815 (1991), *review denied*, April 17, 1991; Scates v. Rydingsword, 229 Cal. App. 3d 1085, 280 Cal. Rptr. 544 (1991). The legislation adding California Welfare and Institutions Code § 17000.5 was enacted on June 30, 1991. 1991 Cal. Legis. Serv. ch. 91, sec. 34, at 410 (enacting CAL. WELF. & INST. CODE § 17000.5).

179. *Scates*, 229 Cal. App. 3d at 1091, 280 Cal. Rptr. at 547.

general assistance.[180] This kind of supplementary program was not subject to the same legal requirements as a section 17000 program, including the requirement of a needs assessment.[181]

The other case also involved a needs assessment, but differed from the Contra Costa case in that the issue before the court was more directly addressed by section 17000.5's subsequent enactment. In this case, *Whitfield v. Board of Supervisors*,[182] the plaintiffs challenged the Alameda County Board of Supervisors' 1986 adoption of an ordinance implementing an agreement with Legal Aid.[183] The agreement committed the county to set its general assistance grant at $1 less than the state Aid to Families with Dependent Children (AFDC) payment levels.[184] When indigent plaintiffs filed suit against the county in November 1989,[185] the county grant level was $340 per month.[186] Plaintiffs challenged the ordinance because it was not based on any factual study of actual subsistence costs in Alameda county.[187] They sought to compel the county to conduct a factual study of minimum subsistence needs.[188]

The court found for the plaintiffs, stating that the county had "impermissibly abdicated all responsibility for setting a standard of aid and care . . . as mandated by section 17001" because it had not based its payments on a current study of actual subsistence costs in Alameda county.[189] Although the court found it understandable that the county would want to simplify its process of setting general assistance standards by negotiating with the local legal aid society and following the state's AFDC grant levels, these actions were held to be an arbitrary and capricious manner of setting the county's general assistance grant levels.[190] It seems ironic and not coincidental that several months after the *Whitfield* decision invalidated a county's decision to tie general

180. *Id.* A spirited dissent by Justice Kline disagreed with this holding, finding "absurd" the county's argument that the question before the court was whether or not the county had *intended* that the emergency assistance program help discharge its § 17000 obligations. *Id.* at 1106, 280 Cal. Rptr. at 557.

181. *Id.* at 1098, 280 Cal. Rptr. at 552.

182. 227 Cal. App. 3d 451, 277 Cal. Rptr. 815 (1991).

183. Whitfield v. Board of Supervisors, 227 Cal. App. 3d 451, 453, 277 Cal. Rptr. 815, 816 (1991).

184. *Id.* at 455, 277 Cal. Rptr. at 817.

185. *Id.* at 453, 277 Cal. Rptr. at 816. Unlike plaintiffs in most other cases discussed in this Article, these plaintiffs were not represented by Legal Aid, but instead by the Bay Area Legal Foundation.

186. *Id.* at 455, 277 Cal. Rptr. at 817.

187. *Id.*

188. *Id.*

189. *Id.* at 460, 277 Cal. Rptr. at 821.

190. *Id.*

assistance grant levels to AFDC grant levels, a new statute was enacted that specifically allowed counties this option.[191]

D. County Budget Considerations

Although many courts have publicly acknowledged counties' difficulties in meeting their indigent care responsibilities during tight budget times, the majority view[192] does not accept budget constraints as a valid justification for section 17000 eligibility restrictions or limits on assistance and care.[193] In fact, one court stated that:

> It is clear that section 17000 imposes upon the [county] a mandatory duty to relieve and support its indigents, and the excuse that it cannot afford to do so is unavailing . . . [citations to California Supreme Court decisions omitted]. In each of these cases, the supreme court considered the plight of the taxpayers, but in each case concluded that their burdens were not so grievous as to permit indigents, in the midst of plenty, to go hungry, cold and naked, without fault.[194]

If budget constraints require that a county cut back on its support for section 17000 indigents, courts have required that the county be prepared to show that it still meets these people's minimum subsistence needs for

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191. 1991 Cal. Legis. Serv. ch. 91, sec. 34, at 410 (enacting CAL. WELF. & INST. CODE § 17000.5). Although the language of § 17000.5 as originally enacted spoke of tying general assistance levels to 62% of the federal poverty level, this standard was chosen because it was the AFDC payment level for a family of one, which was the standard used for general assistance levels in many counties under court order at that time. Telephone interview with Carol Wallisch, Senior Consultant to the Assembly Health and Human Services Committee (April 5, 1993) (copy on file with the author).

192. *See* Mooney v. Pickett, 4 Cal. 3d 669, 680, 1483 P.2d 1231, 1238, 94 Cal. Rptr. 279, 286 (1971); Cooke v. Superior Court, 213 Cal. App. 3d 401, 413-14, 261 Cal. Rptr. 706, 714 (1989); Poverty Resistance Ctr. v. Hart, 213 Cal. App. 3d 295, 303, 271 Cal. Rptr. 214, 219 (1989); Boehm v. Superior Court, 178 Cal. App. 3d 494, 503, 223 Cal. Rptr. 716, 722 (1986); City and County of San Francisco, 57 Cal. App. 3d 44, 45-47, 128 Cal. Rptr. 712, 714-15 (1976).

193. Proposition 165, which was rejected by the California electorate when it appeared on the November 1992 ballot, attempted to repeal this part of the § 17000 case law by adding a new subdivision to § 17000 stating that the county Board of Supervisors shall set general assistance grants levels "in its sole discretion, taking into consideration the availability of county . . . funds for such aid. . . ." The Initiative Constitutional Amendment, Prop. 165, § 19 (November 1992).

194. *City and County of San Francisco*, 57 Cal. App. 3d at 44-45, 128 Cal. Rptr. at 714-15.

each of the basic necessities of life.[195] It seems appropriate that the court decision containing language most sympathetic to county budget problems was based on a factual situation in Butte County, which later came to the brink of declaring bankruptcy.[196] The court stated that, "[f]or whatever reason, the Legislature has seen fit to place a large portion of the burden of caring for the indigent upon those units of government — the counties — least able to generate necessary revenues."[197] Even the court hearing Butte County's case, however, firmly rejected the county's budget-based arguments, finding that these arguments were not a defense to the county's statutory obligation to provide benefits to indigent residents.[198]

Washington v. Board of Supervisors[199] is the one judicial decision that has allowed a county's defense of fiscal impossibility to justify standards of indigent care that would otherwise be unacceptable.[200] In *Washington*, plaintiffs alleged that San Diego County violated sections 17000 and 10000 of the Welfare and Institutions Code when it imposed a three month time limit on general relief payments to employable recipients.[201] The court acknowledged that this limit would appear unlawful and that case law has historically rejected a budget-based defense of county regulations that violate the requirements of sections 10000 and 17000.[202] Even so, the *Washington* court was clearly influenced by its factual findings that the county's three-month limit was precipitated and driven by fiscal considerations[203] and that the county would have to further reduce expenditures in other programs "of critical importance to the overall health, safety and welfare of this County" if the county could not realize the cost savings expected from that time limit.[204] The *Washington*

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195. One court stated that, "[t]his court is not unmindful of the fiscal restraints imposed by Proposition 13 and the consequent need for strict control of all county expenditures. However, budgetary constraints cannot justify excluding from minimum subsistence grants to the indigent allowance for each of the basic necessities of life. . . ." *Boehm*, 178 Cal. App. 3d at 503, 223 Cal. Rptr. at 722.

196. The near-bankruptcy of Butte County in late 1989 brought increased public attention to many counties' precarious fiscal condition. SIMPSON & JUNG, *supra* note 37, at xi, 26-27.

197. Cooke v. Superior Court, 213 Cal. App. 3d 401, 413, 261 Cal. Rptr. 706, 713-14 (1989).

198. *Id.* at 414, 261 Cal. Rptr. at 714. The court stated: "A lack of funds is no defense to a county's obligation to provide statutorily required benefits. . . ." *Id. Accord* Mooney v. Pickett, 4 Cal. 3d 669, 680, 483 P.2d 1231, 1238, 94 Cal. Rptr. 279, 286 (1971); Poverty Resistance Ctr. v. Hart, 213 Cal. App. 3d 295, 303, 271 Cal. Rptr. 214, 219 (1989).

199. No. 647805 (Sup. Ct. S.D. County 1992) (statement of intended decision) (copy on file with the *Pacific Law Journal*).

200. *Id.*

201. *Id.* at 4.

202. *Id.* at 16.

203. *Id.* at 9.

204. *Id.* at 13.

court's approval of San Diego County's actions is based on somewhat confusing reasoning that seems to approve a budget-based defense while also arguing in the alternative that the aid limitation for employable indigents did meet the standards articulated in section 10000.[205] In this alternative analysis, the court acknowledged well settled case law that a county cannot deny an indigent person assistance merely because the resident is employable.[206] Then the court characterized the county's limitation as "not inherently inhumane" and as a motivation for employable aid recipients to find work and reduce welfare dependency, thereby enhancing a statutory scheme that is meant to promote self-respect and a desire to become a useful member of society.[207]

The *Washington* court characterized the fiscal impossibility defense as a reasonable one that challenged the county raising this defense to present sufficient evidence that the money saved from indigent assistance reductions was not available from other sources without causing substantial harm to other programs of "equal importance and significance" to the overall health, welfare and safety of county residents[208] The court found that the county had presented sufficient evidence to support its defense of fiscal impossibility.[209] This trial court's approval of a budget defense to justify an otherwise impermissible reduction of indigent assistance was a significant departure from the prior case law. However, it appears to have laid the basis for proposed 1993 statutory changes only a short time later that will expressly allow a county in "significant financial distress" to reduce its general assistance payment levels below the amount that would otherwise be "sufficient."[210]

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205. *Id.*

206. *Id.* at 13 (citing *Mooney v. Pickett*, 4 Cal. 3d 669 (1971)).

207. *Id.* at 15. Section 10000 reads, in pertinent part:

> It is the legislative intent that aid shall be administered and services provided promptly and humanely . . . and that aid shall be so administered and services so provided as to encourage self-respect, self-reliance, and the desire to be a good citizen, useful to society.

CAL. WELF. & INST. CODE § 10000 (West 1991).

208. Washington v. Board of Supervisors, No. 647805 at 17 (Sup. Ct. S.D. County 1992) (statement of intended decision) (copy on file with the *Pacific Law Journal*).

209. *Id.*

210. 1993 Cal. Legis. Serv. ch. 72, sec. 1, at 905-06 (enacting CAL. WELF. & INST. CODE §§ 17000.6) (copy on file with the *Pacific Law Journal*); *see supra* notes 118-125 and accompanying text (discussing the 1993 statutory changes to the law governing what constitutes a "sufficient standard of aid" under § 17000).

IV. MINIMUM STANDARDS FOR MEETING HEALTH CARE NEEDS OF COUNTY INDIGENTS

The question of a minimum standard for indigent health care can be complicated when the words "standard of care" are used to signify different ideas.[211] The first, more traditional, use of those words alludes to the requirement that a physician exercise the same skill and diligence for any patient, regardless of the patient's income or payment source.[212] A more recent usage of "standard of care" implies the amount and comprehensiveness of health care services available and accessible to indigent people. For example, the shorthand label often given to a recently repealed part of the Beilenson Act followed the second usage by calling this the "community standard of care" provision.[213] This Article does not address the first meaning of "standards of care," rather, it focuses attention on the amount or comprehensiveness of health care services available to indigent people. For this reason, the rest of this Article attempts to avoid linguistic confusion by referring to standards for "levels" of health care.[214] What is the minimum standard for the level of medical care that must be provided to a county's indigent residents? The remainder of this Article discusses the major appellate case on this point, summarizes some differences between the medical and non-medical components of counties' Section 17000 responsibility, and then presents a conceptual framework for past and potential approaches to setting a minimum standard for levels of indigent medical care.

A. *The* Cooke *Case*

Although section 17000 is the legal basis of a county's obligation to relieve and support its indigent residents, it is section 10000 that has played the more important role in case law discussion of the minimum

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211. Partly through an unfortunate linguistic coincidence, the legal standard of "care," which originally meant the degree of carefulness required to be non-negligent, has come to mean also what services themselves are appropriate. Bovberg & Kopit, *supra* note 11, at 916.

212. *See generally* Allan H. McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 555-56 (1959); Bovberg & Kopit, *supra* note 11, at 876.

213. *See supra* note 89 and accompanying text (describing the effect of the repeal of the community standard provision).

214. *See, e.g.*, Cooke v. Superior Court, 213 Cal. App. 3d 401, 415, 261 Cal. Rptr. 706, 714 (1989) (referring to which dental services were and were not provided to indigents when it wrote that "[Section 10000's requirement of] 'humane' care is that level of care which remedies [petitioners'] pain and infection. . . .").

standards for county relief.[215] *Cooke v. Superior Court*, the leading case on minimum standards for county health care for indigents, relied heavily on section 10000's commands that relief be "humane" and that "aid shall be so administered and services so provided . . . as to encourage self-respect, self-reliance, and the desire to be a good citizen useful to society."[216] The *Cooke* case is important because it provides appellate court guidance in distinguishing between an unacceptable and an acceptable standard for county assistance with health and dental care.

The facts in *Cooke* involve indigents in rural Butte County, which participates in the County Medical Services Program (CMSP) administered by the State of California.[217] The plaintiffs in *Cooke* were found to be eligible for the county's health care services, including dental care, but the county had refused to provide treatment for dental services the plaintiffs had requested.[218] The court noted that the county did not dispute the petitioners' assertions that they "suffered pain and infection and were unable to obtain treatment" from the county.[219] Butte County provided certain types of emergency care, but it did not cover any diagnostic, preventive, therapeutic, or restorative dental care to deal with pain or infection.[220] One plaintiff, Ms. Cooke, had a painful front tooth but had been unable to have root canal work done because she could not afford a private dentist's fee and the county had denied this service because it covered only emergency extractions.[221] Another plaintiff had a painful tooth caused by a lost filling, but had been informed that the county did not cover fillings.[222] A third plaintiff had a history of dental problems and cavities, and lost pieces of her teeth when eating anything crunchy.[223]

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215. Boehm v. Superior Court, 178 Cal. App. 3d 494, 500, 223 Cal. Rptr. 716, 719-20 (1986); City and County of San Francisco v. Superior Court, 57 Cal. App. 3d 44, 49, 128 Cal. Rptr. 712, 714-15 (1976); *see also* CAL. WELF. & INST. CODE § 11000 (West 1991) (providing a secondary statute is § 11000, which states that "[t]he provisions of law relating to a public assistance program shall be fairly and equitably construed to effect the stated objects and purposes of the program." For reference to § 11000 in the context of § 10000, see *Boehm*, 178 Cal. App. 3d at 500, 223 Cal. Rptr. at 720; Washington v. Board of Supervisors, No. 647805 at 14 (Sup. Ct. S.D. County 1992) (statement of intended decision) (copy on file with the *Pacific Law Journal*).

216. *Cooke*, 213 Cal. App. 3d at 413-17, 261 Cal. Rptr. at 713-16.

217. *Id.* at 404-05, 261 Cal. Rptr. at 707-08. There are currently 34 County Medical Services Program (CMSP) counties, all of which have less than 300,000 residents. *See supra* notes 22-26 and accompanying text (providing a brief explanation of the CMSP program).

218. *Cooke*, 213 Cal. App. 3d at 405, 261 Cal. Rptr. at 708.

219. *Id.* at 406, 261 Cal. Rptr. at 708.

220. *Id.* at 405, 261 Cal. Rptr. 708.

221. *Id.*

222. *Id.*

223. *Id.* at 405-06, 261 Cal. Rptr. at 708.

The court rejected the plaintiffs' arguments made under the Beilenson Act that the county should provide them the same level of services available to private patients.[224] The *Cooke* court determined that the Act's requirements apply only when a county is closing facilities or reducing services, a situation which was not before the court.[225] The petitioner's argument that the county must provide the same level of dental care that was available through Medi-Cal was also rejected because the court found that the 1982 legislation that transferred Medically Indigent Adults from the Medi-Cal program to the counties and that created the CMSP program was intended to "eliminate persons from the Medi-Cal program, not to shift Medi-Cal standards to counties."[226] Even after declining to apply either the Beilenson Act's "private" standard or the Medi-Cal standard of care, the court found that Butte County's level of dental care fell short of statutory obligations because the county's standards for type of care available to indigents had not met Section 10000's requirement of humane care that encourages self-respect and self-reliance.[227]

After oral arguments were presented to the court but before publication of the court's decision, Butte County adopted a new resolution that increased the level of dental care coverage.[228] This resolution specifically allowed "dental services . . . necessary to alleviate substantial pain, to treat infection, to maintain basic function, to maintain adequate nutrition, and to care for dental conditions which present a serious health risk."[229] The court approved of this new standard, finding it sufficient "on its face" to satisfy sections 10000 and 17000.[230] At the same time, the court seemed anxious to limit the scope of a "humane" standard. Achieving "cosmetically pleasing teeth" was specifically excluded from this minimum

224. *Id.* at 409, 261 Cal. Rptr. at 710. Petitioners' argument was based on the portion of the Beilenson Act repealed in 1992. 1992 Cal. Legis. Serv. ch. 719, sec. 2, at 2881-82 (amending CAL. HEALTH & SAFETY CODE § 1442.5).

225. *Cooke*, 213 Cal. App. 3d at 410, 261 Cal. Rptr. at 711.

226. *Id.* at 412, 261 Cal. Rptr. at 713. *See supra* note 25-29 and accompanying text (discussing the legislation that transferred responsibility for Medically Indigent Adults from the state to the counties and created the CMSP program).

227. *Cooke*, 213 Cal. App. 3d at 415, 261 Cal. Rptr. at 714.

228. *Id.* at 415, 261 Cal. Rptr. at 715.

229. *Id.* at 416, 261 Cal. Rptr. at 715.

230. *Id.* at 416, 286 Cal. Rptr. at 716.

standard, with the reasoning that such a goal did not involve questions of pain and infection, and therefore, its denial was "not inhumane."[231]

B. Some Differences Between Medical and Non-Medical Components of Indigent Assistance

This Article provides several examples of the differences between treatment given to section 17000's general relief and support obligations, and treatment of its medical care component. For example, only the medical care component of a county's indigent care obligation has been subject to separate statutory provisions imposing more specific procedural and substantive language regarding a county's obligations when it reduces its level of indigent health care services.[232] Only the medical care component was benefitted by the annual distribution of approximately $500 million dollars in new cigarette tax funds and the accompanying maintenance of effort requirements for counties accepting those funds.[233] In 1991 and 1992, when major changes were made to the statutes affecting section 17000, these changes provided a more specific option for counties' general assistance payment levels, but they were silent on the medical care component of section 17000.[234]

There are several possible explanations for the different treatment given to medical and non-medical components of section 17000's mandate. First, there is the practical difference between the manner in which a county meets the basic medical and non-medical needs of its indigents. Indigent people typically receive medical care directly from county-reimbursed providers such as county hospitals or clinics, but are usually expected to meet their non-medical needs (e.g., housing, food, and clothing), with the cash available from the county's general assistance payments. The more direct provision of medical services provides two implicit assurances to the

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231. *Id.* at 415, 261 Cal. Rptr. at 714-15. The court also commented on an interesting issue raised implicitly by a petitioner who was denied cosmetic dental care and argued it affected her "employability." *Id.* The court questioned whether counties have a legal or other obligation to provide medical care that promotes their indigent residents' ability to find jobs. *Id.* The *Cooke* court's observation that "[m]any people survive in the workplace in a wide variety of occupations with imperfect teeth" is irrelevant to the court's stated standard of "humane" care, but the court does speak, in dicta, to a broader standard that would promote employability. *Id.*

232. *See supra* notes 74-90 and accompanying text (discussing the Beilenson Act's history and current provisions).

233. *See infra* notes 248-254 and accompanying text (discussing the funds and requirements of Proposition 99).

234. *See supra* notes 105-117 and accompanying text (discussing California Welfare and Institutions Code § 17000.5 and the implications of this new statutory language for county indigent medical care).

general public: (1) that county money is spent on the intended service[235] and (2) that the services received are adjusted to that particular person's needs.[236] In addition, the fact that an indigent person who is ill or injured receives more medical care services than a healthy person has seemed acceptable not only because such a system allows adjustment for that particular person's needs, but also because a sick or disabled person is generally regarded as more worthy of aid and less at fault for being indigent.[237]

Another possible explanation for the different handling of medical and non-medical components of indigent aid reflects the political power[238] and social prestige[239] possessed by medical care providers. Indigent people receive health care from hospitals and physicians, while an indigents' non-medical needs are met by a more diffuse and less powerful collection of people, typically including landlords, store owners, and other small business people. Poor people's lack of access to publicly financed medical care is transformed into their medical care providers' problem of

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235. Although general assistance grant levels are set at an amount that accounts for indigent people's basic needs, cash grant recipients can spend their grants however they choose. In contrast, these same people cannot "spend" their eligibility for medical care on anything except actual receipt of health-related services.

236. County general assistance payments are typically adjusted by only two or three pieces of information such as household size, whether housing is shared, and the cost of living in that geographic region. *See, e.g.*, CAL. WELF. & INST. CODE § 17000.5 (West Supp. 1993); Guidotti v. County of Yolo, 214 Cal. App. 3d 1552, 1557 (1989); Oberlander v. County of Contra Costa, 11 Cal. App. 4th 535, 540 (1992). Provision of county-reimbursed medical care services is, of course, adjusted on a more specific person-by-person basis according to an individual person's health status. *See also* Howard E. Freeman et al., *Americans Report on Their Access to Health Care*, 6 HEALTH AFF. 6, 10-11 (Spring 1987) (stating that poor and near poor individuals in "fair and poor" health had more physician visits and greater number of hospitalizations per year than people in that income category in "excellent and good" health).

237. A California commentator writing in the late 1960s who reviewed past and current social welfare legislation found that "[f]ault is . . . a central concept in welfare law. . . . Changing ideas of fault are bound to affect the structure of welfare laws." Lawrence M. Friedman, *Social Welfare Legislation: An Introduction*, 21 STAN. L. REV. 217, 223-24 (1969). Another commentator writing in the following decade found that the "concepts of 'worthy' and 'unworthy' poor [has] continued to have great influence on the formulation and implementation of public assistance programs, including California's present system." Lisa A. Pearlman, *Welfare Administration and the Rights of Welfare Recipients*, 29 HASTINGS L.J. 19, 22 (1977).

238. If we judge political power by looking at campaign contributions, physicians and hospitals wield significant power. A Common Cause report ranked the California Medical Association as the number one contributor to California legislative campaigns from 1984 to 1989, at which time it dropped to second place. The political action committees of the California Hospital Association and the California Dental Association were also among the top ten campaign donors in 1989. CALIFORNIA COMMON CAUSE, KIM ALEXANDER & MATTHEW SPACEK, A FIST FULL OF DOLLARS 1 (July 1991) (copy on file with the *Pacific Law Journal*). By 1992, the California Medical Association was back as the highest spending "Lobbyist Employer" in the state, and "Health" was the highest spending category after "Miscellaneous." CALIFORNIA SECRETARY OF STATE, LOBBYING EXPENDITURES AND THE TOP 100 LOBBYING FIRMS, JANUARY 1 - MARCH 31, 1992 iii-iv (May 1992) (copy on file with the *Pacific Law Journal*).

239. *See generally* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE (1982) (copy on file with the *Pacific Law Journal*).

"uncompensated care" when those hospitals, physicians, and dentists are unable to collect payment for care provided. So transformed, the problem gains politically powerful constituencies which are able to advocate effectively for health care needs of otherwise disenfranchised, poor people.[240]

V. MINIMUM STANDARDS FOR LEVELS OF INDIGENT HEALTH CARE: A CONCEPTUAL FRAMEWORK FOR DIFFERENT APPROACHES

The following discussion sketches out four different approaches to setting a legal standard for scope and accessibility of health care for people unable to pay for that care and lacking public insurance (such as Medicaid). Although this Article focuses on California case law and statutes, the conceptual framework that follows can be used anywhere in the country where people are re-thinking their legal and policy framework for indigent health care.

The first, "maintenance of effort" approach, has been used in several statutes regarding indigent health care.[241] The second approach, here labeled a "basic human needs" approach, is based on case law that has used this kind of standard for both the medical and non-medical components of counties' section 17000 responsibilities.[242] The third, "linked" approach, combines concepts from recent statutory changes affecting the non-medical components of counties' section 17000 responsibility with concepts from health care policy.[243] Finally, the last approach goes beyond our current state of knowledge and information about medical care to suggest some possibilities based on health care research now in progress.[244]

A. Standards Using Time Comparison ("Maintenance of Effort")

Perhaps the simplest approach to setting a standard for the necessary level of health care is to designate a point in time as time zero, then require or encourage a county to maintain the same level of health care in

240. Bovberg & Kopit, *supra* note 11, at 870.

241. *See infra* notes 245-261 and accompanying text (explaining the "maintenance of effort" approach).

242. *See infra* notes 262-272 and accompanying text (describing the "basic human needs approach").

243. *See infra* notes 273-285 and accompanying text (discussing the "linked" approach).

244. *See infra* notes 286-292 and accompanying text (suggesting possibilities based on current health care research).

subsequent years as it did at time zero. The time zero and later levels of health care can be compared generally, but are more typically compared according to specific measurement criteria such as total dollars spent on indigent health or number of health care visits by people at county facilities. This kind of standard, often called a "maintenance of effort" requirement,[245] has the advantage of being fairly easy for a state agency or a court to enforce because the measurement is a relatively straightforward comparison of two points in time according to specified criteria.

One example of a "maintenance of effort" approach to assuring minimum levels of indigent health care was contained in the AB 8 program.[246] In this program, the state gave each county annual grants that had to be matched by county health care expenditures at a level based on that county's health care spending in the 1977-78 base year.[247] Ten years later, voters approved a ballot initiative that directly affected financing and delivery of indigent health care: the Tobacco Tax and Health Protection Act of 1988 (Proposition 99).[248] This initiative raised cigarette taxes by twenty-five cents per pack and required that forty-five to seventy percent of the collected funds be spent on patients who cannot afford to pay for hospital or physician services and for whom no other reimbursement is available.[249] The initiative also required that the funds raised through its provisions be used only to supplement existing levels of service rather than fund existing levels of service.[250] The first legislative

245. *See, e.g.*, CALIFORNIA SENATE OFFICE OF RESEARCH, FOR YOUR INSIGHT: MAJOR HEALTH ISSUES FACING THE LEGISLATURE 10 (June 23, 1993).

246. 1979 Cal. Stat. ch. 282, sec. 87, at 1047 (enacting CAL. WELF & INST. CODE §§ 16700-16713); *see supra* notes 23-24 and accompanying text (explaining the Assembly Bill 8 program).

247. The "match" amounts were recalculated each year and adjusted for county population and inflation. *See e.g.*, CALIFORNIA DEPARTMENT OF HEALTH SERVICES, HEALTH AND WELFARE AGENCY, EXPLANATION OF AB 8 PROVISIONS 4-7 (April 1984). This report covers Fiscal Year 1982-83, but published reports exist for many of the preceding and subsequent fiscal years. Assembly Bill 8 was recently ended as a separate program when it was folded into the 1991 "realignment" provisions. 1991 Cal. Legis. Serv. ch. 89, secs. 199-200, at 396 (enacting CAL. WELF. & INST. CODE §§ 16720, 16800). *See supra* notes 9-44 and accompanying text (describing realignment).

248. The Initiative Constitutional Amendment — Property Tax Limitation, Prop. 99, § 12 (codified at CAL. CONST. art. XIIIB, § 12).

249. CAL. REV. & TAX. CODE §§ 30122-30124 (West Supp. 1993). The funds are deposited into six accounts, each with a designated percentage of the total funding available. *Id.* § 30124. The three accounts of interest here are the Physician Services Account (10%), Hospital Services Account (35%), and Unallocated Account (25%). *Id.* §§ 30122-30124 (West Supp. 1993).

250. *Id.* § 30125 (West Supp. 1993).

vehicle for allocating most of the Proposition 99 funds[251] tied county funding allocations to four maintenance of effort requirements. First, counties accepting Proposition 99 funds were required to maintain health care spending at a "match" level similar to the AB 8 requirements, but incorporating higher spending levels by using 1988-89 as the base year.[252] Counties were also prohibited from reducing the scope of section 17000 health care benefits and from imposing more stringent eligibility standards compared to 1988.[253] Finally, counties were required to maintain at least the same number of outpatient visits in the two fiscal years following passage of Proposition 99 as there had been in the year the initiative was approved.[254]

The Beilenson Act was another, earlier statute that took a slightly different approach to setting standards for county levels of indigent medical care. The Act's notice and hearing requirements can be thought of as a type of maintenance of effort approach because they apply only to counties planning *not* to maintain services due to closure of a health facility or reductions in the level of services.[255] Under this Act, the time zero of comparison is not fixed at a certain year as it is with AB 8 or Proposition 99-related standards. Instead, the comparison is presumably based on the time immediately before the county's proposed changes.[256] Although prior versions of the Act clearly discouraged or prevented a county from making any change that would have a detrimental impact on levels of indigent health care,[257] the Act's remaining requirements

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251. 1989 Cal. Stat. ch. 1331, sec. 1, at 5381-82. This legislation contains most of the health-related allocations from the almost $1 billion in Proposition 99 funds that were accumulated during the 18 months following enactment of the initiative.

252. 1989 Cal. Stat. ch. 1331, sec. 9, at 5410 (enacting CAL. WELF. & INST. CODE § 16990).

253. *Id.* (enacting CAL. WELF. & INST. CODE § 16995), *repealed by* 1992 Cal. Legis. Serv., ch. 719, sec. 11, at 2875.

254. *Id.* (enacting CAL. WELF. & INST. CODE § 16995.2), *repealed by* 1992 Cal. Legis. Serv. ch. 719, sec. 11, at 2875.

255. CAL. HEALTH & SAFETY CODE § 1442.5 (West Supp. 1993).

256. The Beilenson Act describes the county's public notice required prior to "eliminating or reducing" its county health services as including "a detailed list of the proposed reductions or changes, by facility and service." CAL. HEALTH & SAFETY CODE § 1442.5 (West Supp. 1993).

257. The original version of the Beilenson Act required county supervisors to make findings at public hearings that proposed cuts "will not have a detrimental impact" on indigent health care in that county. 1974 Cal. Stat., ch. 810, sec. 3, at 1764-65 (enacting CAL. HEALTH & SAFETY CODE § 1442.5). Changes made in 1982 weakened the "no detrimental impact" requirement by allowing cuts to be made even if the county supervisors' findings were that a detrimental impact would occur. 1982 Cal. Stat., ch. 328, sec. 2, at 1569 (amending CAL. HEALTH & SAFETY CODE § 1442.5). Finally, even this weakened requirement was eliminated. 1992 Cal. Legis. Serv., ch. 719, sec. 2, at 2865 (repealing CAL. CIV. CODE § 4384.5). *See supra* notes 74-90 and accompanying text (discussing the Beilenson Act's legislative history as it relates to setting standards for the health care counties provide to indigent residents).

impose public notice and hearing requirements on counties that choose not to maintain their existing indigent health services.[258]

In 1992, the partial elimination of the Beilenson Act and of three of the four maintenance of effort requirements in Proposition 99[259] presumably reflects the spirit of county mandate relief that permeated that year's budget negotiations[260] as well as questions the actual effectiveness of at least some of these requirements.[261] Whatever the motives were for eliminating these time comparison or maintenance of effort requirements for county indigent health programs, this seems a good time to question the real value of these kinds of requirements. Although they are fairly easy to administer, "maintenance of effort" standards have no direct connection with the outcome presumably of most interest to health policy makers and funders: appropriate medical care that maintains or improves the health of the people receiving the care. Maintenance of effort standards can even have the unintended effect of discouraging improvements in health care services by locking in the financing and service delivery patterns of the base year or time zero, instead of taking a fresh look at the care being provided or the health outcome for indigent people receiving that care.

B. Standards Using Basic Human Needs

A different approach to standards for levels of care compares the services offered to indigent people with those available to the larger human population. At the lowest level, such a standard has been variously

258. CAL. HEALTH & SAFETY CODE § 1442.5 (West Supp. 1993).

259. All of the Proposition 99-related maintenance of effort requirements, except the financial one were repealed. 1992 Cal. Legis. Serv. ch. 719, secs. 11 & 12, at 2875 (repealing CAL. WELF. & INST. CODE § 16995.2 and amending CAL. WELF. & INST. CODE § 17005).

260. *See, e.g.*, CALIFORNIA STATE ASSOCIATION OF COUNTIES, 29 LEGIS. BULL. 32 (1992).

261. For example, one participant in the 1992 budget negotiations observed that requiring counties to maintain at least the same number of outpatient visits was not a difficult requirement to meet, when growing cost consciousness has generally increased outpatient clinic use throughout the health care system. Telephone interview with Michael Dimmitt, Vice President of Research and Health Policy, California Association of Hospitals and Healthcare Systems (October 1992) (copy on file with the author).

articulated in case law as one of subsistence,[262] minimum needs,[263] or survival.[264]

Throughout its relatively lengthy discussion of the appropriate standard of dental care for indigents, the *Cooke* court rejected the lower level of the "basic needs" type of standard because although it allowed people to survive, this lower level failed to prevent pain and suffering.[265] Instead, the court embraced section 10000's requirement that care be "humane,"[266] stating that: "'humane' care is that level of care which remedies the pain and infection which petitioners have needlessly endured."[267] Although that court rejected the plaintiffs' assertion that they should receive the same level of dental services available to private patients[268] or even Medi-Cal patients,[269] the court also disputed the contention that certain dental procedures such as root canals are beyond the county's required scope of care because they are "cadillac dentistry" not necessary for survival.[270] This slightly higher, "humane" standard has been described in another decision as minimally acceptable to the average person.[271] Another court using the basic human needs standard cited the

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262. *See* Poverty Resistance Ctr. v. Hart, 213 Cal. App. 3d 295, 309, 271 Cal. Rptr. 214, 223 (1989) (utilizing an "adequate to meet subsistence medical needs" standard); Whitfield v. Board of Supervisors, 227 Cal. App. 3d 451, 460, 277 Cal. Rptr. 815, 821 (1991) (delineating an "actual cost of minimum subsistence" standard).

263. City and County of San Francisco v. Superior Court, 57 Cal. App. 3d 44, 46, 128 Cal. Rptr. 712, 714 (utilizing a "benefits sufficient to meet [general assistance recipients'] minimum needs" standard).

264. *Id.* at 49-50, 128 Cal. Rptr. at 716-17 (stating that the standard is "a level of aid [cannot be] below what is necessary to survive"); Boehm v. Superior Court, 178 Cal. App. 3d 494, 501, 223 Cal. Rptr. 716, 720 (1986) (describing the standard as "benefits necessary for basic survival").

265. Cooke v. Superior Court, 213 Cal. App. 3d 401, 414, 261 Cal. Rptr. 706, 714 (1989). "*Boehm II* . . . does not stand for the proposition that a county need assist only when life is threatened . . . [¶] § 17000 requires counties to provide "medical care," not just emergency care. . . ." *Id.*

266. *Id.* at 414, 261 Cal. Rptr. at 714. "In California Health and Safety Code § 10000 the legislature has decreed that counties must provide care "humanely," and it is this court's duty to give that declaration meaning." *Id.*

267. *Id.* at 415, 261 Cal. Rptr. at 715.

268. This claim had been made under the Beilenson Act's "community standard" language. The court stated that the Beilenson Act did not apply because the county was not proposing to reduce services or close facilities. *Id.* at 410, 261 Cal. Rptr. at 711.

269. *Id.* at 411-12, 261 Cal. Rptr. at 712-13.

270. "For instance, abscesses may be treated either through root canal or extraction. The former is sometimes referred to as 'cadillac dentistry' and is not necessary for basic survival." *Id.* at 406, 261 Cal. Rptr. at 709. Although one of the indigent petitioners had originally been denied access to the root canal work she needed, the county resolution that was finally approved by the court included coverage of "anterior root canals" in its dental program. *Id.* at 416, 261 Cal. Rptr. at 715.

271. Guidotti v. County of Yolo, 214 Cal. App. 3d 1552, 1559, 271 Cal. Rptr. 858, 865 (1989). The Court stated that, "[t]he County emphasizes the level of general assistance is measured not by pleasure, generosity or even what is *minimally acceptable to the average person* but what is necessary to survive or basic survival. A person can survive by sleeping on a riverbank, in a car or perhaps even by the side of the road but that could

Universal Declaration of Human Rights, and stated: "Everyone has the right to a standard of living adequate for the health and well being of himself and of his family, including food, clothing, housing and medical care and necessary social services."[272]

C. Linking Medical Care Standards for Indigent People with Standards for Non-Indigent People

The 1991, 1992, and 1993 statutory changes to indigent relief standards[273] make explicit an idea implied by some earlier case law.[274] This idea links indigent care and assistance standards to comparable standards for other people needing the same kind of care. For general assistance levels, California has linked county payment levels with state AFDC payment levels. For health care, no similar statutory linkage existed[275] until the 1993 statutory changes affecting section 17000 set a Medi-Cal linked ceiling on requirements for levels of county indigent medical care.[276] If California courts or lawmakers decide to make a more direct linkage between legal standards for levels of indigent health care and another standard, the two obvious starting places to create such a standard would be Medi-Cal and a basic Health Maintenance Organization (HMO) standard. The scope of services available in a medical program is typically described by a general statement of the criteria for including specific services, followed by a listing of the services included in that program. The general provisions for Medi-Cal's scope of services, echo the *Cooke* court's standard of care by going beyond prevention of significant

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hardly be considered habitable housing [emphasis added]." *Id.*

272. Boehm v. Superior Court, 178 Cal. App. 3d 494, 501-02, 223 Cal. Rptr. 716, 721 (1986) (citing Article 25(1); G. A. Res. 217A(111), U.N. Doc. A/810 (1948)).

273. The statutory changes linked county general assistance payment levels with federal poverty guidelines and state AFDC payment levels. *See supra* notes 105-125 and accompanying text (describing the statutory changes to indigent relief standards).

274. *See, e.g.*, Whitfield v. Board of Supervisors, 227 Cal. App. 3d 451, 457-58, 277, Cal. Rptr. 815, 819 (1991); Poverty Resistance Ctr. v. Hart, 213 Cal. App. 3d 295, 303, 271 Cal. Rptr. 214, 219 (1989) (indicating that indigent care and assistant standards should correspond to comparable standards that apply to other people requiring the same kind of care).

275. *But see supra* note 83 and accompanying text (discussing the only arguable prior statutory linkage between county indigent health care and Medi-Cal). This prior linkage was made in uncodified budget language and was only effective during the 1990-1991 fiscal year. *Id.*

276. 1993 Cal. Legis. Serv. ch. 72, sec. 1, at 905-06 (enacting CAL. WELF. & INST. CODE § 17030.1) (copy on file with the *Pacific Law Journal*) (excusing a county from providing or paying for a service reduced or eliminated from the Medi-Cal program).

illness or disability[277] to include reasonable and necessary services that alleviate severe pain through the diagnosis or treatment of disease, illness, or injury.[278]

A medical care program's actual list of services offered is more informative than its statement of scope of services. For example, Medicaid requires all participating states to include a core of mandatory services including: inpatient and outpatient hospital services, rural health clinic services, laboratory and X-ray services, skilled nursing facility services for people twenty-one years of age or older, physicians' services, early and periodic screening, diagnosis, and treatment (EPSDT) for people younger than twenty-one, family planning services and supplies, home health services, and prenatal care provided by a licensed nurse-midwife.[279] In addition, a state may choose to include any optional services such as: care provided by chiropractors, optometrists, and podiatrists, home health services, non-hospital clinic services under the direction of a physician or dentist, dental services, physical, occupational, or speech therapy, prescribed drugs, dentures, prosthetic devices, orthopedic shoes, and eyeglasses, intermediate care facility services, inpatient psychiatric hospital services, and home and community-based services (only under a waiver agreement) needed for an individual to avoid institutionalization.[280] So far, California's Medi-Cal program has offered a fairly comprehensive benefit package that includes almost all optional services.[281]

A basic HMO standard is another possible, ready-made package of services to which standards for levels of indigent medical care could be linked. For example, California Insurance Commissioner John Garamendi's proposed health care reform plan links its benefits package to services

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277. CAL. CODE REGS., tit. 22, § 51303 (1993) (providing that "[h]ealth care services . . . which are reasonable and necessary to protect life [or] to prevent significant illness or significant disability . . . are covered by the Medi-Cal program, subject to utilization controls. . . .").

278. *Id.*

279. 42 C.F.R. §§ 440.1-440.270 (1993); *see id.* §§ 440.1-440.270 (providing a list of required and optional Medicaid services).

280. *Id.*

281. Governor Wilson's budget for fiscal year 1993-94 specified eight Medi-Cal optional benefits proposed for elimination if California did not receive $1.5 billion in federal funding for "immigration-related services." The benefits identified were outpatient drugs, optometry, prosthetic, orthotic, heroin detox centers, durable medical equipment, hearing aids, and incontinence supplies. GOVERNOR'S BUDGET SUMMARY 1992-93: FROM ADVERSITY TO OPPORTUNITY 30-32 (January 1993) (copy on file with the *Pacific Law Journal*). In fact, the 1993-94 budget signed by the Governor on July 1, 1993 preserved all Medi-Cal optional benefits except for specified reductions in adult dental services. CALIFORNIA ASSOCIATION OF HOSPITALS AND HEALTH SYSTEMS, BUDGET WATCH 2 (July 1, 1993) (copy on file with the *Pacific Law Journal*).

provided by a comprehensive HMO plan.[282] The Garamendi plan specifies the following services: physician office visits, home health care, prenatal care, well baby care, laboratory and radiology, outpatient drugs, emergency room visits, outpatient mental health, and inpatient hospital care (including mental health).[283] Routine dental and vision care are not included, although certain high-cost vision and dental procedures, such as a root canal, would be covered.[284] This benefit package does in fact generally correspond with the scope of services provided by at least one large HMO, the Kaiser Foundation Health Plan (Northern California Region).[285]

The whole question of linking indigent medical care standards to other standards for other people assumes the continuation of several separate systems for people whose eligibility is defined by certain income and eligibility criteria. If this state or this nation decides to move toward a single, unified system in which every person has access to basic or necessary medical care, many of the issues discussed in this Article will disappear. Instead, concerns about the health care for low-income people will take a fundamentally different approach, based less on deciding which medical care low-income people can or cannot receive, and more on assessing the health outcome of care that all people are eligible to receive.

D. Outcome or Public Health Measures

As state and county health care budgets come under increasing fiscal and caseload pressure, policy makers may want to rethink the kinds of standards used to judge the legal sufficiency of county health care programs for indigent people. Rather than looking primarily at medical care input measures, such as total program expenditures or total number of medical visits, attention should be shifted to the health outcome of the

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282. JOHN GARAMENDI, INSURANCE COMMISSIONER, STATE OF CALIFORNIA, CALIFORNIA HEALTH CARE IN THE 21ST CENTURY: A VISION FOR REFORM 3 (Feb. 1992) (copy on file with the *Pacific Law Journal*).

283. *Id.* at Attachment 3.

284. *Id.*

285. Although the Garamendi plan's list of covered services is not specific enough to allow detailed comparisons with Kaiser's coverage, it does permit general comparisons. The Garamendi plan would probably cover everything that Kaiser does, with the addition of "high-cost" dental procedures. *See* KAISER PERMANENTE, DISCLOSURE FORM AND EVIDENCE OF COVERAGE FOR GROUP MEMBERSHIP (1993) (copy on file with the *Pacific Law Journal*).

money spent and of the services provided.[286] Although the area of health care research known as "outcomes research" is just being developed, we can expect increased interest in this kind of research for all areas of health care, including health care for indigent people. For example, health care researchers studied the effects of the 1988 closure of Shasta General Hospital, a 73-bed county hospital in northern California that provided 74,000 outpatient visits and had more than 3,200 admissions in the year prior to its closing.[287] When researchers compared former Shasta General patients to patients in another rural county that still had a public hospital, they found significant declines in the Shasta patients' reported health status on four dimensions: pain, health perception, social function, and role function.[288]

Another new area of health outcomes research evaluates rates of potentially avoidable hospitalizations among low- and high-income populations.[289] For example, a team of researchers examined hospital admissions in Massachusetts and Maryland for certain medical conditions that can often be avoided if effective health care is provided on a timely basis in a clinic, physician's office, or other setting that does not require an overnight hospital stay.[290] When these researchers compared avoidable hospitalization rates for privately insured patients with rates for uninsured patients and for Medicaid patients, they found that people without insurance or with Medicaid had higher rates of avoidable hospital admissions than people with private insurance.[291]

An editorial in a leading medical journal has suggested that this kind of health outcomes research be used to evaluate policy changes that affect

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286. *See generally* Warren Winkelstein, Jr., *Health Care is Not Medical Care*, 1 PUB. HEALTH AT BERKELEY 9-11 (1993) (copy on file with the *Pacific Law Journal*); HAROLD S. LUFT, POVERTY AND HEALTH: ECONOMIC CAUSES AND CONSEQUENCES OF HEALTH PROBLEMS 4 (Ballinger Pub. Co. 1978) (stating that "[w]hile there is still concern about access to [medical] care . . . the emphasis, it seems, is beginning to shift from *medical care* to *health* and to the prevention of *health problems* [emphasis in original].")

287. Andrew B. Bindman, et al., *A Public Hospital Closes: Impact on Patients' Access to Care and Health Status*, 264 JAMA 2989, 2900 (1990).

288. *Id.* at 2902.

289. *See generally* John Billings, et. al., *Impact of Socioeconomic Status on Hospital Use in New York*, 12 HEALTH AFF. 162 (Spring 1993) (copy on file with the *Pacific Law Journal*).

290. Joel S. Weissman, et. al., *Rates of Avoidable Hospitalization by Insurance Status in Massachusetts and Maryland*, 268 JAMA 2388 (1992). The study described this kind of care as "ambulatory care," which is the term frequently used in health care delivery and research. *Id.*

291. *Id.* at 2393; *see also* Helen R. Burstin, et al., *Socioeconomic Status and Risk for Substandard Medical Care*, 268 JAMA 2383 (1992) (stating that, "[o]ur findings suggest that the uninsured are at greater risk for suffering medical injury due to substandard medical care.").

the availability and quality of primary care.[292] Ongoing development of these kinds of health outcome measures should lead to information that can form the basis for more effective standards by with which to judge many aspects of our health care system, including county health care programs. One possible way of utilizing this new health care research would be to continue California's broad, flexible statutory language regarding indigent medical care, but link this to a statewide advisory group charged with providing more specific and up-to-date recommendations on the most useful, appropriate measures of a county health care program's adequacy or effectiveness. These recommendations of the advisory group would provide courts with medical and public health expertise presented in a way designed to be most useful in interpreting the guidelines set forth in section 17000. This new approach would also give counties the advantage of knowing in advance and with more certainty the specifics against which their indigent health care program would be judged, and would provide policy makers and advocates for indigent people with a more effective method of evaluating progress toward the goal of maintaining and improving the actual health status of indigent residents of California.

CONCLUSION

After decades of slow evolution, the statutory and case law regarding standards for county-financed care and assistance to indigent people have changed dramatically in the last few years. For non-medical assistance, standards have become more specific and have been lowered in many counties. For medical care, the standards have become fewer and less specific. Any future changes in California's standards of indigent medical care should continue the long-standing tradition of guaranteeing poor and powerless people at least a basic or "humane" level of care, while recognizing both evolving methods of measuring health outcomes and the counties' need for flexibility in providing medical care.

292. Andrew B. Bindman, et. al., *America's Safety Net: The Wrong Place at the Wrong Time?*, 268 JAMA 2426 (1992).