



1-1-1997

Health and Welfare

University of the Pacific, McGeorge School of Law

Follow this and additional works at: <https://scholarlycommons.pacific.edu/mlr>



Part of the [Legislation Commons](#)

Recommended Citation

University of the Pacific, McGeorge School of Law, *Health and Welfare*, 28 Pac. L. J. 873 (1997).

Available at: <https://scholarlycommons.pacific.edu/mlr/vol28/iss3/18>

This Greensheet is brought to you for free and open access by the Journals and Law Reviews at Scholarly Commons. It has been accepted for inclusion in McGeorge Law Review by an authorized editor of Scholarly Commons. For more information, please contact mgibney@pacific.edu.

Chapter 1014: The Use of Financial Incentives to Induce Doctors to Deny Patients Needed Medical Services

David E. Haddock

I. INTRODUCTION

There is a health care crisis in America. More money per capita is spent on health care in the United States than in any other country.¹ Yet at least fifteen percent of the population, more than in any other developed nation, remains uninsured.² According to analysts, the aging "baby boom" generation may push per capita health care spending three and one-half times higher than current levels by the year 2030.³

Perhaps the biggest cause of the explosion in health care spending, and certainly the cause that has received the most attention, is waste. Robert Brook, director of health sciences research for the Rand Corporation, has suggested that as much as one-third of American health care spending may be unnecessary.⁴ For example, a study of California patients concluded that, of 300 coronary bypass procedures, barely a majority were clearly justified.⁵ If this finding held true for the rest of the country, where 350,000 bypasses were performed in 1990, unnecessary treatment could have enormous costs indeed.⁶

One of the most promising approaches to eliminating the waste associated with unnecessary treatment is "managed care." Managed care includes several types of prepaid health care plans, such as health maintenance organizations (HMOs) and preferred provider organizations, whose primary objective is to provide equal or better benefits while cutting out wasteful spending.⁷ In order to eliminate waste, managed care insurers typically employ a primary care physician, called a "gatekeeper," who has the responsibility for coordinating the treatment of patients.⁸ In a managed care system, patients are only referred to costly specialists, or admitted to hospitals, when the gatekeeper determines such a referral to be medically necessary.⁹

1. Lee Smith, *A Cure for What Ails Medical Care*, FORTUNE, July 1, 1991, at 44.

2. *Id.*

3. *Boomers to Face Higher Health Costs*, SAN DIEGO UNION-TRIB., May 19, 1996, at I3.

4. Smith, *supra* note 1, at 44.

5. *Id.*; *see id.* (discussing a Rand study of patients who had undergone bypasses at several California hospitals).

6. *See id.* (noting that \$14 billion worth of bypasses were performed nationwide).

7. John Merline, *Shortcomings of Managed Care*, INVESTOR'S BUS. DAILY, March 30, 1995, at A1.

8. *Id.*

9. *Id.*

Some evidence exists that this approach is succeeding. In 1995, despite an overall increase in health care costs, the cost of HMO health benefits decreased by nearly four percent.¹⁰ Managed care plans have also been able to trim costs by reducing the number of patients sent to hospitals by almost one-third.¹¹

Many health plans use "capitation" payments that reward their frugal doctors.¹² In a capitation system, health insurance companies pay doctors a fixed monthly sum for each patient in their care.¹³ If patients tend to remain healthy, and physicians keep costs down, the capitation payment represents a significant profit for the doctor, because the doctor does not have to provide many costly services.¹⁴ However, treatments for sick patients can be so expensive that, after paying all the bills, little is left to compensate doctors.¹⁵ Because sixty percent of health plans hold doctors partially responsible for the cost of caring for sick patients, doctors can often make more money by limiting expensive treatments.¹⁶

Some insurers offer more direct incentives. For example, some health plans give bonuses to the physicians who make the fewest number of referrals to specialists, or who limit most significantly the number of days their patients spend in hospitals.¹⁷ Many insurers will withhold part of a physician's compensation, and will give it to the physician only if certain cost-containment guidelines are met.¹⁸ According to one report, this type of incentive is not uncommon. In a study of 108 managed care companies nationwide, Mathematica Policy Research reported that fifty-seven percent of managed care plans consider "utilization rates and costs" when awarding bonuses and withholding payment penalties.¹⁹

Despite the success of these programs at lowering costs, observers are concerned that financial incentives to avoid waste also encourage doctors to withhold needed

10. Ronald Kotulak & Peter Gomer, *Medicine Aches with HMO Fever*, CHI. TRIB., Apr. 14, 1996, at 1.

11. *Id.*

12. See Susan Brink, *How Your HMO Could Hurt You*, U.S. NEWS & WORLD REP., Jan. 15, 1996, at 62 (reporting that 56% of independent practice associations, 34% of group or staff HMOs, and 7% of preferred provider organizations use capitation as the main method of paying doctors).

13. *Id.*

14. *Id.*

15. *Id.*; see *id.* (noting that, in 1989, one California physicians' group received only \$27.94 per month as payment for treating a patient whose medical needs cost thousands of dollars more).

16. *Id.*; see *id.* (reporting that one survey revealed that 84% of independent practice associations, 68% of HMOs, and 10% of preferred provider organizations held doctors partially responsible for some portion of expenses).

17. Karen Cheney, *What You Can Learn from an M.D.: Mutiny in a Managed Care Plan*, MONEY, Dec. 1, 1995, at 21; see *id.* (describing the financial incentives offered to physicians by Intergrupp, an Arizona company owned by Foundation Health of Sacramento).

18. SENATE RULES COMMITTEE, COMMITTEE ANALYSIS OF AB 2649, at 4 (Aug. 29, 1996); see *id.* (identifying "withholds" as one type of financial incentive used by managed care health plans); Merline, *supra* note 7, at A1 (explaining that some managed care health plans provide financial incentives to limit care by withholding part of the doctor's salary until the doctor meets the plan's goals).

19. *Fiscal Incentives Get Doctors to Limit Care*, AM. HEALTH LINE, Dec. 21, 1995, at 13.

services.²⁰ Congressional Representative Bernie Sanders echoes this view: "Many HMOs use what are essentially 'fee-for-denying-service' systems, which pay doctors for denying care and penalize them for providing it."²¹

In an effort to ensure that cost containment does not lead to the denial of needed treatment, several state legislatures have considered bills that would prohibit health plans from offering financial incentives to encourage doctors to deny necessary medical services.²² California's Chapter 1014 shares these objectives.²³

Does the cost-cutting zeal that accompanies managed care really contribute to the under utilization of medical services? If so, how does Chapter 1014 address this problem? How effective will Chapter 1014 be at assuring that patients are not denied needed medical services because of financial incentives? This Legislative Note will address each of these questions.

II. DO FINANCIAL INCENTIVES LEAD TO UNDER UTILIZATION?

Are the cost savings of managed care achieved by denying patients needed treatment? Some critics say yes.²⁴ Merrill Matthews, director of the Center for Health Policy Studies, claims that "[m]anaged care can succeed in lowering health-care costs only to the extent that it succeeds in preventing patients from obtaining all the services it is in the patients' self-interest to obtain when the price is zero."²⁵ Thus, industry observers maintain that the goals of eliminating waste and lowering costs can only be reached by withholding needed and appropriate care. According to

20. See Kotulak & Gomer, *supra* note 10, at 1 (explaining that, "[i]n the short run [patients] may be denied treatments and therapies they need because of expense"); Merline, *supra* note 7, at A1 (reporting University of Southern California physician and economist William Schwartz's view that long-term health care costs can be controlled only by denying patients useful services).

21. 142 CONG. REC. E562-04 (Apr. 17, 1996) (statement of Rep. Sanders); see Milt Freudenheim, *Managed Care's Cost-Trimming Starts Backlash*, AUSTIN AM.-STATESMAN, May 19, 1996, at A1 (describing the efforts of at least 34 state legislatures to outlaw methods that some HMOs use to shorten hospital stays and keep patients uninformed regarding incentive programs that may limit care). Representative Sanders has introduced The Hippocratic Oath & Patient Protection Act in an effort to eliminate what he feels are harmful incentives to limit needed care. 126 CONG. REC. E562-04 (Apr. 17, 1996) (statement of Rep. Sanders).

22. See, e.g., ALA. CODE § 27-48-3 (Supp. 1996) (preventing health plans from penalizing physicians who order medical care, and prohibiting health plans from offering any financial incentive or disincentive to anyone for encouraging or causing the early discharge of a hospital patient from postpartum care); GA. CODE ANN. § 33-20A-6 (1996) (preventing any managed care plan from using a financial incentive program that compensates doctors for providing less than medically necessary care); N.H. REV. STAT. ANN. § 420-I:2 (Supp. 1996) (prohibiting managed care insurers from entering into any "exclusive arrangement," which is defined to include any agreement between a managed care insurer and a person that has the purpose or the effect of providing financial incentives to restrict treatment or financial disincentives for failing to restrict treatment); see also Freudenheim, *supra* note 21, at A1 (describing the efforts of numerous state legislatures to outlaw some tactics for shortening hospital stays and keeping patients uninformed).

23. See ASSEMBLY COMMITTEE ON HEALTH, COMMITTEE ANALYSIS OF AB 2649, at 3 (May 7, 1996) (suggesting that Chapter 1014 was proposed in order to address the concerns of those who fear that efforts to avoid over utilization of medical services could lead to under utilization).

24. See *supra* note 20 and accompanying text (reporting the claims of some industry observers).

25. Merline, *supra* note 7, at A1.

William Schwartz, a physician and economist at the University of Southern California, "[n]either managed care nor fee-for-service providers will be able to control the long-term rise in costs except by denying some patients access to certain types of expensive but useful services."²⁶

There are many approaches to limiting costs. Sometimes HMOs will deny access to expensive services by failing to tell the patient about treatment options.²⁷ In other cases, HMOs will simply delay needed treatment by weeks or months.²⁸ Perhaps most disturbing is when managed care providers shorten or eliminate hospital stays, or minimize referrals to specialists.²⁹

Surprisingly, doctors who withhold needed medical services can often be rewarded for the practice through the use of financial incentives. J.B. Silvers, director of the Health Systems Management Center at Case Western Reserve University, claims that financial incentives are important tools for encouraging doctors to reduce costs: "When people start doing tough discounting they have to crank down utilization. Use of (financial incentives) is one tool in the arsenals that's not going to go away."³⁰ According to Silvers, the right economic incentives ensure that doctors will "perform properly" by focusing on quality and preventative care, including immunizations, Pap smears, and mammograms.³¹ However, as Silvers admits, the wrong incentives could discourage physicians from making needed referrals or conducting important tests.³²

Are doctors, Hippocratic oaths and all, really willing to risk the health of patients in pursuit of fat paychecks? Perhaps not. While it may be unlikely that doctors generally are so unscrupulous that they would intentionally endanger patients' lives, even the most moral physicians may be susceptible to the power of money in shifting the benefit of the doubt. As Dr. Arnold Relman, nephrologist and editor of the *New England Journal of Medicine*, explains, "Like anybody else, a cardiac surgeon wants to maintain his income."³³ Accordingly, it is in the borderline cases that financial factors may have the most influence.³⁴ In the past, when doctors were paid for each service they performed, it was more likely that questions as to whether a patient

26. *Id.* (quoting from Schwartz's article in the journal *Health Affairs*).

27. *Id.*; *see id.* (citing a report from the National Kidney Cancer Foundation claiming that HMO doctors will sometimes fail to disclose treatment options, or will offer "second opinions" from physicians within the same department, rather than authorize a patient to go outside the physician group).

28. *See id.* (reporting findings of both *Investor's Business Daily* and a Medicare Advocacy Project study showing that managed care doctors sometimes delay needed treatment). The Health Care Financing Administration has also found examples of Florida HMOs delaying care and failing to act on test results. *Id.*

29. *See Cheney, supra* note 17, at 21 (claiming that "[s]trong financial incentives exist to keep down referrals and shorten hospital stays").

30. Raquel Santiago, *Use of Physician Bonuses Gaining Popularity*, CRAIN'S CLEVELAND BUS., Oct. 2, 1995, at 43 (alteration in original); *see id.* (explaining the importance of financial incentives in lowering costs).

31. *Id.*

32. *Id.*; *see id.* (discussing the hazards of financial incentives that provide too much compensation).

33. Smith, *supra* note 1, at 44.

34. *See id.* (claiming that finances can be a factor in the borderline cases).

really needed a particular treatment would be resolved in favor of over utilization; the patient got the benefit of the doubt.³⁵ In such cases, over treatment protected the patient's health, and rewarded the doctor with more fees.³⁶ In a managed care system, it is more likely that the benefit of the doubt will be shifted to the insurer. Because financial incentives now reward doctors for avoiding expensive treatments, some doctors may be unwilling to risk their monthly bonuses over a treatment that may or may not be helpful.³⁷

However, despite decreases in the cost of managed care, and claims that health-care costs can only be trimmed by denying needed services, there is no evidence that patients in managed care health plans receive inferior treatment.³⁸ For example, the *Journal of the American Medical Association* reported that, in a recent study, patients with high blood pressure or diabetes had equivalent outcomes whether they were enrolled in traditional fee-for-service plans or HMOs.³⁹ Likewise, although participants in managed care health plans tend to be less satisfied than participants in fee-for-service health plans, patients in managed care plans consider themselves as healthy as do fee-for-service users.⁴⁰ Accordingly, even if financial incentives do encourage doctors to deny services, the incentives may not be bad as long as they do not adversely affect the health of patients. Nevertheless, as the very idea of incentives

35. See Kay Stewart, *Bad Medicine*, COURIER-J. (Louisville, Ky.), Nov. 1, 1994, at 6A (claiming that giving patients the benefit of the doubt leads physicians to over prescribe); see also Merline, *supra* note 7, at A1 (noting that in traditional fee-for-service arrangements, where patients pay little out of pocket, the system encourages them to over consume and to be indifferent to the cost of health care); Smith, *supra* note 1, at 44 (explaining that in a 1990 study, 14% of patients who had bypass surgery could have forgone surgery and would have survived as well with drugs, 30% were borderline, and barely a majority of the patients' conditions clearly justified surgery).

36. See Brink, *supra* note 12, at 62 (explaining that, while in the past doctors made money when they provided care, now when they order a hospital stay or a referral to an expensive specialist, they stand to lose money); Merline, *supra* note 7, at A1 (noting that traditional fee-for-service arrangements encourage over consumption).

37. See Merline, *supra* note 7, at A1 (citing a report from the American Medical Association claiming that financial incentives "may erode patient trust as patients wonder whether they are receiving all necessary care or are being denied care because of the physician's pecuniary concern"); Paul C. Roberts, *Health-Care Plan Would Pit Budget Against Patients*, ROCKY MOUNTAIN NEWS (Denver, Colo.), Jan. 29, 1994, at 58A (claiming that borderline cases no longer get the benefit of the doubt); *id.* (suggesting that in HMOs, budgetary considerations prevail over patient care); see also *supra* note 35 and accompanying text (discussing the differences between managed care and care under traditional fee-for-service systems).

38. See *supra* note 10 and accompanying text (reporting that the cost of HMO health care has declined, despite an increase in the cost of health care generally); *supra* notes 25-26 and accompanying text (discussing claims by industry analysts that the cost of health care can only be decreased by denying patients needed services).

39. Brink, *supra* note 12, at 62 (repeating the findings of the study as reported in the November 8, 1995 *Journal of the American Medical Association*).

40. See Karen Davis et al., *Managed Care on the March: Choice Matters for Consumers*, HEALTH AFF., Summer 1995, at 99, 103-04 (describing the results of a survey of patients in managed care and fee-for-service settings which showed that, although managed care patients claim less satisfaction and quality of care than fee-for-service members, the reported health status of managed care participants and fee-for-service patients does not differ). In responding to the survey, equivalent numbers of managed care members (89%) and fee-for-service members (91%) described their own health as either excellent or good. *Id.* at 102. Similar percentages of managed care (22%) and fee-for-service (23%) members had immediate family that had what they considered to be a serious illness requiring extensive medical care within the past year. *Id.* at 103.

concedes, ultimately doctors control patient's access to medical services.⁴¹ Whether or not most physicians are likely to take this approach, financial incentives provide a reason for the rare unscrupulous doctor to withhold needed treatment in the pursuit of money.

III. CHAPTER 1014'S APPROACH TO THE PROBLEM OF FINANCIAL INCENTIVES

The California Legislature has addressed the potential problems associated with financial incentives by enacting Chapter 1014.⁴² Chapter 1014 prohibits contracts between doctors and health care service plans, as well as subcontracts between doctors and other doctors, from containing any "incentive plan" that includes "specific payments" of any kind made to doctors "as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services."⁴³ Chapter 1014 explicitly excludes from its reach contracts and subcontracts that contain incentive plans that involve general payments, such as capitation payments, that are not related to specific enrollees or groups of enrollees with similar medical conditions.⁴⁴

Although Chapter 1014 seems to provide patients protection from insurers who are more concerned about finances than health care, upon closer examination it is unclear what the enacted statutes really cover. For example, the language only refers to "incentive plans" that are actually contained in contracts or subcontracts.⁴⁵ Presumably, Chapter 1014 would not reach incentives that are not mentioned in contracts. Likewise, incentives that are not considered part of "incentive plans," but are perhaps more spontaneous rewards for frugality, may not be proscribed. This limitation may provide a loophole through which health care plans may be able to induce physicians to deny needed but expensive services using bonuses that are not part of contracted compensation.

41. By offering doctors financial incentives to perform a certain way, health insurers are implicitly admitting that doctors are free to behave differently.

42. CAL. BUS. & PROF. CODE § 511 (enacted by Chapter 1014); CAL. HEALTH & SAFETY CODE § 1348.6 (enacted by Chapter 1014); *id.* § 1367.10 (amended by Chapter 1014); CAL. INS. CODE § 10175.5 (enacted by Chapter 1014).

43. CAL. BUS. & PROF. CODE § 511(a) (enacted by Chapter 1014); *see id.* (applying to subcontracts between doctors and other doctors); CAL. HEALTH & SAFETY CODE § 1348.6(a) (enacted by Chapter 1014) (applying to contracts between doctors and health care service plans). Although, for simplicity, this discussion will only refer to incentive payments that encourage doctors to *deny* services, Chapter 1014 also forbids payments that induce doctors to *reduce, limit, or delay* services. Each of the points made applies equally to incentive payments that deny services and to payments that reduce, limit, or delay services.

44. CAL. BUS. & PROF. CODE § 511(b) (enacted by Chapter 1014); *see id.* (forbidding incentives in subcontracts between doctors and other doctors); CAL. HEALTH & SAFETY CODE § 1348.6(b) (enacted by Chapter 1014) (forbidding incentives in contracts between doctors and health care service plans).

45. *See* CAL. BUS. & PROF. CODE § 511(a) (enacted by Chapter 1014) (prohibiting financial incentives in subcontracts between doctors and other doctors); CAL. HEALTH & SAFETY CODE § 1348.6(a) (enacted by Chapter 1014) (prohibiting financial incentives in contracts between doctors and health care service plans). The language in question is identical in both of these sections.

Chapter 1014 may also be limited insofar as it only applies to a "specific payment" made "as an inducement" to deny services.⁴⁶ This language seems to focus on the purpose of the payment, only forbidding payments that are specifically intended to encourage doctors to deny services. Would Chapter 1014 ban payments that have multiple purposes, only one of which is to encourage doctors to deny services? Does Chapter 1014 apply to payments that have legitimate purposes, but coincidentally have the effect of encouraging doctors to deny services? Chapter 1014 itself does not answer these questions.

Because Chapter 1014 focuses on the purpose of the incentive payments, rather than on the effect of the payments, it may overlook harmful incentives. For example, Chapter 1014 only prohibits contracts from containing "any incentive plan that includes a specific payment made . . . as an inducement to deny . . . services."⁴⁷ If a health care plan adopts compensation schemes for other purposes, those schemes may escape Chapter 1014's prohibition, even if they have the effect of encouraging doctors to withhold needed care. For example, although thirty-seven percent of managed care companies nationwide compensate their doctors with capitation payments,⁴⁸ managed care companies insist that those payments are not intended to induce doctors to deny needed care.⁴⁹

Should capitation payments be overlooked by Chapter 1014 simply because they are only intended to compensate doctors for performing their regular duties? To overlook them is to ignore their enormous persuasive power. As one critic explained, using capitation payments is like giving doctors a pile of money and telling them that they can keep anything they don't spend.⁵⁰ Certainly payments like these can have the effect of encouraging doctors to deny necessary care, even if the purpose for the payments is more legitimate.⁵¹ Like capitation payments, bonuses and withholds can have similar effects, despite their purposes.⁵²

Even though the language of Chapter 1014 probably would not apply to capitation payments, Chapter 1014 contains a provision explicitly exempting incentive plans that include general payments, like capitation payments, that are not

46. CAL. BUS. & PROF. CODE § 511(b) (enacted by Chapter 1014) (subcontracts between doctors and other doctors); CAL. HEALTH & SAFETY CODE § 1348.6(b) (enacted by Chapter 1014) (health care service plan contracts with doctors).

47. See CAL. BUS. & PROF. CODE § 511(a) (enacted by Chapter 1014) (subcontracts between doctors); CAL. HEALTH & SAFETY CODE § 1348.6(a) (enacted by Chapter 1014) (contracts between doctors and health care service plans). The language in question is identical in both of these sections.

48. See *Fiscal Incentives Get Doctors to Limit Care*, *supra* note 19, at 13 (reporting the findings of research conducted by Mathematica Policy Research).

49. See Freudenheim, *supra* note 21, at A1 (noting that managed care companies claim that capitation is not designed to deny necessary treatment).

50. *Fiscal Incentives Get Doctors to Limit Care*, *supra* note 19, at 13 (quoting Dr. Steffie Woolhandler, who wrote an editorial on the subject of financial incentives in the *New England Journal of Medicine*).

51. See *id.* (reciting Dr. David Himmelstein's claim that because of capitation payments, "doctors are getting offered big financial rewards for denying care").

52. See *supra* notes 17-19 and accompanying text (discussing other compensation plans such as bonuses and withholds).

tied to the denial of specific treatments.⁵³ Because capitation payments encourage doctors to deny necessary care, and because they are so common, by exempting them from the prohibition of Chapter 1014 the legislature has neglected to curtail a significant method for denying patients necessary and appropriate care.⁵⁴ Accordingly, the legislature's attempt, through Chapter 1014, to prohibit incentive plans that limit necessary medical care seems less than sincere.

Another problem is that Chapter 1014 only forbids payments that encourage the denial of services that are both "specific, medically necessary, and appropriate."⁵⁵ Since the language of Chapter 1014 does not include a list or even describe the types of "specific" services that cannot be denied due to incentives, the meaning of that phrase is unclear. How can the medical services be "specific?" Is Chapter 1014 prohibiting contracts from specifying particular medical services that doctors must deny? Or rather, does Chapter 1014 forbid only incentives that deny services that are specifically listed somewhere and are also medically necessary and appropriate? Again, Chapter 1014 itself does not explain this confusion. If the denied services must be specified in the contract for Chapter 1014 to apply, Chapter 1014 is a very weak protection indeed. Presumably, such a rule would allow doctors to receive financial incentives to deny medically necessary and appropriate services as long as those services are not enumerated in the contract. Nevertheless, whether this or some other interpretation is correct is unclear.

The most significant provision of Chapter 1014 is the disclosure requirement.⁵⁶ Chapter 1014 requires that every health care service plan that will affect the patient's choice of doctor or hospital clearly describe the ways participation in the plan may affect the choice of physicians or hospitals, the basic methods of reimbursement, and whether financial bonuses or incentives are used.⁵⁷ Chapter 1014 further requires that information given to prospective enrollees include, conspicuously, the following statement: "Please read the following information so you will know from whom or what group of providers health care may be obtained."⁵⁸

53. See CAL. BUS. & PROF. CODE § 511(b) (enacted by Chapter 1014) (prohibiting such payments from being mentioned in subcontracts between doctors and other doctors); CAL. HEALTH & SAFETY CODE § 1348.6(b) (enacted by Chapter 1014) (forbidding such payments from being mentioned in contracts between doctors and health care service plans).

54. See *supra* note 51 and accompanying text (discussing the effect of capitation payments as an incentive to deny needed medical care); see also *Fiscal Incentives Get Doctors to Limit Care*, *supra* note 19, at 13 (noting that 37% of American managed care companies use capitation payments).

55. See CAL. BUS. & PROF. CODE § 511(b) (enacted by Chapter 1014) (prohibiting such payments from being mentioned in subcontracts between doctors and other doctors); CAL. HEALTH & SAFETY CODE § 1348.6(b) (enacted by Chapter 1014) (forbidding such payments from being mentioned in contracts between doctors and health care service plans).

56. See CAL. HEALTH & SAFETY CODE § 1367.10 (amended by Chapter 1014) (outlining the disclosure requirements).

57. *Id.*

58. *Id.*

Significantly, the disclosure requirement only applies to health care service plans "that will affect the choice of physician, hospital, or other health care providers."⁵⁹ Chapter 1014 does not require health care plans that do not affect such choices to disclose the basic methods of reimbursement or the existence of financial bonuses or incentives.⁶⁰ Still, by requiring health care providers to disclose to prospective enrollees whether financial bonuses or incentives are used in compensating doctors, Chapter 1014 empowers consumers with the information they need to effectively shop for the best health care. Consumers can know, before they enroll, whether their doctor will be paid to limit access to specialists, or to minimize days spent in hospitals, or to deny treatments that they may or may not need. Thus, even if Chapter 1014 is ineffective at eliminating financial incentives that encourage doctors to deny necessary care, California consumers can avoid such incentives by choosing a health care plan that does not use them.

IV. CONCLUSION

As the health care industry strives to reduce costs, health insurance plans are rewarding doctors for limiting waste.⁶¹ However, critics fear that efforts to reduce waste are having such a strong effect that they are going too far.⁶² Some doctors are being rewarded for denying patients needed and appropriate care.⁶³ Chapter 1014 is California's attempt to ensure that doctors do not get paid for limiting access to treatment that patient's really need.

However, since the language of Chapter 1014 is so limiting and so unclear, the law may not have its desired effect. Because it forbids only incentives that are mentioned in contracts, it will have no effect on less formal incentive plans.⁶⁴ Because Chapter 1014 prohibits only payments made for the specific purpose of inducing the denial of treatment, it ignores incentive plans that may have multiple, or hidden, purposes, and it neglects plans, such as those involving capitation payments, that may have legitimate purposes but harmful effects.⁶⁵ Chapter 1014 even explicitly exempts capitation plans from its prohibitions.⁶⁶

Thankfully, Chapter 1014 also requires health care plans that affect the patient's choice of a doctor or a hospital to disclose to potential enrollees whether the plan

59. *Id.*

60. *Id.*

61. *See supra* notes 12-19 and accompanying text (discussing incentives for limiting waste).

62. *See supra* notes 20-21, 24-26 and accompanying text (noting the views of some industry observers).

63. *See supra* notes 20-21, 24-26 and accompanying text (noting the views of some industry observers).

64. *See supra* note 45 and accompanying text (examining Chapter 1014's limitation to incentives that are mentioned in contracts).

65. *See supra* notes 46-52 and accompanying text (addressing ambiguities in the language of Chapter 1014).

66. *See supra* notes 53-54 and accompanying text (considering the exemption of capitation payments from the application of Chapter 1014).

uses bonuses or incentives in compensating doctors.⁶⁷ This provision ensures that even if Chapter 1014 does not eliminate financial incentives by its own terms, California consumers will still have the ability to choose health plans and doctors that are more concerned with the health of patients than their own wallets.⁶⁸

APPENDIX

Code Sections Affected

Business and Professions Code § 511 (new); Health and Safety Code § 1348.6 (new), § 1367.10 (amended); Insurance Code § 10175.5 (new).
AB 2649 (Thompson, Figueroa, Sweeney); 1996 STAT. ch. 1014

67. See *supra* notes 56-60 and accompanying text (discussing Chapter 1014's disclosure requirement).

68. See *supra* notes 56-60 and accompanying text.

Disabled Access and Dog Tags: "Cleaning Up" Equal Access for Disabled Individuals

Joshua M. Dickey

I. INTRODUCTION

In 1990, the federal government passed the Americans with Disabilities Act (ADA), which guarantees equal access rights for disabled persons.¹ Prior to the passage of the ADA, California adopted statutes dealing with disabled access.² The legislature amended these laws and added other laws subsequent to the passage of federal law.³ Chapter 498 makes various technical amendments to improve existing California law.⁴ This Legislative Note will first review the changes in California law made by Chapter 498,⁵ and then will examine the politics, controversy, and possible problems the Chapter may encounter.⁶

II. AMENDMENTS

A. Public Places

Existing law provides that persons with disabilities⁷ have the same rights as the general public to full and free use of public places.⁸ Chapter 498 makes a violation of the ADA a violation of existing California law.⁹

1. See 42 U.S.C.A. §§ 12101-12213 (West 1995).

2. See, e.g., 1994 Cal. Legis. Serv. Stat. ch. 1257, secs. 1-4, at 4-8 (amending CAL. CIV. CODE §§ 54-54.3) (providing equal access rights to disabled individuals in various contexts); *id.* sec. 11, at 10-11 (amending CAL. PENAL CODE § 365.5) (making the denial of a disabled individual's equal access rights a misdemeanor).

3. See CAL. CIV. CODE §§ 54-54.3 (amended by Chapter 498) (enumerating the rights of disabled persons to equal access in various contexts); CAL. GOV'T CODE § 12948 (amended by Chapter 498) (same); CAL. PENAL CODE § 365.5 (amended by Chapter 498) (same).

4. See Telephone Interview with Joan Riddle, Legislative Consultant on SB 1687 to Senator Milton Marks (June 21, 1996) (notes on file with the *Pacific Law Journal*) (stating that Chapter 498 is a "clean-up" bill making necessary technical changes to existing law).

5. See *infra* Part II.

6. See *infra* Part IV.

7. See CAL. CIV. CODE § 54(b) (amended by Chapter 498) (defining "disability" as any of the following: "(1) a physical or mental impairment that substantially limits one or more of the major life activities of the individual[,], (2) a record of such an impairment[,], or (3) being regarded as having such an impairment").

8. *Id.* § 54(a) (amended by Chapter 498) (specifying such public places as streets, highways, sidewalks, walkways, public buildings, medical facilities, public facilities, and other public places).

9. *Id.* § 54(c) (amended by Chapter 498).

B. Housing, Transportation, Facilities, and Accommodations

California law states that disabled persons shall be entitled to full and equal access¹⁰ to transportation, accommodations,¹¹ and facilities.¹² Under existing law, refusing access to an individual because he or she uses an assistance dog¹³ constitutes a denial of that person's right to equal access.¹⁴ In addition, persons licensed to train dogs for disabled persons have the right to be accompanied by either a guide dog, signal dog, or service dog in any place specified in Civil Code § 54.1.¹⁵ California law also prohibits persons from charging disabled persons or trainers of assistance dogs extra money for the admission of the assistance dog.¹⁶ Persons accompanied by such a dog must have the dog on a leash and have the dog tagged¹⁷ identifying the dog as a guide dog, signal dog, or service dog.¹⁸ People accompanied by these dogs will be liable for all damage caused by the dogs.¹⁹ Chapter 498 makes a violation of the Americans with Disabilities Act a violation of California law.²⁰

Prior California law declared it an unlawful practice "for a person to deny or to aid, incite, or conspire in the denial of the rights created by section 51 or 51.7 of the

10. See *id.* § 54.1(a)(3) (amended by Chapter 498) (defining "full and equal access" with respect to transportation as that required under Titles II and III of the ADA and federal regulations adopted in furtherance of the ADA); *id.* (further providing that if California law mandates higher standards, those standards shall apply).

11. See *id.* § 54.1(b)(2) (amended by Chapter 498) (defining "housing accommodations" as "any real property, or portion thereof, which is used or occupied, or is intended, arranged, or designed to be used or occupied, as a home, residence, or sleeping place of one or more human beings"); *id.* (excluding from the definition of housing accommodations those accommodations set forth in § 54.1(a) and any single family residence in which the occupants rent, lease, or furnish not more than one room); see also *id.* § 54.1(a) (amended by Chapter 498) (listing the following accommodations: airplanes, motor vehicles, railroad trains, motorbuses, streetcars, boats, or any other public transportation, telephone facilities, hotels, lodging places, places of public accommodation, amusement, or resort, and other public places).

12. *Id.* § 54.1(b)(1) (amended by Chapter 498); see *id.* (including accommodations, facilities, medical facilities, and common carriers as places to which disabled individuals are entitled to full and equal access, but not limiting equal access rights to these places).

13. See *id.* § 54.1(b)(6)(C)(i) (amended by Chapter 498) (defining a "guide dog" as any dog that was trained by a person licensed under Chapter 9.5 of Division 3 of the Business and Professions Code or as defined by the ADA); *id.* § 54.1(b)(6)(C)(ii) (amended by Chapter 498) (defining a "signal dog" as a dog trained to alert a deaf or hearing impaired individual to intruders or sounds); *id.* § 54.1(b)(6)(C)(iii) (amended by Chapter 498) (defining a "service dog" as any dog individually trained to the requirements of a disabled person, including fetching items, protecting, and pulling wheelchairs).

14. *Id.* § 54.1(b)(6)(A) (amended by Chapter 498).

15. *Id.* § 54.2(b) (amended by Chapter 498).

16. *Id.* § 54.2 (amended by Chapter 498).

17. See CAL. FOOD & AGRIC. CODE § 30850 (amended by Chapter 498) (stating that such tags shall be issued by the county clerk or animal control department).

18. CAL. CIV. CODE § 54.2(b) (amended by Chapter 498).

19. *Id.* § 54.2 (amended by Chapter 498).

20. *Id.* §§ 54.1-54.2 (amended by Chapter 498).

Civil Code."²¹ Chapter 498 amends prior law by adding §§ 54, 54.1, and 54.2 of the Civil Code to this list of unlawful practices.²²

C. Dog Tag Requirements

Chapter 498 changes several aspects regarding the tags assistance dogs are required to wear.²³ First, existing law requires the tags to be of uniform shape, size, and color statewide as determined by the Department of Food and Agriculture in consultation with the State Department of Health Services.²⁴ Ordinarily, adoption of regulations must adhere to the administrative procedures specified in Chapter 3.5 (commencing with § 11340), Division 3 of Part 1 of Title 2 of the Government Code.²⁵ This process requires, among other things, public notice, hearings, and review in order to adopt a new regulation.²⁶ Chapter 498 exempts the decision regarding the uniform statewide appearance of the assistance dog tags from these requirements.²⁷ This change saves the Department of Food and Agriculture from incurring the ordinary expenses involved in adopting administrative regulations.²⁸

Second, Chapter 498 adds a new element in the context of the assistance dog tags, by providing that nothing in the chapter regarding the assistance dog tags shall be construed to limit the ADA.²⁹ This provision was added to make this chapter consistent with §§ 54 through 54.2 of the Civil Code, which already provide that nothing in existing law shall be construed to limit the ADA.³⁰ Chapter 498 further states that the provisions in the Chapter dealing with assistance dog tags are severable should they conflict with the ADA.³¹ Thus, should the courts find that part of Chapter 498 conflicts with the ADA, those portions of the Chapter that do not conflict will stand on their own.

21. 1980 Cal. Stat. ch. 992, sec. 4, at 3154 (enacting CAL. GOV'T CODE § 12948); *see* CAL. CIV. CODE § 51 (West Supp. 1997) (stating that persons have equal rights regardless of their sex, race, color, ancestry, or national origin); *id.* § 51.7 (West Supp. 1997) (declaring that all persons in California have the right to be free of violence and/or intimidation against themselves or their property because of race, color, religion, ancestry, national origin, political affiliation, or position in a labor dispute).

22. CAL. GOV'T CODE § 12948 (amended by Chapter 498); *see* CAL. CIV. CODE §§ 54-54.2 (amended by Chapter 498) (enumerating the rights of disabled persons to equal access in various contexts).

23. *See* CAL. CIV. CODE § 54.2(b) (amended by Chapter 498) (requiring assistance dogs to be tagged).

24. CAL. FOOD & AGRIC. CODE § 30852 (amended by Chapter 498).

25. CAL. GOV'T CODE §§ 11340-11356 (West 1992 & Supp. 1997) (specifying procedures to follow when adopting administrative regulations).

26. *See, e.g.*, CAL. GOV'T CODE § 11346.5 (West Supp. 1996) (specifying, at length, the notice requirements that must be followed prior to hearings and adoption of a regulation); *id.* § 11346.8 (West Supp. 1997) (articulating procedural requirements for public hearings regarding the regulation); *id.* § 11349.1 (West Supp. 1997) (providing standards by which the adopted regulation shall be reviewed).

27. CAL. FOOD & AGRIC. CODE § 30852(b) (amended by Chapter 498).

28. Telephone Interview with Joan Riddle, *supra* note 4.

29. CAL. FOOD & AGRIC. CODE § 30853 (enacted by Chapter 498).

30. CAL. CIV. CODE §§ 54-54.2 (amended by Chapter 498).

31. CAL. FOOD & AGRIC. CODE § 30854 (enacted by Chapter 498).

Third, Chapter 498 adopts certain procedural provisions in an effort to prevent fraud. Chapter 498 requires a person applying for assistance dog tags to sign an affidavit declaring that the individual understands California Penal Code § 365.5.³² Chapter 498 also directs an individual to return assistance dog tags immediately upon the death or retirement of the assistance dog.³³ Prevention of fraud underlies the purpose of these specific amendments.³⁴ The drafters of Chapter 498 hope that these provisions will eliminate the fraud problem experienced under past law.³⁵

California is one of the only states that requires tags that identify a dog as an assistance dog.³⁶ More importantly, federal law does not require assistance dog tags.³⁷ Accordingly, requiring assistance dog tags could be construed as a violation of federal law.³⁸ Chapter 498 amends prior California law to guarantee access equivalent to that provided by the ADA and the Air Carrier Access Act of 1986³⁹ in order to rectify this discrepancy.⁴⁰ Thus, Chapter 498 aims to avoid a conflict with federal law.⁴¹

32. *Id.* § 30850(b) (enacted by Chapter 498); *see* CAL. PENAL CODE § 365.5 (amended by Chapter 498) (prohibiting any person from fraudulently or knowingly representing himself or herself as an owner or trainer of an assistance dog and providing that a violation of this section is a misdemeanor punishable by a jail term not to exceed six months and/or a \$1000 fine).

33. CAL. FOOD & AGRIC. CODE § 30850(c) (amended by Chapter 498).

34. *See* Telephone Interview with Joan Riddle, *supra* note 4 (stating that problems with fraud existed before the passage of Chapter 498).

35. *Id.*

36. Memorandum from Senator Milton Marks to Legislative Counsel (Jan. 16, 1996) (copy on file with the *Pacific Law Journal*). Compare CONN. GEN. STAT. ANN. § 46a-64(a) (West 1995) (requiring a disabled individual to outfit his or her guide dog with either a harness or an *orange colored leash*) (emphasis added) and FLA. STAT. ANN. § 413.08 (West 1993 & Supp. 1997) (providing that the guide dog or service dog must be capable of being identified as such a dog) with ALA. CODE § 21-7-9(d) (1990) (providing that disabled individuals are entitled to equal access with their assistance dog but failing to require tags identifying such dogs as assistance dogs); DEL. CODE ANN. tit. 16, § 9505(d) (1995) (same); D.C. CODE ANN. § 6-1702(b) (1995) (same); GA. CODE ANN. § 30-4-2(c) (1993) (same); IND. CODE ANN. § 22-9-6-5 (West Supp. 1996) (same); ME. REV. STAT. ANN. tit. 17, § 1312(3) (West Supp. 1996) (same); MINN. STAT. ANN. § 256C.025(4) (West 1992) (same); MO. ANN. STAT. § 209.190(4) (West 1996) (same); MONT. CODE ANN. § 49-4-214 (1995) (same); N.H. REV. STAT. ANN. § 167-C:2 (1994) (same); TENN. CODE ANN. § 66-7-104(d) (1993) (same); UTAH CODE ANN. § 26-30-2(1) (1995) (same); and VA. CODE ANN. § 51.5-45(B) (Michie 1994) (same).

37. Telephone Interview with Joan Riddle, *supra* note 4; *see* 42 U.S.C.A. §§ 12101-12213 (West 1990) (failing to require dog tags identifying dogs as assistance dogs); 49 U.S.C.A. §§ 1301-1542 (West Supp. 1996) (same).

38. Memorandum from Senator Milton Marks, *supra* note 36; *see supra* note 36 (listing other state laws which do not require tags identifying dogs as assistance dogs); *infra* notes 71-79 and accompanying text (discussing how California law may conflict with federal law).

39. *See* 49 U.S.C.A. §§ 1301-1542 (West Supp. 1996) (prohibiting discrimination against disabled persons).

40. CAL. PENAL CODE § 365.5(g)(2) (amended by Chapter 498).

41. Memorandum from Senator Milton Marks, *supra* note 36.

D. Remedies

Existing law provides remedies for violations of § 54 through § 54.2 of the Civil Code.⁴² Any person who interferes with a disabled person's rights enumerated in the above referenced sections can be sued in civil court and be held liable for up to three times the actual damages.⁴³ California used to specify minimum damages of \$750 plus attorney's fees for a violation of these sections.⁴⁴ Chapter 498 raises the minimum recovery to \$1000.⁴⁵ Further, Chapter 498 creates an administrative remedy by authorizing the filing of verified complaints with the Department of Fair Employment and Housing.⁴⁶ The administrative remedy provides injunctions or equitable relief, the sale or rental of like property, the payment of a civil penalty, or the payment of actual damages.⁴⁷ It was added to provide administrative oversight and to provide claimants with a choice regarding which type of action they seek.⁴⁸

Moreover, any person who interferes with or prevents a disabled person from exercising his or her rights is guilty of a misdemeanor punishable by a maximum fine of \$2500.⁴⁹ This criminal penalty does not affect any civil penalties a disabled individual may seek for a violation of his or her rights.⁵⁰

Furthermore, Chapter 498 adopts language making the language of California Penal Code § 365.5 congruent with California Civil Code § 54.1(c).⁵¹ Additionally, Chapter 498 expressly adds medical facilities, telephone facilities, and adoption agencies to the list of public places where access shall not be denied to a disabled person because they are accompanied by an assistance dog.⁵²

III. HISTORY OF EXISTING LAW

In 1994, Senator Marks introduced Senate Bill 1240⁵³ because, despite the enactment of the ADA and California law, disabled persons were being denied access to

42. CAL. CIV. CODE §§ 54-54.2 (amended by Chapter 498).

43. *Id.* § 54.3(a) (amended by Chapter 498).

44. 1994 Cal. Legis. Serv. ch. 1257, sec. 4, at 6478 (amending CAL. CIV. CODE § 54.3).

45. CAL. CIV. CODE § 54.3(b) (amended by Chapter 498).

46. *Id.*

47. CAL. GOV'T CODE § 12987 (West Supp. 1997).

48. Telephone Interview with Joan Riddle, *supra* note 4.

49. CAL. PENAL CODE § 365.5(c) (amended by Chapter 498).

50. *Id.* § 365.5(g)(1) (amended by Chapter 498); *see* CAL. CIV. CODE § 54.3 (amended by Chapter 498) (specifying the type of civil penalties that may be imposed for violating the right to equal access of disabled persons).

51. *Compare* CAL. PENAL CODE § 365.5 (amended by Chapter 498) (requiring that the person using or training an assistance dog ensure that the dog is on a leash and tagged properly as a guide dog, service dog, or signal dog and stating that such person shall be liable for any provable damages to the premises caused by the dog) with CAL. CIV. CODE § 54.1(c) (amended by Chapter 498) (containing the same language added to California Penal Code § 365.5 by Chapter 498).

52. CAL. PENAL CODE § 365.5 (amended by Chapter 498).

53. 1994 Cal. Legis. Serv. ch. 1257, sec. 1, at 6475-76.

public accommodations and facilities because they were accompanied by an assistance dog.⁵⁴ Senate Bill 1240 provided disabled individuals accompanied by assistance dogs and persons training assistance dogs with equal access to public facilities and accommodations.⁵⁵

Although laudable, SB 1240 met opposition from a few interest groups.⁵⁶ Groups such as the restaurant, hotel, and grocery industries opposed the bill because the bill did not require assistance dogs to be tagged or identified as assistance dogs.⁵⁷ These industries argued that without a tag identifying a dog as an assistance dog, operators and employees in these industries would have a hard time distinguishing a pet from an assistance dog, particularly if the person accompanied by the dog had no visible disability.⁵⁸ The restaurant, grocery, and hotel industries were concerned that they would be forced to admit dogs into their facilities without knowing whether the dogs were adequately trained as assistance dogs.⁵⁹ They feared that the admittance of inadequately trained dogs posed a risk of health and safety violations.⁶⁰

The employee base in the restaurant, hotel, and grocery industries enhanced these legitimate concerns.⁶¹ These industries employ a large number of short-term, low-skill employees who do not have the requisite knowledge to make decisions regarding disabled access laws.⁶² Thus, employers in these industries felt particularly exposed to liability due to their employees' general lack of knowledge and skill in this area.⁶³ Consequently, the legislature added provisions requiring assistance dog tags in order to accommodate the restaurant, hotel, and grocery industries and ensure passage of the bill.⁶⁴

IV. POTENTIAL PROBLEMS

Existing California law requires identification of assistance dogs with special tags.⁶⁵ However, the ADA provides equal access for individuals with disabilities, but does not require tags that identify a dog as an assistance dog.⁶⁶ Thus, California law

54. ASSEMBLY COMMITTEE ON JUDICIARY, COMMITTEE ANALYSIS OF SB 1240, at 5 (Aug. 10, 1994).

55. 1994 Cal. Legis. Serv. ch. 1257, sec. 1, at 6475-76.

56. ASSEMBLY COMMITTEE ON JUDICIARY, COMMITTEE ANALYSIS OF SB 1240, at 1 (Aug. 10, 1994).

57. *Id.*

58. *Id.* at 5.

59. *Id.* at 6.

60. *Id.*

61. Telephone Interview with Joan Riddle, *supra* note 4.

62. *Id.*; see *Restaurant Kicks Out Blind Women With Guide Dogs*, L.A. TIMES, July 20, 1995, at B5 (describing the experience of two blind women who were kicked out of a Burger King restaurant by employees because of concerns about health code violations, despite the fact that the women showed the employees a card citing state law that allows a guide dog to accompany a disabled person into a restaurant).

63. Telephone Interview with Joan Riddle, *supra* note 4.

64. See ASSEMBLY COMMITTEE ON JUDICIARY, COMMITTEE ANALYSIS OF SB 1240, at 1 (Aug. 10, 1994) (stating that the bill was amended to require identification tags of assistance dogs).

65. See *supra* notes 17-18 and accompanying text (requiring assistance dogs to be tagged).

66. See *supra* note 37 and accompanying text (stating that the ADA does not require assistance dog tags).

may conflict with federal law. This potential conflict presents two problems with California's assistance dog tag law.

A. A False Sense of Security

First, California's assistance dog tag requirement may prove to be a trap for the unwary. For instance, if an individual denies a disabled person access to a public accommodation or facility because the disabled person's dog is not tagged, he or she still may be held liable for violating the disabled person's rights. This is because although California law requires assistance dogs to be tagged, the ADA does not require tags.⁶⁷ Thus, a person may still incur liability under federal law for denying a disabled individual access because his or her dog lacks tags.

Moreover, Chapter 498 provides that the tag requirement under California law shall not be construed to limit the access provided by the ADA.⁶⁸ Since the ADA does not require assistance dog tags, California law, by its own terms, cannot limit a disabled individual's access based upon this requirement.⁶⁹ In addition, Chapter 498 makes a violation of federal law a violation of California law.⁷⁰ Accordingly, an individual who relies on California's dog tag requirement in denying a disabled individual access may incur liability under both federal and state laws. Thus, California's dog tag requirement does nothing except pose a greater threat of liability to the concerned industries because it purports to require dog tags when in essence it cannot.

B. Supremacy

Second, the ADA may preempt California's assistance dog tag requirement. The Federal Constitution provides for the supremacy of federal law where federal and state laws conflict.⁷¹ Such a conflict may exist between Chapter 498 and the ADA given that Chapter 498 requires tags identifying assistance dogs where federal law does not.⁷²

Congressional intent underlying federal law determines whether federal law preempts state law.⁷³ Congress may preempt state law by expressly stating so or by occupying the field.⁷⁴ In addition, federal law preempts state law where state law

67. See *supra* note 37 and accompanying text (stating that the ADA does not require assistance dog tags).

68. CAL. FOOD & AGRIC. § 30853 (amended by Chapter 498).

69. See *id.* (providing that California law shall not be construed to limit access guaranteed under the ADA).

70. See CAL. CIV. CODE §§ 54-54.2 (amended by Chapter 498) (stating that a violation of the ADA is a violation of these provisions of state law).

71. See U.S. CONST. art. VI (providing that federal law is the supreme law of the land).

72. See *supra* notes 36-37 and accompanying text (stating that California law requires dog tags whereas federal law does not make such a requirement).

73. California Fed. Sav. & Loan Ass'n v. Guerra, 479 U.S. 272, 280 (1987).

74. *Id.* at 280-81.

directly conflicts with federal law.⁷⁵ The ADA expressly allows states to provide equal or greater protections to disabled individuals.⁷⁶ By expressly allowing states to pass laws of equal or greater force than the ADA, Congress arguably intended to preempt less stringent state laws. Moreover, congressional intent strongly backs this inference.⁷⁷ Hence, Congress likely intended the ADA to preempt less stringent state laws.

Congress passed the ADA to ensure equal access for disabled persons but did not require those utilizing assistance dogs to obtain special dog tags.⁷⁸ This implies that Congress did not intend the rights of a disabled individual to hinge on the presence of identification tags. California's dog tag provisions create an additional hurdle that disabled individuals must surpass in order to ensure equal access. Thus, federal law provides more stringent protection because it guarantees equal access to disabled individuals unconditionally. Therefore, the provisions requiring assistance dog tags most likely will be stricken if challenged.⁷⁹

The drafters of Chapter 498 have provided for this contingency by making all provisions of this chapter severable.⁸⁰ Therefore, if any provision of Chapter 498 is found to conflict with the ADA, other valid provisions of Chapter 498 will not be affected.⁸¹ Hence, the objectives of prior California law and Chapter 498—equal access for disabled individuals accompanied by their assistance dogs—will be maintained regardless of the validity of the assistance dog tag requirements.

V. CONCLUSION

What was meant to be a law ensuring equal access for disabled people turned into an argument pitting proprietors, who were concerned about having dogs in their establishments, against disabled advocates, who were concerned about equal access for disabled persons. This argument spawned California's assistance dog tag requirements. The legislature enacted Chapter 498 to clean up problems with the existing

75. *Id.* at 281.

76. 42 U.S.C.A. § 12201(b) (West 1995).

77. *See id.* §12101(b) (West 1995) (specifying the intent to: (1) Provide clear and comprehensive national mandates; (2) provide strong, enforceable standards; (3) ensure the federal government's involvement in enforcing the standards; and (4) invoke the "sweep" of congressional authority).

78. *See supra* note 37 and accompanying text (stating that federal law does not require tags for assistance dogs).

79. *See* Memorandum from Senator Milton Marks, *supra* note 36 (stating that the identification tag requirement could be a violation of federal law and other states' law); *see also* Telephone Interview with Joan Riddle, *supra* note 4 (stating that the provision requiring assistance dog tags is probably a violation of the ADA); *cf.* Crowder v. Kitagawa, 81 F.3d 1480, 1485 (9th Cir. 1996) (holding that Hawaii's law requiring a 120-day quarantine for carnivorous animals violates the ADA, and requiring that the law be modified to comply with the ADA).

80. CAL. FOOD & AGRIC. CODE § 30854 (enacted by Chapter 498).

81. *See id.*

California law. However, in doing so, Chapter 498 presents interesting problems for those establishments concerned about allowing dogs onto their premises.

The state law dog tag requirements apparently quelled the concerns of the hotel, grocery, and restaurant industries. However, individuals who deny access to a disabled person because his or her dog is not properly tagged may incur liability under both the ADA and California law. Furthermore, the courts will likely strike the tag requirements because they conflict with federal law. In essence, the tag requirements did nothing except mollify the concerns of some powerful industries. Although in practice the tag requirements arguably do nothing, they enabled the passage of both prior law and Chapter 498. Thus, clever drafting enabled the furtherance of a worthy and needed goal—truly equal access for disabled individuals.

APPENDIX

Code Sections Affected

Civil Code §§ 54, 54.1, 54.2, 54.3 (amended); Food and Agricultural Code §§ 30853, 30854 (new), §§ 30850, 30852 (amended); Government Code § 12948 (amended); Penal Code § 365.5 (amended).
SB 1687 (Marks); 1996 STAT. Ch. 498

Enforcing the Prohibition Against Inmates Receiving Welfare Benefits While Incarcerated

Mike A. Cable

I. INTRODUCTION

After a jury convicted him of the murder, torture, and sexual assault of fourteen boys and young men, the public paid William George Bonin \$79,000 while awaiting his execution.¹ Although federal law prohibits social security benefits from being paid to persons incarcerated for over thirty days,² Bonin, better known as the "Freeway Killer," continued to receive social security benefits while on death row.³ Public awareness of this issue, and general resentment toward welfare,⁴ has prompted state and federal legislation that would provide better enforcement of the law that prohibits inmates from receiving welfare funds.⁵

Allowing inmates to receive welfare benefits is viewed as contrary to the basic principle of having a welfare system.⁶ Specifically, welfare acts as a web of support programs that provide a disabled and needy population with the necessities of life.⁷ Taxpayers, through their tax dollars, provide food and housing to incarcerated

1. Marc Lifsher, *State Says Federal Officials Let Checks Go to Prisoners*, ORANGE COUNTY REG., Mar. 9, 1996, at A18 [hereinafter Lifsher, *Checks Go to Prisoners*]; see *Man Known as the Freeway Killer Is Executed*, N.Y. TIMES, Feb. 24, 1996, at 7 (explaining that a jury convicted Bonin of murdering 14 boys and young men).

2. See 42 U.S.C.A. § 402(x) (West Supp. 1996) (explaining that individuals shall not be paid benefits for any month during which they are incarcerated).

3. Marc Lifsher, *Alert Didn't Keep Funds from Bonin*, ORANGE COUNTY REG., June 5, 1996, at B01 [hereinafter Lifsher, *Alert Didn't Keep Funds*]; see *id.* (explaining that the "Freeway Killer" received social security payments throughout the 14 years he was on death row); Lifsher, *Checks Go to Prisoners*, *supra* note 1, at A18 (stating that the "Freeway Killer" received illegal social security benefits while he was on death row). See generally *Man Known as the Freeway Killer Is Executed*, *supra* note 1, at 7 (reporting about the execution of the "Freeway Killer").

4. See Francis X. Clines, *Clinton Signs Bill Cutting Welfare*, N.Y. TIMES, Aug. 23, 1996, at A1 (stating that President Clinton acknowledges the nation's frustration over welfare).

5. See HR 2320, 104th Cong. (1995) (amending the Social Security Act to require institutions to report individuals that are confined); see also Lifsher, *Alert Didn't Keep Funds*, *supra* note 3, at B01 (reporting that social security now receives computer reports from approximately 90% of the inmate population); *Money for Nothing*, SAN DIEGO UNION-TRIB., Oct. 30, 1995, at B6 (explaining that house member Bob Clement of Tennessee introduced a new Criminal Welfare Prevention Act to save the government money from prisoners that double-dip).

6. See Nancy Weaver, *Check's in the Mail and Jail Inmates Are Cashing In*, SACRAMENTO BEE, Nov. 11, 1995, at A1 (explaining that inmates receiving welfare payments is illegal because the county already pays for the meals and shelter).

7. *Money for Nothing*, *supra* note 5, at B6; see *id.* (stating that a portion of social security benefits goes to help the disabled acquire food, housing, and other necessities); see also Rachel M. Schulman, *Welfare Reform: Fact or Fiction?*, 20 SETON HALL LEGIS. J. 169, 170 (1996) (explaining that 75% of the economically disadvantaged in the United States receive government benefits to aid their daily survival).

individuals.⁸ Thus, providing inmates with welfare compensation allows prisoners to "double-dip" into the public's pocket,⁹ thereby inhibiting the state's ability to provide welfare assistance to those that desperately need it. Chapter 205 seeks to end this abuse by establishing a statewide reporting system that alerts the State Department of Social Services of prisoners that have been incarcerated for thirty days.¹⁰

II. BACKGROUND

A. Ideological Shift in Providing Welfare Assistance

The welfare system's goals have changed in recent years.¹¹ In the past, society viewed welfare as a means of providing assistance to those who have fell victim to poverty.¹² Various systems that were created to reform the individual were considered beneficial to the public and a humanitarian way of providing families with the necessities of life.¹³ Today, people view poverty as a personal choice.¹⁴ No longer are welfare recipients considered a group the system should reform, but rather, society stigmatizes them as a group that seeks out welfare as a way of life.¹⁵ Moreover, critics of the welfare system argue that it allows recipients to become dependent upon public support, and thus critics call for its elimination.¹⁶

8. *Money for Nothing*, *supra* note 5, at B6; *see id.* (explaining that taxpayers pay for inmates' housing, food, and medical care during incarceration); *see also* Weaver, *supra* note 6, at A1 (stating that an inmate's receipt of welfare while in jail is illegal because the county is already paying for meals and shelter).

9. *Money for Nothing*, *supra* note 5, at B6; Weaver, *supra* note 6, at A1; *see* Lifsher, *Checks Go to Prisoners*, *supra* note 1, at A18 (quoting the Regional Commissioner of Social Security as stating that illegal payments to county jail inmates cost the state and federal governments millions of dollars per year).

10. SENATE FLOOR, COMMITTEE ANALYSIS OF SB 1556, at 2 (July 9, 1996); *see* CAL. WELF. & INST. CODE § 10985(a) (enacted by Chapter 205) (stating that every jail shall report twice each month to the Department of Social Services those inmates that the jails have incarcerated for 30 days).

11. Schulman, *supra* note 7, at 169; *see id.* (explaining that Congress intends to reform the welfare system).

12. *Id.* at 172-73; *see id.* (explaining that the goals of welfare used to be to help those that needed assistance, and to find ways to terminate poverty).

13. *See Money for Nothing*, *supra* note 5, at B6 (describing social security as a system that helps disabled people pay for food, housing, and other necessities).

14. *See* Schulman, *supra* note 7, at 175 (stating that during the 1980s, justifications for poverty turned toward individual choice).

15. *See id.* at 169 (explaining that Congress thinks of welfare as a dependency web); *see also* Clines, *supra* note 4, at A1 (quoting President Clinton's statement that his current welfare reform will prevent welfare from becoming a way of life).

16. Schulman, *supra* note 7, at 170; *see id.* (stating that the elimination of the Aid to Families with Dependent Children program is one of the goals of Congress); *see also* Clines, *supra* note 4, at A1 (describing President Clinton's new welfare reform as eliminating a pillar of President Roosevelt's social welfare program).

B. Prohibiting Prisoners from Receiving Public Funds

For the last sixteen years, the United States Congress has enacted legislation limiting the ability of inmates to receive social security.¹⁷ The rationale in creating this legislation was that prisoners do not need to receive welfare compensation because they are being maintained in prison at public expense.¹⁸ As intolerance toward inmates receiving compensation grew, Congress enacted legislation prohibiting the inmates of any public institution from receiving public funds for any month that they are incarcerated.¹⁹ Moreover, individuals confined at public expense because of a verdict finding the person mentally incompetent are also prohibited from receiving public assistance.²⁰ Although constitutional concerns have been raised regarding this prohibition, these concerns appear to be in vain.²¹

C. Constitutional Scrutiny of Prohibiting Prisoners' Benefits

Since the time that Congress first prohibited the distribution of public funds to inmates, many inmates have challenged the prohibition on constitutional grounds.²² However, courts have consistently upheld Congress's power to prohibit inmates from receiving social security benefits.²³

1. Bill of Attainder

Some inmates have argued that prohibiting their ability to receive welfare benefits violates the constitutional prohibition against bills of attainder.²⁴ A bill of

17. See *infra* notes 19-20 and accompanying text (describing legislation that has prohibited the extension of social security benefits to inmates).

18. *Zipkin v. Heckler*, 790 F.2d 16, 18 (2d Cir. 1986).

19. 42 U.S.C.A. § 402(x) (West Supp. 1996).

20. *Id.*

21. See, e.g., *Sulie v. Bowen*, 653 F. Supp. 849, 851 (N.D. Ind. 1987) (stating that the constitutionality of Social Security Act section 202(x) continues to be upheld in numerous courts); see also *infra* Parts II.C.1., 2. (discussing cases that have upheld the constitutionality of prohibitions against inmates receiving welfare benefits). See generally Gregory G. Sarno, Annotation, *Validity, Construction, and Effect of 202(x) of Social Security Act (42 USCS § 402(x))*, *Mandating Suspension of Old-Age, Survivors, and Disability Insurance Benefits for Incarcerated Felons*, 86 A.L.R. FED. 748 (1988) (describing cases that have dealt with the constitutionality of section 202(x) of the Social Security Act).

22. See Sarno, *supra* note 21, at 753-63 (discussing the various constitutional challenges brought against section 202(x) of the Social Security Act, including attacks based on double jeopardy, equal protection, and due process).

23. See *infra* Parts II.C.1., 2. (discussing why courts have upheld statutes that prohibit inmates from receiving social security benefits).

24. See, e.g., *Jones v. Heckler*, 744 F.2d 997, 998 (10th Cir. 1985) (rejecting the plaintiff's contention that the suspension of his disability benefits while he is in prison violates the Constitution because it constitutes bill of attainder); *Hopper v. Schweiker*, 596 F. Supp. 689, 693 (M.D. Tenn. 1984) (noting the plaintiff's belief that suspending his welfare benefits while he is incarcerated constitutes a bill of attainder); *Pace v. United States*, 585 F. Supp. 399, 402 (S.D. Tex. 1984) (explaining the plaintiff's argument that suspension of his welfare benefits

attainder is a legislative act that inflicts punishment upon an individual or an ascertainable group without a judicial trial.²⁵ Specifically, plaintiffs argue that Congress passed a bill of attainder by eliminating their welfare benefits without affording them a judicial trial.²⁶ Inmates believe that prohibiting them from receiving welfare benefits amounts to punitive punishment by legislative authority.²⁷ Courts, on the other hand, have held that prohibiting an inmate from receiving public assistance while in prison is not a form of punishment, but a mere denial of a government benefit.²⁸ Consequently, the protection against bills of attainder is not violated because the prohibition of benefits does not constitute a "punishment."²⁹

2. Substantive Due Process

Another constitutional challenge is that prohibiting inmates from receiving public assistance violates substantive due process.³⁰ Substantive due process protection provides people with freedom from all arbitrary and purposeless restraints.³¹ In particular, inmates believe that congressional restrictions that prohibit inmates from receiving welfare benefits deprive them of their right to the funds without due process of law.³² The inmates contend that they have a property interest in the receipt of welfare funds, and that the constitutional protection of life, liberty, and property is being violated because of an arbitrary decision to withhold welfare benefits from inmates.³³

while incarcerated violates the Constitution because it is a bill of attainder).

25. *United States v. Lovett*, 328 U.S. 303, 315 (1946) (quoting *Cummings v. Missouri*, 71 U.S. (4 Wall.) 277, 323 (1866)).

26. *Hopper*, 596 F. Supp. at 693; *Pace*, 585 F. Supp. at 402.

27. *Hopper*, 596 F. Supp. at 693; *Pace*, 585 F. Supp. at 402.

28. See, e.g., *Jones*, 774 F.2d at 998 (citing *Flemming v. Nestor*, 363 U.S. 603 (1960), for the proposition that the denial of governmental benefits does not constitute punishment within the meaning of the bill of attainder clause); *Pace*, 585 F. Supp. at 401 (stating that the *Flemming* court held that the disqualification of benefits does not constitute punishment).

29. See *Jones*, 774 F.2d at 998 (holding that suspension of governmental benefits does not constitute double jeopardy because it is not considered a punishment); *Pace*, 585 F. Supp. at 402 (explaining that the denial of governmental benefits does not violate the cruel and unusual punishment protection because suspension of governmental benefits is not punishment).

30. *Davis v. Bowen*, 825 F.2d 799, 799 (4th Cir. 1987); *Zipkin v. Heckler*, 790 F.2d 16, 17-18 (2d Cir. 1986); *Jones*, 774 F.2d at 998; *Washington v. Secretary of Health & Human Servs.*, 718 F.2d 608, 609 (3d Cir. 1983).

31. Harry S. Dannenberg, Case Comment, *Parratt v. Taylor: Don't Make a Federal Case Out of It*, 63 B.U. L. REV. 1187, 1215 (1983); see *id.* (describing Justice Harlan's definition of substantive due process in a dissenting opinion).

32. See *supra* note 30 (citing cases that have challenged restrictions on inmates receiving public assistance on due process grounds).

33. See, e.g., *Washington*, 718 F.2d at 610 (relating the plaintiff's claim that the suspension of benefits while incarcerated is unconstitutional because it deprives the plaintiff of property without due process of law).

The United States Supreme Court held that the availability of social security benefits is not an accrued property right protected by the Constitution.³⁴ Instead, as one court held, social security benefits are “noncontractual benefits under a social welfare system.”³⁵ Accordingly, the strict protection guaranteed by the Due Process Clause does not apply to the prohibition of welfare benefits.³⁶ However, the Court did conclude that such prohibitions must satisfy a rational basis standard.³⁷ The limitation on receiving public assistance, in other words, must be rationally related to a legitimate government interest.³⁸

Consistently, courts have held that Congress’s prohibition on inmates from receiving social security benefits serves a legitimate government interest.³⁹ Public resources are scarce, and prohibiting inmates from “double-dipping” into this finite and limited pool of money is a legitimate interest of government.⁴⁰ Moreover, the fact that inmates are being taken care of while incarcerated demonstrates that there is no dire concern in providing them with money intended for necessities.⁴¹ Consequently, courts have held that legislation that prohibits welfare payments to inmates incarcerated for thirty days does not violate the Constitution because it is a rational means of promoting the government’s interest in preventing inmates from “double-dipping” into scarce public resources.⁴²

III. CHAPTER 205 AND PROHIBITING INMATES FROM RECEIVING PUBLIC ASSISTANCE

The failure to enforce welfare restrictions that prohibit inmates from receiving public assistance has recently been criticized.⁴³ Chapter 205 strengthens enforcement by requiring statewide reporting of inmates who are ineligible for public assistance.⁴⁴ Reports of inmates receiving welfare checks while in prison have prompted state and

34. *Flemming*, 363 U.S. at 608 (1960).

35. *Davis*, 825 F.2d at 800.

36. *See Fleming*, 363 U.S. at 611 (explaining that the Constitution is not violated with every defeasance of interest covered by the Social Security Act, and that such interests are protected only from arbitrary governmental action).

37. *See id.* (holding that the Due Process Clause interposes a bar only to arbitrary classifications that lack a rational justification).

38. *Id.*

39. *See, e.g., Davis*, 825 F.2d at 801.

40. *Id.*; *see id.* (discussing the legitimate interest in protecting scarce national resources).

41. *See supra* notes 6-9 and accompanying text (explaining that providing inmates with governmental assistance while incarcerated is contrary to the welfare system because the government already provides the inmates with the necessities of life).

42. *See supra* note 39 and accompanying text.

43. *See Lifsher, Checks Go to Prisoners, supra* note 1, at A18 (quoting the Deputy Director of Adult Services as stating that the federal government has grown accustomed to not enforcing the law); Weaver, *supra* note 6, at A1 (reporting that 10% of California’s 74,000 county jail inmates get social security benefits).

44. CAL. WELF. & INST. CODE § 10985 (enacted by Chapter 205).

local authorities to assess the enforcement of public assistance laws in California.⁴⁵ Specifically, the movement toward enhanced enforcement focuses on improving communication between local jails and the Department of Social Services (DSS).⁴⁶ Improving communication between these offices will prevent "double-dipping" because DSS will notify other agencies when a person becomes ineligible for public assistance due to incarceration.⁴⁷

Chapter 205 mandates communication between local jails, DSS, and the agencies that administer public benefits.⁴⁸ Specifically, Chapter 205 requires every city and county jail to report to DSS, twice each month, every person who has been incarcerated for more than thirty days, unless that person has already been reported for their current incarceration.⁴⁹ A format for reporting the information may be established, and each report must contain the inmate's name, known aliases, birth date, social security number, and, if available, their expected release date.⁵⁰

Chapter 205 aims to eliminate illegal distribution of public assistance by requiring DSS to relay the information it receives to the various agencies that distribute welfare funds.⁵¹ Since administrative costs of local jails will increase because of the burden of reporting their inmate population, Chapter 205 mandates an appropriation from the General Fund so that implementation of this program will begin immediately.⁵² Proponents of Chapter 205 believe that urgency is required to preserve the public welfare system.⁵³

IV. CONCLUSION

Most people agree that recipients who become incarcerated should have their benefits suspended.⁵⁴ Unfortunately, the laws that prohibit inmates from receiving

45. See Lifsher, *Alert Didn't Keep Funds*, *supra* note 3, at B01 (stating that the Director of the California Department of Corrections has pledged to work with the federal government to prevent prisoners from receiving illegal payments); Lifsher, *Checks Go to Prisoners*, *supra* note 1, at A18 (noting a computer match up of California prison inmates that showed approximately 600 to 2800 inmates might be receiving illegal social security payments); *Money for Nothing*, *supra* note 5, at B6 (describing a Butte County sheriff who independently checked the welfare status of his inmates); see also Weaver, *supra* note 6, at A1 (reporting that California officials estimate that the state could save \$36 million to \$60 million a year by stopping inmates from receiving public assistance).

46. See CAL. WELF. & INST. CODE § 10985 (enacted by Chapter 205) (requiring local jails to report to DSS twice every month).

47. *Id.* § 10985(c) (enacted by Chapter 205).

48. *Id.* § 10985(a) (enacted by Chapter 205).

49. *Id.* § 10985(a) (enacted by Chapter 205).

50. *Id.* § 10985(b)(1) (enacted by Chapter 205).

51. SENATE FLOOR, COMMITTEE ANALYSIS OF SB 1556, at 2 (July 9, 1996).

52. See 1996 Cal. Legis. Serv. ch. 205, sec. 2, at 3 (enacting CAL. WELF. & INST. CODE § 10985) (stating that \$230,000 is appropriated from the General Fund to the DSS for implementing this Act in the 1996-97 fiscal year).

53. See *id.*, sec. 4, at 3 (enacting CAL. WELF. & INST. CODE § 10985) (stating that this Act shall go into immediate effect to prevent inappropriate payments of public benefits).

54. See *supra* Part I (explaining that inmates are receiving public assistance and that this is contrary to the welfare system).

welfare assistance are not being enforced.⁵⁵ Consequently, persons that are convicted and incarcerated are sent public funds in addition to receiving food, shelter, and medical assistance while in prison.⁵⁶ Chapter 205 seeks to enhance enforcement by requiring local jails to inform public agencies of every person who has been incarcerated for thirty days.⁵⁷ Proponents of Chapter 205 contend that improving the communication between these agencies will allow stricter enforcement of the law prohibiting inmates from receiving welfare.⁵⁸ Thus, public agencies will know who is ineligible for welfare benefits, and stop the inmate from taking advantage of public assistance.⁵⁹

APPENDIX

Code Section Affected

Welfare and Institutions Code § 10985 (new).
SB 1556 (Johnston); 1996 STAT. Ch. 205

55. See *supra* notes 43-45 and accompanying text (noting that the enforcement of restrictions upon welfare is not adequate).

56. See *supra* notes 6-9 and accompanying text.

57. See *supra* notes 46-47 and accompanying text.

58. SENATE FLOOR, COMMITTEE ANALYSIS OF SB 1556, at 3 (July 9, 1996).

59. *Id.*

Law Enforcement Intervention on Behalf of Endangered Adults

Michael C. Weed

I. INTRODUCTION

Growing old is inevitable, and as the saying goes, it's better than the alternative. However true this statement may be, as Americans age, the situations they confront may not be as pleasant as would be desired. Today, abuse of the elderly¹ has become a significant social problem.

Over the past several decades, the American population has seen a steady rise in the percentage of elderly citizens.² California, in particular, has experienced a steady increase in its elderly population, and that trend is expected to continue or even accelerate.³ As the elderly population increases in number and percentage, simple mathematics lead to the conclusion that the problem of elder abuse, if left unaddressed, will grow as well.⁴

The causes of elder abuse have many theoretical explanations, from family financial pressures to the additional emotional strain caused by having to care for a dependent adult.⁵ Whatever the cause, however, it is the resulting abuse that requires immediate attention.⁶

Although elder adults are vulnerable to financial misdeeds by their caretakers, the most common and pressing problem is the physical abuse and neglect which en-

1. Chapter 913 addresses both elderly adults and dependent adults. See CAL. WELF. & INST. CODE § 15700(a) (1) (enacted by Chapter 913) (stating that both elder and dependent adults are subject to the abuses Chapter 913 addresses); see also *id.* § 15701.15 (enacted by Chapter 913) (defining "dependent adults" as people between the ages of 18 and 64 who have a physical or mental condition that limits their ability to carry out normal activities or to protect their individual rights). For the purposes of Chapter 913, both categories are encompassed by the term "endangered adult." See *id.* § 15701.25 (enacted by Chapter 913) (including both elder and dependent adults in the definition of "endangered adult"). Though at times the discussion will be focussed on the elderly adult, all provisions applicable to the elderly are also applicable to a dependent adult.

2. See Audrey S. Garfield, Note, *Elder Abuse and the States' Adult Protective Services Response*, 42 HASTINGS L.J. 859, 862-63 (1991) (noting the "greying" of America and the steady rise in the elderly population, predicted to reach 35 million, or 13% of the population, by the year 2000).

3. See *id.* at 863 (detailing the dramatic increase in California's elderly population over the past two decades); *id.* (noting the staggering predictions that California's population of people 80 and older is expected to increase by 94% by the year 2000, and those over 85 are expected to increase by 138% in the same period).

4. See ASSEMBLY FLOOR, COMMITTEE ANALYSIS OF AB 2881, at 3 (Aug. 30, 1996) (noting that the number of elder abuse incidents is increasing).

5. See Garfield, *supra* note 2, at 867-69 (reviewing several of the more common causes of elder abuse, such as economic pressures, alcohol and drug abuse, and family pressures in conflict with caring for the elderly, such as the pressure of getting children off to college and the accompanying financial difficulties that entails).

6. While not minimizing the importance of finding solutions to the causes of elder abuse, which would certainly be the most desirable result in the long run, it seems clear that addressing the resulting abuse is the most direct and immediate method of bringing about positive results. There is nothing inherently wrong with curing symptoms in the present, even though eradicating the disease in the future is the ultimate goal.

dangers many elder adults.⁷ At times, this physical abuse can reach crisis dimensions, at which point immediate action is necessary to protect the elder adult from serious harm.⁸ It is these situations, requiring rapid action to prevent serious harm, which Chapter 913 addresses and seeks to remedy.⁹

II. THE TOOLS PROVIDED BY CHAPTER 913

Chapter 913 enacts a statutory mechanism whereby local law enforcement officials¹⁰ are authorized to remove an elder or dependent adult from an abusive situation.¹¹ Upon specific determinations,¹² the law enforcement official is empowered by Chapter 913 to take the endangered adult¹³ into emergency protective custody.¹⁴ Prior to removal of the endangered adult, however, the law enforcement official must determine, from personal observation, that the elder or dependent adult is in fact at immediate risk of serious harm and that no other alternative exists to mitigate the endangering circumstances.¹⁵ Upon reaching this determination, the law enforcement official is authorized to remove the endangered adult from the situation, and transport

7. Garfield, *supra* note 2 at 864 (citing HOUSE SELECT COMM. ON AGING, 97TH CONG., 1ST SESS., ELDER ABUSE: AN EXAMINATION OF A HIDDEN PROBLEM (Comm. Print 1981)); *see id.* (noting that among the many forms of elder abuse, physical abuse and neglect are the most prevalent); *see also* CAL. WELF. & INST. CODE § 15700(a)(1) (enacted by Chapter 913) (stating the legislature's finding that elder adults may be the victims of physical abuse, neglect, and abandonment).

8. *See* CAL. WELF. & INST. CODE § 15700(a)(4) (enacted by Chapter 913) (stating that cases of severe abuse may create the immediate risk of serious harm or death); *see also* ASSEMBLY FLOOR, COMMITTEE ANALYSIS OF AB 2881, at 3 (Aug. 30, 1996) (noting that the abuse of elder adults which results in life-threatening situations needs to be addressed).

9. CAL. WELF. & INST. CODE § 15700(b) (enacted by Chapter 913); *see id.* (stating the legislature's intent that Chapter 913 provide a mechanism to remove elder adults at risk of imminent harm from abusive situations); ASSEMBLY FLOOR, COMMITTEE ANALYSIS OF AB 2881, at 3 (Aug. 30, 1996) (noting that Chapter 913 provides the means to remove elder adults from life-threatening situations); SENATE FLOOR, COMMITTEE ANALYSIS OF AB 2881, at 5 (Aug. 27, 1996) (stating that the intent of the author is to enhance the protection of elder adults who are in imminent danger of serious harm).

10. *See* CAL. WELF. & INST. CODE § 15701.1 (enacted by Chapter 913) (defining "local law enforcement" as a member of a city police or county sheriff department).

11. *Id.* § 15703 (enacted by Chapter 913); *see id.* § 15700(b) (enacted by Chapter 913) (noting the intent of the legislature in enacting Chapter 913 to create a mechanism which allow law enforcement officials to intervene in abusive situations).

12. *See infra* note 15 and accompanying text (explaining the conclusions the local law enforcement official must reach prior to emergency removal of the endangered adult).

13. *See* CAL. WELF. & INST. CODE § 15701.25 (enacted by Chapter 913) (defining "endangered adults" as elder or dependent adults who are at risk of immediate serious injury due to suspected abuse or neglect, and who lack the capacity to protect themselves from the consequences of remaining in the situation); *see supra* note 1 (discussing the scope of the term "endangered adult").

14. CAL. WELF. & INST. CODE § 15703(a) (enacted by Chapter 913); *see id.* § 15700(b) (enacted by Chapter 913) (stating that the vehicle by which Chapter 913 provides protection to the endangered adult is removal into emergency protective custody).

15. *Id.* § 15703(a) (enacted by Chapter 913).

the person to an appropriate temporary residence.¹⁶ The power to remove is granted regardless of whether the endangered adult consents to the removal.¹⁷

After removal of the endangered adult, Chapter 913 mandates certain procedural requirements.¹⁸ Upon removal, the removing authority must notify the superior court, the endangered adult's next of kin, if appropriate, and Adult Protective Services.¹⁹ Within twenty-four hours of removal, a designated county agency must initiate an investigation, and file a petition with the court for issuance of an emergency protective order.²⁰ The court must then hold a preliminary hearing in order to determine if probable cause exists for the emergency protective order.²¹ This hearing must be held no later than the day after a forty-eight hour period since the removal has occurred.²² Following the preliminary hearing, the court must render its decision regarding probable cause no later than the day after a seventy-two hour period since removal has occurred.²³ By operation of these requirements, no endangered adult may be held under emergency protective custody, based on the law enforcement official's determination alone, for more than seventy-two hours.²⁴

During the hearing process, Chapter 913 requires that the endangered adult be represented by counsel.²⁵ Prior to the hearing, notice of the petition for the emergency protective order must be given to the endangered adult, in language as reasonably understandable as possible.²⁶ Chapter 913 requires further that the endangered adult be permitted to present evidence and cross-examine witnesses,²⁷ and

16. *Id.* § 15703.1(b) (enacted by Chapter 913); *see id.* (requiring the endangered adult to be transported to an appropriate temporary residence pending the outcome of the investigation and judicial hearing provided by Chapter 913); *see also id.* § 15701.5(a)-(c) (enacted by Chapter 913) (defining "appropriate temporary residence" as the home of a relative, if free from further risk to the endangered adult, a licensed adult residential care facility designated as an emergency shelter, or a 24-hour health facility, as designated by § 1250, § 1250.2, and § 1250.3 of the California Health and Safety Code). *But see id.* § 15701.05(e) (enacted by Chapter 913) (prohibiting Chapter 913 from being utilized to place endangered adults into jails or correctional treatment centers).

17. *See* ASSEMBLY FLOOR, COMMITTEE ANALYSIS OF AB 2881, at 2 (Aug. 30, 1996) (stating that Chapter 913 provides local law enforcement with the ability to take endangered adults into emergency protective custody without the consent of the individual); *see also* CAL. WELF. & INST. CODE § 15705.2(e) (enacted by Chapter 913) (requiring a statement of the attempts to obtain the consent of the endangered adult to the intervention, which implicitly authorizes removal despite the failure to obtain that consent).

18. *See* CAL. WELF. & INST. CODE §§ 15705-15705.30 (enacted by Chapter 913) (detailing the various procedural requirements within Chapter 913, such as a timely post-removal hearing and representation).

19. *Id.* § 15703(c) (enacted by Chapter 913).

20. *Id.* § 15705(a) (enacted by Chapter 913).

21. *Id.* § 15705(b)(1) (enacted by Chapter 913).

22. *Id.*

23. *Id.* § 15705(b)(2) (enacted by Chapter 913).

24. *Id.* § 15703.1(a) (enacted by Chapter 913).

25. *Id.* § 15705.30(b) (enacted by Chapter 913). Chapter 913 provides that if the endangered adult is indigent or lacks the capacity to waive counsel, the court shall appoint counsel. *Id.*

26. *Id.* § 15705.25(a) (enacted by Chapter 913).

27. *Id.* § 15705.30(c) (enacted by Chapter 913).

that the court issue its findings in support of any emergency protective order, for the record.²⁸

If the court determines that probable cause does not exist for an emergency protective order, the court must order the release of the endangered adult.²⁹ Alternatively, if probable cause is determined to exist, the court may order the continuation of emergency protective custody.³⁰ In order to find probable cause, the court must determine, based on clear and convincing evidence, that the party is in fact an endangered adult,³¹ and that no appropriate alternative to continued emergency protective custody would mitigate the risk of the endangering situation.³² However, any emergency protective order issued is effective for no longer than fourteen days, excluding Saturdays, Sundays, and legal holidays.³³ It is during this period that a hearing seeking long-term protective custody must be initiated.³⁴

Thus, Chapter 913 devotes much attention to detail to procedurally protect the endangered adult as much as possible. Its provisions attempt to establish concrete criteria by which emergency protective custody can be implemented and continued. However, even with the procedural precautions engrafted into Chapter 913, concerns may arise.

III. CONCERNS REGARDING CHAPTER 913

A. *The Justification for the Intervention*

Emergency protective custody, and the nonconsensual removal of the adult that may be necessitated, is based on the moral position that society has the duty to protect its endangered citizens who cannot protect themselves.³⁵ This doctrine has been applied most commonly to the protection of children, but is being increasingly applied to situations involving endangered adults.³⁶ In order to be applicable to adults, the adults must be determined to be incapable of protecting or caring for themselves.³⁷

28. *Id.* § 15705.30(e) (enacted by Chapter 913).

29. *Id.* § 15705.05 (enacted by Chapter 913). Though no reference is included in Chapter 913, it is reasonable to assume that accompanying the order to release the endangered adult would be provisions for safe transportation back to the residence from which the person was removed.

30. *Id.* § 15705.1 (enacted by Chapter 913).

31. *See supra* notes 1, 13 (defining "endangered adult").

32. CAL. WELF. & INST. CODE § 15705.1(a)-(b) (enacted by Chapter 913).

33. *Id.* § 15705.15(c) (enacted by Chapter 913).

34. *Id.*

35. *See* Garfield, *supra* note 2, at 377 (explaining that most state intervention statutes are founded on the doctrine of *parens patriae*, the state's responsibility to act as guardian over those who cannot care for themselves).

36. *See id.* at 377-78 (criticizing states' reliance on the doctrine as more appropriate to child protection than to adult protection, but acknowledging that many state adult protective statutes are founded on the concept).

37. *Id.*

A difficulty arises because adults are presumed to be competent to manage their own affairs and to be capable of protecting themselves.³⁸ However, Chapter 913 provides that adults may be determined to be incapable of fending for themselves solely on the personal observations of local law enforcement officials.³⁹ Nonconsensual removal of the adult can follow this determination,⁴⁰ which essentially subjugates the autonomy of the adult to the personal determinations of a local law enforcement official. Critics of intervention statutes, such as Chapter 913, suggest that subjective determinations based on perceptions of the elderly's capacity only serve to unjustifiably deny the person's right to self-determination.⁴¹

Although this concern has validity, on balance, the temporary loss of self-determination Chapter 913 may create is outweighed by the harm it certainly prevents. In an emergency situation, where the risk of serious harm is imminent, the state's responsibility to intervene becomes primary.⁴² This shifts the balance between the adult's autonomy and the state's responsibility, such that the nonconsensual intervention is justified by the prevention of the potential for irreparable harm to the individual.⁴³ Through emergency intervention, the risk of harm is alleviated at least temporarily, and in many situations, the reality of serious harm is likely avoided.⁴⁴

38. See *id.* at 878 (stating that adults are presumed to be competent to make their life decisions, as opposed to children who are presumed to need custodial supervision).

39. CAL. WELF. & INST. CODE § 15703(a) (enacted by Chapter 913); see *id.* (authorizing local law enforcement officers to remove an adult if the officer determines, based on personal observations alone, that the adult is an endangered adult, as defined by Chapter 913, and that no alternative exists to mitigate the situation).

40. See ASSEMBLY FLOOR, COMMITTEE ANALYSIS OF AB 2881, at 2 (Aug. 30, 1996) (explaining that Chapter 913 provides the mechanism for the designated official to remove the endangered adult with or without consent for up to 72 hours); see also CAL. WELF. & INST. CODE § 15705.2(e) (enacted by Chapter 913) (mandating that a statement summarizing the petitioner's attempts to obtain the endangered adult's consent be included within the petition for emergency protective custody, suggesting that intervention without the adult's consent is permitted by Chapter 913); cf. FLA. STAT. ANN. § 415.1051(2)(a), (b) (West Supp. 1997) (providing for the nonconsensual removal of an endangered adult based on the determinations of a law enforcement official, to be followed within twenty-four hours by a petition to the court for continued emergency protective custody); S.C. CODE ANN. § 43-35-55(a) (Law. Co-op. Supp. 1996) (authorizing nonconsensual removal of an endangered adult when an emergency situation exists, and expressly noting that the immediacy of the situation would not allow for prior application for a court order).

41. See Garfield, *supra* note 2, at 878-79 (explaining that old age itself can at times be perceived as the basis for incapacity, which then fosters ageism and further clouds the determinations of who is and is not lacking in capacity).

42. See ASSEMBLY FLOOR, COMMITTEE ANALYSIS OF AB 2881, at 3 (Aug. 30, 1996) (explaining that Chapter 913 is a response to the increase of abusive incidents involving life-threatening situations to elder and dependent adults, and that the State needs to address the situation).

43. See Garfield, *supra* note 2, at 915 (explaining that in an emergency situation, the concern for the adult's self-determination must be subordinate to protection of physical well-being).

44. See *id.* (stating that the encroachment on the individual's autonomy, in a true emergency, is certainly justified by the resulting prevention of serious injury or death).

Thus, the potential loss of autonomy Chapter 913 creates is offset by the harm that it prevents.⁴⁵

B. Procedural Shortcuts Within Chapter 913

A further concern related to Chapter 913 is that it provides for nonconsensual emergency protective custody of an adult, without providing for a prior hearing and opportunity to be heard.⁴⁶ However, the emergency situation addressed by Chapter 913 again shifts the balance between the formal requirements of due process, and the need to protect human life.⁴⁷ When a life-threatening situation exists, rigid adherence to due process requirements may increase the risk of harm,⁴⁸ and seems to place societal priorities in exactly the opposite positions common sense would dictate. Inherent to the concept of an emergency is the need for immediate action, and often, the time required to obtain prior court approval for the intervention would make the point moot.⁴⁹

Furthermore, Chapter 913 mandates thorough and detailed post-removal procedures, designed to ensure that the endangered adult is provided due process protection throughout the hearing process.⁵⁰ In this way, Chapter 913 ensures that the endangered adult receives the formal procedural protection the law requires, as near

45. An alternative rationale has been offered as well. An endangered adult mired in an abusive situation may have already lost autonomy, due to the abusive situation itself. If removed from that situation, the autonomy of the individual is not in fact reduced, but enhanced. Thus, nonconsensual intervention, viewed in this light, furthers the opportunity for the endangered adult's expression of self-determination. See CAL. WELF. & INST. CODE § 15700(a)(5) (enacted by Chapter 913) (stating that endangered adults are often deprived of their autonomy and dignity by the very situations from which Chapter 913 seeks to provide relief).

46. See *id.* § 15705(a), (b)(2) (enacted by Chapter 913) (requiring that the preliminary hearing occur within seventy-two hours after emergency protective custody has been initiated, rather than prior to the initial intervention).

47. See *id.* § 15700(a)(6), (7) (enacted by Chapter 913) (stating that the limitations of existing law, *i.e.*, the requirement of court action prior to intervention, have prevented state agencies from being able to intervene in time, leading to unnecessary and preventable injury and loss of life); see also *Wayne v. United States*, 318 F.2d 205, 212 (D.C. Cir. 1963) (explaining that "[t]he need to protect or preserve life or avoid serious injury is justification for what would be otherwise illegal absent an exigency or emergency").

48. See CAL. WELF. & INST. CODE § 15700(a)(6) (enacted by Chapter 913) (stating that the limitations of prior law often delay intervention by the designated agencies, thus preventing them from stopping serious injury or death).

49. See *id.* § 15700(a)(7) (enacted by Chapter 913) (stating that delays caused by prior law limitations have led to injury and death, thus making the later intervention pointless); see also *Garfield*, *supra* note 2, at 915 (explaining that in a true emergency, intervention after consent, or after court action, may be unnecessary because the harm to be avoided has already occurred).

50. See *supra* notes 18-34 and accompanying text (detailing the notice, representation, hearing, and timing requirements mandated by Chapter 913, and the grounds on which the court may issue an order continuing emergency protective custody).

in time to the intervention as the emergency situation will allow.⁵¹ When certain injury or death has been prevented, it seems a little sacrifice for such a large return.

V. CONCLUSION

Although the mechanism created by Chapter 913 may encroach upon an adult's autonomy from time to time, the harm that it will prevent provides a large benefit to society overall. At the very least, Chapter 913 provides local law enforcement agencies with a tool to combat a significant social problem.⁵² As the percentage of elderly citizens rises, the incidence of adults exposed to abusive situations will rise as well.⁵³ In turn, the need for methods to address this problem will become more immediate. Until we can find a solution to the problem at its roots, and thus eliminate the problem, it is necessary to prevent as much of the suffering as possible. By providing an efficient and immediate method for intervention in life-threatening situations, with little sacrifice of autonomy, Chapter 913 takes a large step in the right direction.

APPENDIX

Code Section Affected

Welfare and Institutions Code § 15700 (new).
AB 2881 (Woods); 1996 STAT. Ch. 913

51. See *Fuentes v. Shevin*, 407 U.S. 67, 90-91 (1972) (explaining that when property is sought to be attached prior to a hearing or opportunity to be heard, "exigent circumstances," such as the need for immediate action, can justify proceeding without a prior hearing, with due process requirements being satisfied by a post seizure hearing close in time to the seizure).

52. See SENATE FLOOR, COMMITTEE ANALYSIS OF AB 2881, at 5 (Aug. 27, 1996) (stating that Chapter 913 was enacted because of requests by local law enforcement agencies who were frustrated by their inability to intervene into life-threatening situations due to prior law). Funding is also a concern surrounding Chapter 913. Chapter 913 may force additional expenditures in an area of social activism where funding is already insufficient. However, Chapter 913 provides flexibility where funding may be a significant issue by expressly requiring local adoption of Chapter 913 by a county's Board of Supervisors, in order for Chapter 913 to be binding on the county. CAL. WELF. & INST. CODE § 15705.37 (enacted by Chapter 913). Thus, if funding is a determinative factor, a county is free not to adopt Chapter 913 and its mechanisms for intervention. *Id.* Furthermore, proponents of Chapter 913 point out that, absent the ability to intervene, avoidable injury and death will continue to occur, thus causing public health care expenditures that also could have been avoided. See *id.* § 15700(a)(7) (enacted by Chapter 913) (stating that avoidable pain and suffering results in unnecessary, additional public expenditures). Viewed from this perspective, the expense created by Chapter 913 is offset at least partially by the savings created by fewer incidents of injury or death.

53. See *supra* notes 2-4 and accompanying text (noting that as the elderly population rises so does the incidence of elder abuse).

The Timely Demise of "Gag Orders" in Physicians' Contracts with Managed Care Providers

Justin D. Harris

I. INTRODUCTION

Escalating health costs gave birth to the alleged paragon of efficiency and cost control—the health maintenance organization (HMO).¹ At its birth, witnesses applauded the good fortune they thought it would bring, good fortune manifest in the form of lower health care costs to be borne by consumers and greater profits for the operators of these organizations.² Some doctors likely welcomed the new arrival as well.³ The hassles and financial pressures of running a medical office would be handled by business professionals. The doctors could focus just on treating their patients as they poured in by the hundreds.

The doctors, however, soon realized that a trade-off was involved. Associating with a large business organization involved a loss of autonomy.⁴ Most doctors likely realized the trade-off, but were taken aback by the intrusion of the so-called "gag-clause."⁵ A gag clause prohibits a physician from taking any action or making any communication that could or might undermine the confidence of enrollees, prospective enrollees, their employers, unions, or the public in the health plan and provider.⁶ Though the existence of such clauses is often denied, they are confirmed in the contracts of the biggest HMOs in the country, and are rumored to be present in contracts of smaller HMOs as well.⁷

Doctors have interpreted these clauses to mean that they cannot recommend treatments that the HMO will not pay for, or does not have; they believe that such

1. See Deven C. McGraw, Note, *Financial Incentives to Limit Services: Should Physicians Be Required to Disclose These to Patients*, 83 GEO. L.J. 1821, 1822-23 (1995) (noting that in the late 1960s, rising health care costs and a demand for high technology care spawned the health maintenance organization).

2. See *id.*

3. See Diane Watson, *Keynote Address: The Future of Managed Care*, in 16 WHITTIER L. REV. 941, 942 (1995) (illustrating that many health care practitioners have embraced the trend toward managed care).

4. *A Gagged Physician Cannot Fully Serve the Patient; If the Offending HMOs Persist, New Laws May Be Needed*, L.A. TIMES, Apr. 21, 1996, at pt.-M [hereinafter *A Gagged Physician*]; see *id.* (opining that "[m]any physicians . . . are angry about what they see as a loss of income and control under managed care").

5. See *id.*

6. See, e.g., Suzanne Gordon, *Perspective on Health Care: Hippocratic or Hypocritical Oath?*, L.A. TIMES, Jan. 21, 1996, at M-5 (quoting U.S. Healthcare's gag clause which mandates the following: "Physician, shall agree not to take any action or make any communication which undermines or could undermine the confidence of enrollees, potential enrollees, their employers, their unions, or the public in U.S. Healthcare or the quality of U.S. Healthcare coverage . . .").

7. See *id.*; see also Tim Bonfield, *Doctors Freed of Gag Rule Choice Care Contract No Longer Curbs Them*, CINCINNATI ENQUIRER, Jan. 26, 1996, at 102 (setting forth the "gag clause" in ChoiceCare contracts prior to May 1, 1996, and discussing how ChoiceCare has eliminated such clauses from contracts entered into subsequent to May 1, 1996).

advice will be construed as undermining the confidence of enrollees, a specific prohibition in gag clauses.⁸ Contravention of such clauses would result in penalties ranging from being fined to being fired.⁹

Recently, California joined other states in prohibiting these gag clauses through the enactment of Chapter 260¹⁰ and Chapter 1089.¹¹ Additionally, California enacted Chapter 1094,¹² which provides for specific disciplinary actions against health care plans that either violate Chapter 1089 or otherwise inhibit the ability of physicians to advocate medically appropriate treatments.¹³

II. LEGAL BACKGROUND

A. Existing State Law

Existing law declares that it is the public policy of the state to encourage physicians and surgeons to advocate "medically appropriate health care" for their patients.¹⁴ The law further provides that any person who penalizes a physician for advocating such care violates public policy.¹⁵ Prior law, however, neither defined *penalize* nor prescribed the penalties imposed for such actions.¹⁶ The relevant code sections simply noted that actions penalizing physicians for advocating medically appropriate health care violated *public policy*.¹⁷

Existing law strives to protect physicians from entities which attempt to interfere with a physician's ability to provide needed health care to patients.¹⁸ Such interference not only poses a risk of harm to the patient, but also subjects the treating physician or surgeon to a malpractice suit.¹⁹ California case law mandates that a physician or surgeon must provide care on par with physicians or surgeons similarly

8. See *A Gagged Physician*, *supra* note 4, at M-4 (describing how physicians interpret gag clauses).

9. See *id.* (listing penalties for physicians who violate gag clauses).

10. CAL. BUS. & PROF. CODE § 2056 (amended by Chapter 260).

11. *Id.* § 2056.1 (enacted by Chapter 1089).

12. CAL. HEALTH & SAFETY CODE § 1386 (amended by Chapter 1094); CAL. INS. CODE § 10120.5 (enacted by Chapter 1094).

13. CAL. INS. CODE § 10120.5 (enacted by Chapter 1094).

14. CAL. BUS. & PROF. CODE § 2056(b) (amended by Chapter 260); see *id.* (defining "advocate for medically appropriate health care" as appealing a payor's decision to deny payment for a service through the grievance or appeal procedure available to the physician or surgeon, or "protest[ing] a decision, policy, or practice" that prevents the physician from providing medically appropriate health care); see also *Wickline v. State*, 192 Cal. App. 3d 1630, 1644-45, 239 Cal. Rptr. 810, 819 (1986) (holding that physicians or surgeons are subject to a malpractice action if they do not protest a third-party payor's denial, when means for protest or appeal are provided).

15. CAL. BUS. & PROF. CODE § 2056(c) (amended by Chapter 260); see SENATE JUDICIARY COMMITTEE, COMMITTEE ANALYSIS OF SB 1847, at 2 (May 14, 1996) (explaining that interference with doctor-patient discourse violates public policy).

16. 1994 Cal. Legis. Serv. ch. 1119, sec. 2, at 5532 (amending CAL. BUS. & PROF. CODE § 2056).

17. See *id.*

18. See CAL. BUS. & PROF. CODE § 2056 (amended by Chapter 260); CAL. HEALTH & SAFETY CODE § 1386 (amended by Chapter 1094).

19. SENATE JUDICIARY COMMITTEE, COMMITTEE ANALYSIS OF SB 1847, at 5 (May 14, 1996).

situated.²⁰ Additionally, the physician must obtain the patient's informed consent before rendering treatment; failure to obtain such consent can subject the physician to charges of battery.²¹

Informed consent requires that the patient be given sufficient information to make an intelligent decision about either consenting to, or rejecting, a proposed treatment.²² Further, the courts have held that to qualify as *informed* consent the patient must be apprised of alternatives to the proposed treatment, as well as the dangers inherent in those alternatives.²³ Prior to the enactment of Chapter 260, California law did not specifically address the issue of limitations imposed by health care providers on physician-patient dialogue regarding alternative treatments.²⁴

Existing law broadly prescribes penalties for health care providers who interfere with a physician's or surgeon's ability to provide needed care.²⁵ Prior to the enactment of Chapter 1089, California law neglected to specifically mention gag clauses or confidentiality clauses that inhibit a physician's ability to provide that care.²⁶ Chapter 1089 fills this void, thereby protecting the 12 million Californians that belong to health maintenance organizations.²⁷

B. The Effects of Chapters 260, 1089, and 1094

1. Chapter 260

By enacting Chapter 260, California directly addresses the physicians' plight with health maintenance organizations. Chapter 260 adds needed specificity to the Business and Professions Code, thereby accomplishing two important goals. First, Chapter 260 specifically prohibits persons from discouraging physicians or surgeons from advocating for medically appropriate health care.²⁸ This prevents physicians and surgeons from being terminated, retaliated against, or otherwise penalized for advocating care for their patients.²⁹ Second, Chapter 260 includes a specific provision that prohibits persons from discouraging physicians from communicating to a patient "information in furtherance of medically appropriate health care."³⁰

20. *Landeros v. Flood*, 17 Cal. 3d 399, 408, 551 P.2d 389, 392-93, 131 Cal. Rptr. 69, 72-73 (1976).

21. *Cobbs v. Grant*, 8 Cal. 3d 229, 243, 104 Cal. Rptr. 505, 514 (1972).

22. *Id.*

23. SENATE JUDICIARY COMMITTEE, COMMITTEE ANALYSIS OF SB 1847, at 4 (May 14, 1996); *see, e.g.*, *Cobbs v. Grant*, 8 Cal. 3d 229, 104 Cal. Rptr. 505 (1972).

24. *Id.*

25. *See* CAL. HEALTH & SAFETY CODE § 1386 (amended by Chapter 1094).

26. *See* 1994 Cal. Legis. Serv. ch. 1119, sec. 2, at 5532 (amending CAL. BUS. & PROF. CODE § 2056).

27. *See* ASSEMBLY COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 3013, at 2 (Apr. 16, 1996) (noting that 12 million Californians subscribe to HMOs).

28. CAL. BUS. & PROF. CODE § 2056(c) (amended by Chapter 260).

29. *Id.*

30. *Id.*

2. Chapter 1089

Chapter 1089 expands the protection afforded to consumers and physicians one step further. Chapter 1089 adds a provision to the Business and Professions Code which addresses the so-called “gag” or “confidentiality clauses” found in some physicians’ contracts with HMOs.³¹ Chapter 1089 seeks to ensure that health care service plans do not enter into contracts with physicians and surgeons which affect a physician’s and surgeon’s “ethical responsibility to discuss with [his or her] patients information relevant to a patient’s health care.”³² Accordingly, Chapter 1089 provides that “health care service plans and their contracting entities shall not include provisions in their contracts that interfere with the ability of a physician and surgeon . . . to communicate with a patient”³³ In effect, this language prohibits gag or confidentiality clauses.

3. Chapter 1094

Chapter 1094 gives teeth to Chapters 260 and 1089 by providing for enforcement against health care providers who utilize gag or confidentiality clauses.³⁴ Section 1386 of the California Health and Safety Code provides the health and safety commissioner with the power and authority to suspend or revoke licenses issued to health care service plans by the Board of Commissioners, if the provider is in violation of one of the provisions listed under § 1386.³⁵ Loss of a license to operate could be potentially devastating to a service provider.

Chapter 1094 adds another item to the list of conditions which could precipitate the suspension or loss of a health care service plan’s license.³⁶ The addition provides that a violation of § 510, § 2056, or § 2056.1 of the Business and Professions Code may result in suspension or loss of license by the health care service plan.³⁷ As explained previously, § 2056 and § 2056.1 relate to the interference by health care service plans with a physician’s or surgeon’s ability to advocate for appropriate medical care.³⁸

31. *Id.* § 2056.1 (enacted by Chapter 1089).

32. *Id.* § 2056.1(a) (enacted by Chapter 1089).

33. *Id.* § 2056.1(b) (enacted by Chapter 1089).

34. *See* CAL. HEALTH & SAFETY CODE § 1386(b) (amended by Chapter 1094).

35. This license allows health care service plans to operate in the State of California. *See id.* (listing specific acts or omissions that constitute grounds for disciplinary action by the Commissioner, including operating in such a manner as to constitute a substantial risk to the plan’s enrollees or subscribers).

36. *Id.* § 1386(b)(13) (amended by Chapter 1094).

37. *Id.*

38. CAL. BUS. & PROF. CODE § 2056 (amended by Chapter 260); *see id.* § 2056.1 (enacted by Chapter 1089) (defining “interference with physicians and surgeons” and articulating their responsibilities to advocate for their patients).

Similarly, Chapter 1094 affects disability insurers by expanding the Insurance Code.³⁹ Chapter 1094 provides that disability insurers are also subject to loss or suspension of licenses if they violate § 510, § 2056, or § 2056.1 of the California Business and Professions Code.⁴⁰ In short, disability insurers are now subject to the same restrictions as health care service plan operators, insofar as they may not interfere with a physician's or surgeon's attempt to advocate for medically appropriate care.⁴¹ This *interference*, as prohibited, relates not only to contracts, but to other interactions with physicians and surgeons as well.⁴²

C. State Attempts at Eliminating Gag Clauses

California is not the first to enact legislation eliminating gag clauses from contracts and liberalizing a physician's ability to communicate with patients.⁴³ A number of other states have responded to the growing dissatisfaction with HMOs by passing legislation that, like the newer California legislation, prohibits HMOs from inserting gag clauses in their contracts.⁴⁴ In some states, HMOs are being fought indirectly through the courts also.⁴⁵ In short, HMOs are being attacked from all sides.

Stronger than California's approach, Tennessee is working on a bill that imposes civil penalties for HMOs that violate the soon-to-be-passed anti-gag clause legislation.⁴⁶ Such an approach may curtail gag-clause abuse. The difficulty might only lie in the enforcement of such fines. Considering the fines are \$1000 to \$5000 per violation, they may not be large enough to seriously dissuade HMOs from continuing to include the prohibited provisions in their contracts.⁴⁷

39. CAL. INS. CODE § 10120.5 (enacted by Chapter 1094).

40. Compare *id.* § 10120.5 (enacted by Chapter 1094) (inhibiting the ability of disability insurers to interfere with doctor-patient discourse) with CAL. BUS. & PROF. CODE § 2056(c) (amended by Chapter 260) (providing that no person may prevent a doctor from communicating necessary information to a patient).

41. CAL. INS. CODE § 10120.5 (enacted by Chapter 1094).

42. *Id.*

43. See Nancy W. Dickey, *AMA to Big Managed Care: Ungag Doctors*, AM. MED. NEWS, Feb. 26, 1996, at 37 (noting that Massachusetts banned gag clauses and New Jersey and California are "poised to follow"); Patrick Graham, *State Doctors Win Legislative Ban on 'Gag Clauses'*, MEMPHIS BUS. J., Apr. 22, 1996, at 25 (explaining that anti-gag clause legislation passed the Tennessee Legislature and will likely be signed into law).

44. Dickey, *supra* note 43, at 37 (listing Massachusetts, California, New Jersey, and New York as states that have either banned 'gag' clauses altogether or are presently attempting to eliminate them).

45. See *Physicians Sue N.Y. Health Department over HMO Contracts*, MANAGED CARE OUTLOOK, Jan. 9, 1996, at *1, available in 1996 WL 10117063 (noting that doctors are attacking HMOs indirectly by suing the State of New York that reviews HMO contracts with physicians).

46. Graham, *supra* note 43, at 25; see *id.* (listing the fines for violation of the anti-gag clause legislation as ranging from \$1000 to \$5000 per day and per violation).

47. *Id.*

D. Birth of the Patient Right to Know Act

The legislative action of other states and the persistent lobbying of the American Medical Association likely provided impetus for the Patient Right to Know Act.⁴⁸ The act, similar in effect to Chapters 260, 1089, and 1094, aims to prevent health plans from interfering with doctor-patient communication.⁴⁹ In particular, it strictly prohibits interference with certain medical communications.⁵⁰ The bill defines "medical communications" as including almost all communications between a physician and patient, excluding only knowing and willful misrepresentations from protection.⁵¹

Part of the congressional impetus to eliminate gag rules centers on the problems that "gag" clauses present in the area of informed consent.⁵² Similar to the concerns at the state level, inhibiting informed consent not only places the patient at risk, but subjects the physician or surgeon to potential medical malpractice.⁵³ On the subject of malpractice and overriding patient concerns, Dr. Robert McAfee, a former president of the American Medical Association, testified that "gag" clauses in contracts are analogous to a wedge between a physician and his patient.⁵⁴

Attendant to specific prohibitions against interference, the Patient Right to Know Act contains some serious penalty provisions. The bill prescribes a penalty of \$25,000 per violation, or up to \$100,000 per violation if a pattern of violations can be established over the previous five years.⁵⁵ Such strict provisions might give this legislation the "teeth" it needs to be effective once signed into law.

Congress has never addressed the issue of gag clauses in providers' contracts directly.⁵⁶ Accordingly, this resolution may signal Congress's willingness to regulate an additional area.⁵⁷ Bipartisan support for the measure is evidenced by Repre-

48. HR 2976, 104th Cong. §§ 1, 2 (1996). This bill is also known as the "Patient Right to Know Act," and has not been enacted yet.

49. *Id.* § 1

50. *See id.* § 2 (the doctor-patient communications with which HMOs may not interfere include communications "regarding the mental or physical health care needs or treatment of a patient and the provisions, terms, or requirements of the health plan").

51. *Id.*

52. *Prepared Statement of Rep. Ed Markey Before the House Comm. on Ways and Means Health Subcommittee on HR 2976, The Patient Right to Know Act*, FED. DOCUMENT CLEARING HOUSE, July 30, 1996, at *1, available in 1996 WL 10830250 [hereinafter *Statement of Rep. Markey*].

53. *Cobbs v. Grant*, 8 Cal. 3d 229, 243, 104 Cal. Rptr. 505, 514 (1972); *see id.* (explaining that lack of informed consent from the patient subjects a doctor to a malpractice claim).

54. *Managed Care: Congress Looks at Physician "Gag" Clauses*, AM. HEALTH LINE, May 31, 1996, at *1, available in Westlaw, 5/31/96 APN-HE3; *see id.* (quoting testimony by Dr. Robert McAfee, past president of the AMA, as stating that gag clauses "present an inherent ethical conflict of interest" by placing a wedge between physicians and patients).

55. HR 2976, 104th Cong. § 2 (1996).

56. Dianne M. Gianelli, *Congress Considers Ban on Managed Care 'Gag' Clauses*, AM. MED. NEWS, June 17, 1996, at 5.

57. *Id.*

sentatives Greg Ganske, M.D. (Republican-Iowa) and Edward J. Markey (Democrat-Massachusetts), who cosponsored the bill.⁵⁸ Additionally, Representative Markey reported that the bill has some 130 sponsors from both sides of the aisle, indicating strong congressional support.⁵⁹

Despite support, the bill is not without its detractors. Managed care executives fear that the bill may impede the HMO's proprietary integrity.⁶⁰ They continue to downplay the existence and prevalence of gag clauses in general, and fear express prohibition will only lead to patients accessing private or unnecessary information.⁶¹

III. ARGUMENTS

A. *Informed Consent*

The infamous gag clause takes many forms, but frequently appears in the form of a "disparagement" clause.⁶² The disparagement clause prohibits the physician or surgeon from making any statements to the enrollee which might undermine that individual's confidence in the plan.⁶³ The Consumers Union notes that doctors have interpreted these provisions to mean that they may not discuss alternative treatment methods if they are not covered by the plan.⁶⁴ Additionally, doctors have interpreted these gag clauses to mean that they may not recommend treatments which they fear will not be approved by the plan, though the treatment is sometimes authorized by the plan.⁶⁵

For instance, one proponent argued that a doctor who fears that machine error produced an inaccurate result in a patient's mammogram may not be able to order an additional mammogram for confirmation.⁶⁶ Why? The doctor may fear that if he or she orders the additional test, and it is rejected, his or her action will be viewed as "undermining" the confidence of the enrollee in the plan.⁶⁷ Prior to the passage of Chapters 260, 1089, and 1094, the doctor would have feared retaliation from the

58. See *id.* (listing members from both the Republican and Democratic parties who support the legislation).

59. See *Statement of Rep. Markey*, *supra* note 52, at *1.

60. See *Gag Clauses Rarely in Contracts, Not Often Used to Dump Physicians*, MANAGED CARE WEEK, Feb. 12, 1996, at M-4 [hereinafter *Gag Clauses*] (noting that HMOs use gag clauses to prevent the disclosure of proprietary information or the unnecessary spoiling of patients' opinions of the health plan).

61. *Id.*

62. SENATE RULES COMMITTEE, COMMITTEE ANALYSIS OF SB 1805, at 4 (May 20, 1996); see *id.* (listing "disparagement" clauses as a form of "gag" clause).

63. *Id.*; see *id.* (defining "disparagement" as the use of statements that undermine a patient's confidence in the plan).

64. *Id.*

65. *Id.*

66. See Gordon, *supra* note 6, at M-5 (relating the story of a 49-year-old woman whose physician was too afraid to order an additional mammogram).

67. *Id.*

HMO for this action. This scenario is but one of many that physicians must endure almost daily.

Gag clauses place doctors between the proverbial rock and hard place. Aside from attendant ethical responsibilities, a doctor or surgeon in California has cause to fear malpractice.⁶⁸ Gag clauses, and other forms of physician-intimidation, only heighten the potential for malpractice.⁶⁹ Of particular concern to physicians in California is the case of *Cobbs v. Grant*.⁷⁰ The *Cobbs* court held that physicians are under a duty to disclose the available choices of possible therapy and the dangers associated with each.⁷¹ Failure to properly inform a patient means that the patient has not given "informed consent."⁷²

On the same note, *Sinz v. Owens*⁷³ requires that a physician refer a patient to a specialist when the physician believes that "superior treatment might thereby be obtained."⁷⁴ Prior to Chapters 260, 1089, and 1094, the physician could not refer a patient to a specialist outside the plan, even if it is believed one is merited.⁷⁵ However, in order to satisfy "informed consent" concerns, as well as ethical ones, a doctor should be able to refer outside the plan, if the plan does not have a specialist.

Proponents, such as the California Liability Insurers, argue that the new legislation frees physicians from the malpractice dilemma.⁷⁶ Now physicians may fully inform their patients about all possible medical alternatives without fear of retribution from health care plans.⁷⁷ Full disclosure of alternatives is likely to satisfy the standards for informed consent and translate into knowledgeable patients. These well-informed patients, in turn, are able to act in their best interest.⁷⁸ For these reasons, the net effect of the new legislation is timely and wise.

B. Ethical Responsibilities

In taking the Hippocratic oath, physicians and surgeons alike pledge to advocate for the best interests of their patients.⁷⁹ Any attempt to interfere with the conveying

68. SENATE RULES COMMITTEE, COMMITTEE ANALYSIS OF SB 1847, at 5 (May 20, 1996); *see id.* (arguing that "a physician is caught between often conflicting legal obligations which places him or her at legal risk of malpractice, and which may prevent the patient from obtaining appropriate medical care").

69. *See id.*

70. 8 Cal. 3d 229, 104 Cal. Rptr. 505 (1972).

71. *Cobbs*, 8 Cal. 3d at 243, 104 Cal. Rptr. at 514; *see* SENATE JUDICIARY COMMITTEE, COMMITTEE ANALYSIS OF SB 1847, at 4 (May 14, 1996) (citing and explaining the holding in *Cobbs v. Grant*).

72. *Cobbs*, 8 Cal. 3d at 243, 104 Cal. Rptr. at 514.

73. 33 Cal. 2d 749, 205 P.2d 3 (1949).

74. *Sinz*, 33 Cal. 2d at 758, 205 P.2d at 8; SENATE JUDICIARY COMMITTEE, COMMITTEE ANALYSIS OF SB 1847, at 4 (May 14, 1996); *see id.* (explaining the holding and its ramifications).

75. SENATE JUDICIARY COMMITTEE, COMMITTEE ANALYSIS OF SB 1847, at 4 (May 14, 1996).

76. SENATE RULES COMMITTEE, COMMITTEE ANALYSIS OF SB 1847, at 5 (May 20, 1996).

77. *Id.*

78. *See Graham, supra* note 43, at 25 (postulating that "[w]ell-informed patients clearly make far better health care decisions").

79. *See Gordon, supra* note 6 (quoting a portion of the Hippocratic Oath taken by doctors).

of medical information would be unethical. With reference to this ethical responsibility, the California Association of Ophthalmology notes that "[w]hen health plans control what can and cannot be spoken between a physician . . . and patients, the physician's ethical responsibility to act as an advocate and advisor is seriously impaired."⁸⁰ Although fear of retaliation or intimidation by the health plan was a reality before the enactment of Chapters 260, 1089, and 1094, physicians are now free to communicate without fear.

C. Opposition

Not surprisingly, the newly enacted legislation met opposition from the California Association of HMOs.⁸¹ First, the association denies the extensive use of gag clauses in contracts between physicians and health care service organizations.⁸² Opponents assert that the problem is rooted in physicians' interpretations of the contract provisions, rather than in the contracts themselves.⁸³ Critics argue that there should be a means for HMOs to fight the tendency of some physicians to advocate plan switching.⁸⁴ Plan switching causes problems when a physician has financial interests in another plan, and accordingly advocates that the patient switch over to that plan, under the guise of serving that patient's best interest.⁸⁵ To opponents, the new legislation is overly broad.⁸⁶

Opponents suggest that the new legislation should be confined to discussing a patient's medical condition.⁸⁷ Additionally, opponents believe that eliminating any kind of gag clause will enable the physician to disclose proprietary information.⁸⁸ This information is not needed for the patient to make a good decision about a health care option.⁸⁹ In short, the legislation is deemed unnecessary.⁹⁰

80. SENATE COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 3013, at 4 (June 9, 1996).

81. SENATE RULES COMMITTEE, COMMITTEE ANALYSIS OF SB 1805, at 5 (May 20, 1996); *see id.* (listing the reasons why the association does not support the bills).

82. *See id.* (finding only one gag clause in a review of HMO provider contracts in use in California).

83. *See A Gagged Physician*, *supra* note 4, at M-4 (noting that HMOs claim the clauses are to "encourage doctors to discuss their concerns about payment and treatment policies with health plan representatives rather than complaining to patients").

84. SENATE RULES COMMITTEE, COMMITTEE ANALYSIS OF SB 1847, at 6 (May 20, 1996); *see id.* (explaining that there is nothing in the new legislation which prevents a physician from encouraging a patient to switch to a health plan where the physician has a financial interest).

85. *Id.*

86. ASSEMBLY COMMITTEE ON INSURANCE, COMMITTEE ANALYSIS OF AB 3013, at 3 (Apr. 10, 1996); *see id.* (noting that though opponents are not opposed to free discourse, they believe the present legislation should be narrowly construed).

87. *Id.*

88. *See Gag Clauses*, *supra* note 60, at M-4 (noting that "gag" clauses are intended to prevent the disclosure of proprietary information).

89. SENATE JUDICIARY COMMITTEE, COMMITTEE ANALYSIS OF SB 1805, at 5 (May 14, 1996); *see id.* (citing overbreadth as one of the opponents' reasons for rejecting the bill).

90. *See id.* (suggesting that disputes can be addressed through provider dispute resolution).

IV. CONCLUSION

The antagonism toward managed care companies flowered in the form of legislation limiting the ability of health care plans to inhibit doctor-patient discourse.⁹¹ The intervention manifests itself in the form of both anti-gag clause legislation and legislation which strengthened the prohibition against other kinds of interference, as well.⁹² Chapters 260, 1089, and 1094 force providers to redraw their contracts in order to eliminate the provisions that they claim do not exist.⁹³ California's legislation, though not the first, indicates a trend pointing toward stricter regulation of managed care.⁹⁴

To the HMO industry, which grows bigger each year, this legislation spells the end of an unbridled reign. In fact, in light of the pending federal legislation in this area, regulation may grow more acute as time goes on.⁹⁵ To the consumer, this means a chance at more informed decisionmaking. To the doctor, this legislation marks the end of managed care reprisals for providing patients with all of the information.

APPENDIX

Code Sections Affected

Business and Professions Code § 2056.1 (new).

AB 3013 (Alby); 1996 STAT. Ch. 1089

Health and Safety Code § 1386 (amended); Insurance Code § 10120.5 (new).

SB 1805 (Rosenthal); 1996 STAT. Ch. 1094

Business and Professions Code § 2056 (amended).

SB 1847 (Russel); 1996 STAT. Ch. 260.

91. See Dickey, *supra* note 43, at 37 (listing states that have proposed or passed legislation to eliminate gag clauses).

92. See *id.* (illustrating the nature of the anti-gag clause legislation being considered by various states).

93. See CAL. BUS. & PROF. CODE § 2056 (amended by Chapter 260); *id.* § 2056.1 (enacted by Chapter 1089); CAL. HEALTH & SAFETY CODE § 1386 (amended by Chapter 1094); CAL. INS. CODE § 10120.5 (enacted by Chapter 1094).

94. See Dickey, *supra* note 43, at 37.

95. See HR 2976, 104th Cong. §§ 1, 2 (1996) (setting forth restrictions on the ability of managed care providers to restrict doctor-patient discourse through gag-clauses).

Who Will Receive the Organs: Will You Receive a Life-Saving Transplant If You Have a Disability?

Jennifer L. Gibson

I. INTRODUCTION

Sandra Jensen had impressive credentials. She has been a consultant with the World Interdependence Fund, a nonprofit agency assisting the disabled; a speaker at conferences in Sacramento and Washington, D.C.; and a White House guest for the 1990 signing of the Americans with Disabilities Act.¹ Sandra Jensen also had Down Syndrome² and was denied the opportunity for the heart-lung transplant that would ultimately be needed to save her life for more than two years.³ On January 22, 1996, Sandra Jensen finally received the heart-lung transplant, necessary because of a life-long heart murrer that is a direct result of her Down Syndrome.⁴ Ms. Jensen became the first person with Down Syndrome to undergo a heart-lung transplant, and did so after winning a two-year legal battle and a struggle with government agencies to secure the necessary funding for the operation.⁵

II. BACKGROUND

In an effort to prevent others from facing the same discrimination that was faced by Sandra Jensen, Assemblymember Villaraigosa introduced legislation to prevent any hospital, physician, surgeon, or procurement organization from determining the recipient of an anatomical gift on the basis of the potential recipient's physical or

1. Peter Rowe, *All She Can Ask Is a Fair Chance at Life*, SAN DIEGO UNION-TRIB., Aug. 22, 1995, at E1.

2. "Down Syndrome" is defined as mongolism, trisomy 21 S., a syndrome of mental retardation associated with a variable constellation of abnormalities caused by representation of at least a critical portion of chromosome 21 three times instead of twice in some or all cells. *STEDMAN'S MEDICAL DICTIONARY* (25th ed. 1990) No single physical sign is diagnostic, and most stigmata are found in some normal persons. *Id.* The abnormalities include: retarded growth, flat hypoplastic face with short nose, prominent epicanthic skin folds, protruding lower lip, small rounded ears with prominent antihelix, fissured and thickened tongue, lackness of joint ligaments, pelvis dysplasia, broad hands and feet, stubby fingers usually with dysplasia of the middle phalanx of the fifth finger, transverse palmar crease, dermatoglyphic changes including distal displacement of the palmar axial triradius, dry rough skin in older patients and abundant slack neck skin in newborns, muscle hypotonia, and absence of Moro reflex in newborns. *Id.* Most patients are trisomic for chromosome 21 as a result of nondisjunction. *Id.* Some patients are mosaic, with both normal and trisomic cell lines. *Id.* A few patients have 46 chromosomes but are effectively trisomic because of translocation on a major portion of chromosome 21 to another chromosome. *Id.* In rare patients no chromosome abnormality can be detected. *Id.*

3. Cynthia Hubert, "I Feel Pretty Good," SACRAMENTO BEE, Feb. 20, 1996, at A1.

4. *Id.*

5. See Rowe, *supra* note 1, at E1 (indicating that the large numbers of people waiting for transplants necessitates that doctors be convinced of the potential success of an organ transplant, as well as the patient's ability to maintain a regime of post-operative care, before allowing a patient to undergo a transplant).

mental disability.⁶ This law's definition of "disability" conforms with the definition found in the Americans with Disabilities Act.⁷ Also, the potential recipient of the anatomical gift would not be required to demonstrate post-operative independent living skills in order to receive a transplant.⁸ The potential recipient simply must demonstrate that the recipient will receive the adequate support and assistance necessary for long-term post-operative success.⁹ Proponents of Chapter 96 argue that while it is necessary to make certain determinations about potential organ recipients, the medical establishment should not make arbitrary decisions on the basis of a person's disability.¹⁰ By denying access to disabled persons simply because of unfounded beliefs about the person's mental and physical capabilities, a hospital or physician would effectively be refusing a patient a much needed organ solely on the basis of stereotypes and arbitrary policies.¹¹

However, Chapter 96 still allows physicians and surgeons to evaluate each recipient on a case-by-case basis to determine if the person's disability would medically hinder the successful transplantation of an anatomical gift.¹² Chapter 96 would not require physicians to perform any medically inappropriate transplant.¹³ Chapter 96 applies to the entire transplant process beginning with the referral by a primary care provider, to a specialist, and finally, continuing to the official placement of the person on the transplant waiting list.¹⁴ Chapter 96 also requires courts to give priority to those actions brought to seek the enforcement of its provisions under the law.¹⁵

6. CAL. HEALTH & SAFETY CODE § 7153.2 (enacted by Chapter 96).

7. See 42 U.S.C.A. § 12102(2) (West 1995) (defining "disability" with respect to an individual as an impairment either mental or physical that places considerable limits on one or more of the major life activities enjoyed by the individual; and requiring a record of such an impairment or that the person must be seen as having a substantial physical or mental impairment); see also Americans With Disabilities Act, 42 U.S.C.A. §§ 12101-12213 (West 1995 & Supp. 1996).

8. CAL. HEALTH & SAFETY CODE § 7153.2(c) (enacted by Chapter 96); see *id.* (enacted by Chapter 96) (providing that a person need not present these skills as a prerequisite to obtaining the transplant, if there is evidence that the person will have sufficient assistance in maintaining the post-operative care).

9. *Id.*

10. ASSEMBLY FLOOR COMMITTEE, COMMITTEE ANALYSIS OF AB 2861, at 2 (May 24, 1996).

11. *Id.*

12. CAL. HEALTH & SAFETY CODE § 7153.2(a) (enacted by Chapter 96).

13. See SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES, COMMITTEE ANALYSIS OF AB 2861, at 2 (June 12, 1996) (providing that there are no transplants required under the law, and that the law only requires that physicians and hospitals evaluate each potential transplant recipient on a case-by-case basis, using only legitimate medical concerns when considering the potential success of a transplant).

14. CAL. HEALTH & SAFETY CODE § 7153.2(b) (enacted by Chapter 96).

15. *Id.* § 7153.2(d) (enacted by Chapter 96).

III. DO CURRENT LAWS ALREADY PROTECT THOSE WITH DISABILITIES?

The Americans with Disabilities Act (ADA) prohibits discrimination based on a person's disability.¹⁶ The ADA is comprehensive in providing protections for individuals with disabilities, but it is silent on organ transplantation.¹⁷ Although the denial of organ transplants has not been litigated under the ADA, it is likely that the ADA provides protections for individuals with disabilities who are seeking transplants.¹⁸ In *Kinney v. Yerusalem*,¹⁹ the court held that the ADA was enacted to address and remedy the discrimination experienced by persons with disabilities, and in order to give effect to this ideal, the court must construe the statute broadly.²⁰ Although Ms. Jensen would still have to prove that she was discriminated against by the hospitals, it seems likely that Ms. Jensen could have brought her cause of action alleging discrimination on the part of the hospital under the ADA. Also, it is important to remember that cases that have interpreted the meaning of "public entity" for the purposes of determining who is prohibited from discriminating against those with disabilities have done so to include a wide range of public and private entities.²¹ Proponents of Chapter 96 argue that while the ADA may cover such eventualities, litigation would be required to interpret the ADA in places where it is silent, and could potentially cost the lives of those who do not have the time to litigate a possible organ transplant.²²

Case law is silent on the organ transplant gap in the ADA. However, it is likely that parallels could be drawn to a case like *Coleman v. Zatechka*.²³ In this case, a university student brought suit under the ADA because the university refused to consider her for regular placement among other students who were not disabled when

16. See 42 U.S.C.A. § 12101 (West 1995) (announcing that discrimination against individuals with disabilities can be seen in numerous areas of society, and individuals with disabilities have encountered historical discrimination as well as intentional discrimination; and concluding that the nation should attempt to give those with disabilities the opportunity to fully participate in society); see also *id.* § 12132 (West 1995) (stating that qualified individuals may not be excluded from participating in certain activities, nor may they be denied benefits, services, access to programs, or access to the activities of a public entity because of their disability, nor may they be discriminated against by any entity on the basis of their disability).

17. *Id.* § 12132 (West 1995); see SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES, COMMITTEE ANALYSIS OF AB 2861, at 2 (June 12, 1996); see also 42 U.S.C.A. § 12132 (West 1995) (prohibiting discrimination based on a person's disability, but remaining silent regarding organ transplants).

18. SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES, COMMITTEE ANALYSIS OF AB 2861, at 2 (June 12, 1996).

19. 812 F. Supp. 547 (E.D. Pa. 1993).

20. *Kinney*, 812 F. Supp. at 551.

21. See, e.g., *Coleman v. Zatechka*, 824 F. Supp. 1360, 1367-68 (D. Neb. 1993) (providing that the ADA is not limited to just those entities receiving federal funding, but instead applies to all public entities, which may include states, and any department or agency); see also *Armstrong v. Wilson*, 942 F. Supp. 1252, 1258-59 (N.D. Cal. 1996) (indicating that the ADA expanded the Rehabilitation Act from public facilities receiving federal funding to any public entity).

22. SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES, COMMITTEE ANALYSIS OF AB 2861, at 2 (June 12, 1996).

23. 824 F. Supp. 1360 (D. Neb. 1993).

it came to student housing because the student needed the care of a personal attendant.²⁴ The plaintiff in *Coleman* argued successfully that the university's policy was arbitrary, and that it did not take into account her personal characteristics.²⁵ In essence, the policy excluded her from regular student housing simply because she had a disability.²⁶

Although there was no stated policy at the hospitals who denied Sandra Jensen her transplant, the medical centers at the University of California at San Diego (UCSD), and Stanford both denied Sandra Jensen a transplant based solely on her disability.²⁷ The argument the plaintiff made in *Coleman* is precisely the argument made by Sandra Jensen as she lobbied to receive her life-saving transplant.²⁸ Stanford and the UCSD were convinced to take another look at Ms. Jensen's case after they were warned against rejecting Ms. Jensen without good cause.²⁹

In order for Ms. Jensen to prevail under the relevant ADA case law, she would have to demonstrate that she was: (1) Disabled under the meaning of the ADA, (2) qualified to receive the transplant irrespective of her disability, and (3) was denied the transplant on the basis of her disability and for no other reason.³⁰ Ms. Jensen's toughest battle would have been to prove that the physicians at the respective hospitals denied her request for a transplant solely based on her disability. Undoubtedly, the hospitals would have argued that their denial of Ms. Jensen was based on the medical facts indicating that she was not an appropriate candidate for a heart-lung transplant.

A California act also offered Ms. Jensen a remedy before the legislature even enacted Chapter 96. California Civil Code § 51, also known as the Unruh Civil Rights Act, provides that persons with disabilities are entitled to "full and equal accommodations, advantages, facilities, privileges, or services in all business establishments of every kind whatsoever."³¹ It appears likely that Ms. Jensen's case would have been covered under either the ADA or the Unruh Civil Rights Act.

24. *Coleman*, 824 F. Supp. at 1366.

25. *Id.* at 1372.

26. *Id.*; see *id.* (holding that the school's policy prohibiting the assignment of roommates to students with disabilities who required personal attendant care violated the ADA.)

27. SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES, COMMITTEE ANALYSIS OF AB 2861, at 2 (June 12, 1996); see Letter from Antonio Villaraigosa, Assemblymember, California State Assembly, to Pete Wilson, Governor, State of California (June 24, 1996) [hereinafter Letter from Assemblymember Villaraigosa] (on file with the *Pacific Law Journal*) (explaining that Stanford initially rejected Ms. Jensen with a letter stating "we do not feel that patients with Down Syndrome make appropriate candidates for organ transplants"). Neither hospital took into account her individual abilities or independent living skills. *Id.*

28. Letter from Assemblymember Villaraigosa, *supra* note 27.

29. Hubert, *supra* note 3, at A1.

30. See, e.g., *Bonner v. Lewis*, 867 F.2d 559, 562-63 (9th Cir 1988); *Harding v. Winn-Dixie Stores*, 907 F. Supp. 386, 389-90 (E.D. Pa 1995); see *Wagner v. Fair Acres Geriatric Ctr.*, 49 F.3d 1002, 1009 (3d Cir. 1995) (providing that the evidence must show that the plaintiff is a handicapped individual, otherwise qualified for services, and was excluded because of the handicap, and that the program or activity received federal funding).

31. CAL. CIV. CODE § 51 (West Supp. 1997); see *id.* (explaining also that any violation of the ADA would be determined to be a violation of this Act as well).

However, advocates of Chapter 96 did not wish for Ms. Jensen or others with similar conditions to be forced to litigate their need for an organ transplant when many times these potential recipients are already critically ill.³²

IV. CONCLUSION

Advocates for Chapter 96 are well aware of the scarcity of organs and the number of individuals who are currently waiting for organs.³³ However, it is doubtful that requiring hospitals to evaluate persons with disabilities on a case-by-case basis will dramatically increase those potential recipients placed on the waiting list.³⁴ Although people will be watching closely to see how well Ms. Jensen does with her new transplant, most children born with Down Syndrome today are unlikely to need a heart-lung transplant because now a surgical procedure exists to correct heart and lung problems early in childhood.³⁵

Although it does not appear that Chapter 96 will have far-reaching ramifications when it comes to the number of potential recipients placed on the donor registry, this does give hope to those with disabilities who may have been denied a transplant solely on the basis of their disability. It is difficult to determine who should receive an organ transplant, and physicians struggle with who would be the best candidate for an anatomical gift.³⁶ However, Chapter 96 now requires that all persons, be given an equal opportunity for a transplant, and that their cases be judged on the medical merits instead of denying them initially because of their mental or physical disability.

For fourteen months Ms. Jensen's heart and lung transplant appeared to have been a success.³⁷ It allowed her to continue a healthy and productive life.³⁸ Ultimately, however, Ms. Jensen died as a result of complications of her transplant.³⁹

32. News Release from Antonio R. Villaraigosa, Assemblymember, California State Assembly (Feb. 22, 1996) (on file with the *Pacific Law Journal*) (stating that persons awaiting transplants do not have the time to wait for the courts to reach their case, and explaining it is necessary that the law settle this outside of the courts).

33. See *id.* (indicating that the number of individuals who donate their organs has stayed static for the last five years); *id.* (providing that about 5000 of every 4 million people who die donate their organs, while the waiting list has continued to grow over the last five years to include approximately 41,000 people).

34. Carey Goldberg, *Her Survival Proves Doubters Wrong*, N.Y. TIMES, Mar. 3, 1996, at A1.

35. *Id.*

36. See *id.* (quoting Dr. Nicholas Halasz, chairman of the Ethics Committee of the United Network for Organ Sharing, as stating that while physicians try to decide on medical considerations only, they find themselves agonizing about the benefits the person and society may receive when deciding whether or not to give an organ to a person with a major disability).

37. See Cynthia Hubert, *Transplant Pioneer Loses Battle for Life*, SACRAMENTO BEE, May 25, 1997, at A1 (explaining that while there had been complications after the surgery, Ms. Jensen had been enjoying relatively good health).

38. *Id.*; see *id.* (indicating that Ms. Jensen "felt stronger than she had in years" and did not regret undergoing the transplant operation).

39. *Id.*, see *id.* (explaining that Ms. Jensen developed lymphoma, which is a common side effect of the drugs that suppress the immune system in order to prevent her body from rejecting the transplanted organ).

The complications were unrelated to her disability and could have occurred in any one receiving a like transplant.⁴⁰

APPENDIX

Code Section Affected

Health and Safety Code § 7153.2 (new).

AB 2861 (Villaraigosa); 1996 STAT. Ch. 96.

40. *Id.*, *see id.* (describing Ms. Jensen as an able and cooperative patient who according to her cardiologist, Philip Bach, M.D., “never had one problem with not taking her medications or managing her care. She followed complicated medical regime beautifully”).

