

Dumping the “Anti-Dumping” Law: Why EMTALA Is (Largely) Unconstitutional and Why It Matters

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ABSTRACT

EMTALA—the Emergency Medical Treatment and Active Labor Act requiring hospital emergency departments to screen and stabilize emergency patients, regardless of ability to pay—has played a pivotal and peculiar role in American health care, as the only assured access to care for millions of people. Curiously, although EMTALA imposes enormous costs on hospitals, neither the Supreme Court nor any circuit courts have addressed its constitutionality. This Article argues that, particularly in the paradigm case of an indigent patient at a for-profit hospital, EMTALA violates the Fifth Amendment’s Takings Clause: the government takes property for public use without just compensation.

All the elements of a taking are readily established: property, taking, and public use.

Here, the property is not the hospital as such—this is not a case of land use regulation. Rather, the hospital is the “person” from whom property is taken, including: [1] personal property such as costly pharmaceuticals, medical devices, and paid staff time; and [2] physical invasion of spaces such as the emergency room, operating suites, and intensive care beds.

Such destruction or transfer of personal property and invasion of physical spaces constitute per se takings. Regulatory takings analysis, ordinarily invoked for regulating real property, is inapplicable.

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These takings' public use is to ensure immediate emergency care, regardless of ability to pay. All three elements of a taking are thus satisfied.

As this Article further argues, EMTALA's broad economic coercion of hospitals cannot be justified as simply a condition of participation in Medicare.

In the end, the problem is not that EMTALA mandates takings, but rather that it fails to provide adequately for just compensation. For-profit hospitals often receive no compensation whatever. Even not-for-profit hospitals can quickly cross the threshold from "compensated" (e.g., via tax exemption) into uncompensated care. Where compensation is insufficient, EMTALA's takings are unconstitutional.

The substantial constitutional impairment of EMTALA could trigger an interesting predicament. Historically, EMTALA has been a "fig leaf" obscuring the nation's less-than-universal access to care. After all, the uninsured can always go to the emergency room. Going forward, EMTALA may be an "enabler," encouraging healthy people to forego insurance until they become ill. The Affordable Care Act (ACA) permits anyone, even those with preexisting conditions, to buy insurance at the same cost as anyone else and, although it mandates that everyone be insured, the "tax" for noncompliance is modest and not strongly enforceable. Refusal to buy insurance until after one is ill may thus be attractive because, after all, the emergency room cannot demand advance assurance of payment.

If the cost of insurance thereby spirals out of control because too few healthy people buy it, the Fifth Amendment's Takings Clause could actually salvage the ACA's mandate. Although this Article neither endorses nor disparages the idea, the individual mandate could be re-cast as a constitutionally proper act of eminent domain: the "property" being taken is the citizen's money; the "just compensation" is a health insurance policy; and the "public use" is to save private health insurance as Congress' chosen avenue for broadening access to care. Perhaps most interestingly, the mandate as an exercise of eminent domain need not satisfy the Commerce Clause. Per a long line of Supreme Court rulings, acts of eminent domain need only satisfy the rational basis test.

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I. OVERVIEW

The Emergency Medical Treatment and Active Labor Act (EMTALA), which requires hospitals with emergency facilities to screen and stabilize patients with emergency conditions, has been on the books for over a quarter century.¹ It seems remarkable that the constitutionality of this law, which often requires hospitals to provide costly care with little or no compensation, has never been evaluated by the Supreme Court² or any of the circuit courts.³ As this Article will show, such a challenge is overdue. EMTALA imposes takings, and as it lacks any provision for compensation, is unconstitutional every time the hospital's services are uncompensated or undercompensated.

In 1986 Congress enacted EMTALA to ensure that, when someone comes to a hospital's emergency department (ED), the hospital will at least screen that person for emergency conditions⁴ and stabilize any such condition⁵ before transfer to another hospital or facility.⁶ The days precipitating EMTALA allegedly exhibited a pattern in which more profitable hospitals

1. See, e.g., Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (2006 & Supp. V 2011).

2. The lone Supreme Court case regarding EMTALA is *Roberts v. Galen of Virginia, Inc.*, 525 U.S. 249 (1999), in which the Court found that a plaintiff bringing an action alleging a failure to screen and/or stabilize need not prove that the hospital acted with an improper motive. *Id.* at 253.

3. The Author's extensive research has revealed no circuit court decisions evaluating the constitutionality of EMTALA.

4. 42 U.S.C. § 1395dd(a) ("In the case of a hospital that has an emergency department, if an individual (whether or not eligible for benefits under this subchapter) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination . . .").

5. 42 U.S.C. § 1395dd(b)(1)(A) (requiring "such further medical examination and such treatment as may be required to stabilize the medical condition"); see also 42 C.F.R. § 489.24(a)(1) (2012) ("In the case of a hospital that has an emergency department, if an individual (whether or not eligible for Medicare benefits and regardless of ability to pay) 'comes to the emergency department', as defined in paragraph (b) of this section, the hospital must . . . (ii) If an emergency medical condition is determined to exist, provide any necessary stabilizing treatment, as defined in paragraph (d) of this section, or an appropriate transfer as defined in paragraph (e) of this section. If the hospital admits the individual as an inpatient for further treatment, the hospital's obligation under this section ends, as specified in paragraph (d)(2) of this section.").

6. 42 U.S.C. § 1395dd(c)(1).

were said to “dump” indigent patients—those who “failed the billfold biopsy”—onto public or charity hospitals.⁷ This “anti-dumping” statute, which binds all hospitals having a Medicare contract,⁸ was hailed as a major step toward broadening access to care in a nation that did not otherwise ensure universal coverage.⁹ The statute provides no compensation to hospitals for this care,¹⁰ and forbids hospitals to condition their provision of emergency services on patients’ ability to pay.¹¹

EMTALA forbids transfer of a still-unstable patient to another hospital unless the latter has facilities the treating hospital lacks, or the patient properly consents.¹² Moreover,

7. See Nathan S. Richards, Note, *Judicial Resolution of EMTALA Screening Claims at Summary Judgment*, 87 N.Y.U. L. REV. 591, 591, 595 n.16 (2012) (stating that uninsured and minority individuals are typically the patients being dumped, and citing a Cook County study noting an increase of “interhospital transfers of patients to public general hospitals”). *But see* David A. Hyman, *Patient Dumping and EMTALA: Past Imperfect/Future Shock*, 8 HEALTH MATRIX 29, 48–50 (1998) (casting doubt on the claim that the alleged “dumping” giving rise to the legislation was, in fact, as serious or widespread as advocates claimed).

8. See 42 U.S.C. § 1395cc(a) (2006 & Supp. V 2011); 42 C.F.R. § 489.24.

9. See Hyman, *supra* note 7, at 29–30 (citing the popularity and “overwhelmingly favorable” response to EMTALA and its goal of providing emergency care to those unable to pay).

10. 42 U.S.C. § 1395dd (requiring hospitals to treat all emergency patients, but not providing hospitals compensation if patient cannot pay for the service).

11. See 42 U.S.C. § 1395dd(h) (“A participating hospital may not delay provision of an appropriate medical screening examination required under subsection (a) . . . or further medical examination and treatment required under subsection (b) . . . in order to inquire about the individual’s method of payment or insurance status.”).

12. 42 U.S.C. § 1395dd(c); see also 42 C.F.R. § 489.24(d) (providing for necessary stabilizing treatment for emergency medical conditions); 42 C.F.R. § 489.24(e)(1) (“If an individual at a hospital has an emergency medical condition that has not been stabilized (as defined in paragraph (b) of this section), the hospital may not transfer the individual unless—(i) The transfer is an appropriate transfer (within the meaning of paragraph (e)(2) of this section); and (ii)(A) The individual (or a legally responsible person acting on the individual’s behalf) requests the transfer, after being informed of the hospital’s obligations under this section and of the risk of transfer. The request must be in writing and indicate the reasons for the request as well as indicate that he or she is aware of the risks and benefits of the transfer; (B) A physician (within the meaning of section 1861(r)(1) of the Act) has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual or, in the case of a woman in labor, to the woman or the unborn child, from being transferred. The certification must contain a summary of the

hospitals with specialized capabilities such as a burn unit or neonatal intensive care are required to accept transfers of patients requiring such services, even if that hospital has no ED.¹³ It is not uncommon for EMTALA patients to require inpatient admission followed by lengthy, costly inpatient care.¹⁴ Violations can trigger civil money penalties up to \$50,000¹⁵ and civil actions by injured patients.¹⁶

risks and benefits upon which it is based; or (C) If a physician is not physically present in the emergency department at the time an individual is transferred, a qualified medical person (as determined by the hospital in its by-laws or rules and regulations) has signed a certification described in paragraph (e)(1)(ii)(B) of this section after a physician (as defined in section 1861(r)(1) of the Act) in consultation with the qualified medical person, agrees with the certification and subsequently countersigns the certification. The certification must contain a summary of the risks and benefits upon which it is based.”); *id.* § 489.24(e)(2) (“A transfer to another medical facility will be appropriate only in those cases in which—(i) The transferring hospital provides medical treatment within its capacity that minimizes the risks to the individual’s health and, in the case of a woman in labor, the health of the unborn child; (ii) The receiving facility—(A) Has available space and qualified personnel for the treatment of the individual; and (B) Has agreed to accept transfer of the individual and to provide appropriate medical treatment; (iii) The transferring hospital sends to the receiving facility all medical records (or copies thereof) related to the emergency condition which the individual has presented that are available at the time of the transfer . . . ; and (iv) The transfer is effected through qualified personnel and transportation equipment, as required, including the use of necessary and medically appropriate life support measures during the transfer.”).

13. 42 C.F.R. § 489.24(f) (“A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or, (with respect to rural areas), regional referral centers which, for purposes of this subpart, mean hospitals meeting the requirements of referral centers found at §412.96 of this chapter) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.”).

14. *See, e.g., Roberts v. Galen of Va., Inc.*, 525 U.S. 249, 251 (1999) (stating that a woman run over by a truck had been in-patient for six weeks and required considerable further care); *In re Baby K*, 16 F.3d 590, 592, 598 (4th Cir. 1994) (holding that an anencephalic infant who had lacked major portions of the brain except for brain stem was to be readmitted, for intensive care if necessary, any time that respiratory distress or other emergent condition required it).

15. 42 U.S.C. § 1395dd(d)(1).

16. *Id.* § 1395dd(d)(2). EMTALA does not, however, provide for a civil cause of action against physicians. *See, e.g., Eberhardt v. City of Los Angeles*, 62 F.3d 1253, 1257 (9th Cir. 1995) (holding that “EMTALA does not allow private suits against physicians”); *Burditt v. U.S. Dep’t of Health & Human*

This Article will show that EMTALA is frequently unconstitutional under the Fifth Amendment's Takings Clause.¹⁷ That is, the federal government takes hospitals' property for public use and, whenever that happens without just compensation, it is an unconstitutional taking.¹⁸ The clearest case is the medically indigent patient at a for-profit hospital that pays a full load of taxes and has no residual Hill-Burton obligations.¹⁹ Here there is no compensation

Servs., 934 F.2d 1362, 1373 (5th Cir. 1991) (upholding a civil penalty imposed on a physician by the U.S. Department of Health and Human Services).

17. U.S. CONST. amend. V ("[N]or shall private property be taken for public use, without just compensation."). The Fifth Amendment has been extended to the states. *Compare* *Barron v. Mayor of Balt.*, 32 U.S. (7 Pet.) 243, 250–51 (1833) (holding that the Takings Clause in the Fifth Amendment does not apply to the states), *with* *Chi., Burlington & Quincy R.R. Co. v. City of Chicago*, 166 U.S. 226, 241 (1897) (holding that the Takings Clause applies to the states). The due process language of the Fourteenth Amendment prohibits state governments from taking private property in the absence of just compensation. *See id.* at 241 (holding that "private property . . . taken for the State" without compensation violates due process under the Fourteenth Amendment); *Mo. Pac. Ry. Co. v. Nebraska ex rel. Bd. of Transp.*, 164 U.S. 403, 417 (1896) ("The taking by a State of the private property . . . without the owner's consent, for the private use of another . . . is a violation of the fourteenth article of amendment of the constitution . . .").

18. *See* U.S. CONST. amend. V (stating the unconstitutionality of taking private property for public use in the absence of "just compensation"); 42 C.F.R. § 489.24(b) (defining hospital property as encompassing the "entire main hospital campus").

19. The Hospital Survey and Construction Act, also known as the "Hill-Burton" Act, was an early effort at requiring hospitals to provide care for indigent patients. *See* Hospital Survey and Construction (Hill-Burton) Act, ch. 958, 60 Stat. 1040, 1043 (1946) (codified as amended at 42 U.S.C. §§ 291–291m); 42 U.S.C. § 291c(e) (2006 & Supp. V 2011) ("[T]he State plan shall provide for adequate hospital facilities for . . . persons unable to pay therefor."); *see also* Richards, *supra* note 7, at 597–98 (stating that the Hill-Burton Act, an earlier attempt to "ensure equal access to emergency care," was a failure, lacking adequate provisions authorizing penalties for non-compliance). In exchange for financial assistance toward hospital construction, the recipient hospital was obligated to provide a "reasonable" amount of charity care. *See* Hill-Burton Act, 60 Stat. at 1043 ("[T]here will be made available in each such hospital . . . a reasonable volume of hospital services to persons unable to pay therefor . . ."); *see also* *Am. Hosp. Ass'n v. Schweiker*, 721 F.2d 170, 180 (7th Cir. 1983) (holding the compliance level of 10% of all federal assistance receive, adjusted for inflation, was a reasonable standard for the required "volume of services"). The Act's limited enforcement provisions eventually were amended in 1979 to place clear obligations on hospitals via Title XVI of the Public Health Service Act. 42 U.S.C. §§ 201–301 (2006 & Supp. V 2011). Funding under the Act ceased in 1997 and, at present, only around 170 hospitals in the United States still have Hill-Burton obligations. *Hill-Burton Free and Reduced-Cost Health Care*, HEALTH

whatsoever.²⁰ While more nuanced issues surround public and not-for-profit private hospitals, just compensation often fails there as well.

The analysis below borrows its analytic steps from *Ruckelshaus v. Monsanto Co.*²¹:

[1] Is there a *property* interest;

[2] Is there a *taking* of property;

[3] If there is a taking, is it for *public use*; and

[4] If there is a taking of property for public use, is there *just compensation*.²²

Accordingly, Part II discusses property. Although typical takings cases feature real estate in eminent domain condemnations, in fact “property” can also encompass anything from contract rights, to interest money, to intellectual property, and tangible personal property.²³

In EMTALA cases the property is not the hospital-as-a-whole.²⁴ Rather, two kinds of property are involved: [1] personal property such as drugs, bandages, and medical devices; and [2] transient invasions of real property, specifically into emergency room (ER) spaces, operating rooms (ORs), intensive care unit (ICU) beds, and regular inpatient rooms—essentially the “rental value” of these spaces.²⁵ Correctly identifying the kinds of property at stake permits a correct description of the type of taking that then occurs.

With a brief foray into the historical evolution of takings jurisprudence, Part III distinguishes *per se* takings from regulatory takings. *Per se* takings are characterized by either complete destruction of the property’s value, or alternatively a physical invasion or occupation of property.²⁶ These are takings no matter how small the intrusion, and they need not be

RESOURCES & SERVICES ADMIN., <http://www.hrsa.gov/getthehealthcare/affordable/hillburton/> (last visited Sept. 16, 2013).

20. See 42 C.F.R. § 489.24(a) (providing that hospitals with an ED must provide an appropriate screening and stabilizing treatment to patients that seek treatment at the ED regardless of the patient’s ability to pay); Richards, *supra* note 7, at 592 n.3 (explaining that hospitals receiving Medicare funds, which includes essentially every hospital, are bound by EMTALA).

21. *Ruckelshaus v. Monsanto Co.*, 467 U.S. 986 (1984).

22. See *id.* at 1000–01.

23. See *infra* Part II.A.

24. See *infra* Part II.B.

25. See *infra* Part II.B.

26. See *infra* Part III.A.

permanent.²⁷ Regulatory takings, in contrast, arise in the absence of any such physical invasion or destruction.²⁸ The concept recognizes that at some point a government regulation restricting the use of one's property can become so onerous it is tantamount to a taking.²⁹ Regulatory takings lack any set formula, but rather require a somewhat ad-hoc, fact-intensive inquiry.³⁰ As we will see, EMTALA takings are per se takings, and it is erroneous to invoke regulatory takings analyses.³¹

Part IV shows that EMTALA's legitimate public use is to ensure essential medical care at a time people are most vulnerable,³² and that takings transferring property from one private party to another can still satisfy the "public use" criterion.³³

Collectively, Parts II, III and IV conclude that EMTALA enforcement commits takings under the Fifth Amendment.³⁴ Still, there is nothing inherently wrong with eminent domain. Indeed the Takings Clause presupposes that such acts can be constitutionally permissible.³⁵ However, they must be accompanied by just compensation.³⁶

Part V thus addresses compensation, first by addressing the most common argument that would favor EMTALA's constitutionality. The "voluntariness" argument proposes that EMTALA is simply a Medicare condition of participation (CoP), i.e., that EMTALA cannot be problematic because hospitals are not forced to accept Medicare in the first place.³⁷ "Congress may attach appropriate conditions to federal taxing and spending programs to preserve its control over the use of federal funds."³⁸ On this argument, if EMTALA imposes a taking, the just compensation is the benefit of earning money

27. See *infra* Part III.A.1.

28. See *infra* Part III.A.

29. See *infra* Part III.A.

30. See *infra* Part III.A.

31. See *infra* Part III.

32. See *infra* Part IV.

33. See *infra* Part IV.

34. See *infra* Part V.

35. See U.S. CONST. amend. V.

36. *Id.*

37. See *infra* Part V.A.

38. Nat'l Fed'n of Indep. Bus. v. Sebelius (*NFIB*), 132 S. Ct. 2566, 2603 (2012).

by participating in Medicare.³⁹ If hospitals do not want EMTALA obligations, they can simply withdraw from the program.⁴⁰

This reasoning fails. Although the federal government can place conditions on its funds, financial inducement that becomes coercive becomes an unconstitutional overreaching of federal powers.⁴¹ For most hospitals, Medicare represents such a huge proportion of revenue that Medicare's EMTALA CoP presents an unacceptable "economic dragooning," a "gun to the head"⁴² choice: either provide potentially vast amounts of uncompensated care, or lose an enormous portion of its overall budget via the loss of all Medicare patients.⁴³

Once it is established that the federal government must actually pay for EMTALA services, Part V then discusses just compensation in two settings: patients' payments; and existing federal payments as applied to for-profit hospitals, not-for-profit hospitals, and public hospitals. In the paradigmatic case of medically indigent patients at for-profit hospitals with no Hill-Burton obligations, often there is no compensation whatsoever—a plain violation of the Takings Clause.⁴⁴ The other settings require a more nuanced analysis, but arguably involve a broad spectrum of inadequately compensated takings in plain violation of the Fifth Amendment.⁴⁵

Part VI empowers the foregoing reasoning by discussing the confused state of jurisprudence in a neighboring bit of case law: state statutes that, like EMTALA, require hospitals to provide uncompensated care.⁴⁶ These courts mistakenly conceive of the "property" in terms real estate—applying a regulatory takings analysis to inquire whether the hospital-as-a-whole is heavily damaged by the statute—rather than focusing on the correct sorts of property, namely, personal

39. See *infra* Part V.A.

40. See *infra* Part V.A.

41. *NFIB*, 132 S. Ct. at 2604 (referring to the Affordable Care Act's then-requirement that states broaden their Medicaid programs significantly or lose all federal Medicaid funding); see *infra* Part V.A.

42. *NFIB*, 132 S. Ct. at 2604–05 ("In this case, the financial 'inducement' Congress has chosen is much more than 'relatively mild encouragement'—it is a gun to the head.").

43. See *infra* Part V.

44. See *infra* Part V.C.1.

45. See *infra* Part V.C.

46. See *infra* Part VI.

property and physical invasions of hospital spaces.⁴⁷ As a result, these courts mistakenly undertake a regulatory rather than per se takings analysis.⁴⁸

Finally, Part VII explores one particular public policy implication of overturning or substantially limiting EMTALA, and adds a twist. Because EMTALA assures that if you're sick or injured you can always go to the ER,⁴⁹ EMTALA has historically served as something of a "fig leaf" covering the nation's failure to ensure universal access to health care.⁵⁰

Going forward, EMTALA is likely to serve as an "enabler" encouraging citizens to refrain from buying health insurance. The Patient Protection and Affordable Care Act of 2010 (PPACA, or ACA)⁵¹ mandates that every citizen and legal resident be insured,⁵² yet several factors may predictably deter sufficiently broad compliance: [a] the cost of buying insurance is considerably greater than the penalty ("tax") for not purchasing it;⁵³ [b] those who wait until after they are ill or injured can still buy the same insurance for the same price as anybody else;⁵⁴ and [c] in the interim, they can always count on the ER.⁵⁵ In this way EMTALA may encourage people to forego health insurance.⁵⁶ This could drive the cost of insurance unacceptably high, thereby encouraging still more people to forego that now-higher cost in favor of relying on the emergency room.⁵⁷ An ACA "mandate" that has no teeth could thus, with EMTALA's help, create something of a death-spiral for affordable care.⁵⁸

47. See *infra* Part VI.

48. See *infra* Part VI.

49. See *supra* note 11 and accompanying text.

50. See *infra* Part VII.A.

51. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). For a detailed description of the ACA, see *infra* Part VII.B.

52. See *infra* Part VII.B.

53. See Nat'l Fed'n of Indep. Bus. v. Sebelius (*NFIB*), 132 S. Ct. 2566, 2595-96 (2012) ("[F]or most Americans the amount due will be far less than the price of insurance, and, by statute, it can never be more.").

54. See *id.* at 2585 (discussing the ACA's provisions for "community-rating" and "guaranteed-issue").

55. See *infra* Part VII.B.

56. See *infra* Part VII.B.

57. See *infra* Part VII.B.

58. See *infra* Part VII.B.

If this ominous scenario comes to pass, the Fifth Amendment could actually provide an interesting twist to salvage the ACA's mandate. Although this Article neither endorses nor opposes the idea, the takings analysis offered here could reconfigure the ACA's mandate under the principles of eminent domain as a proper, fully constitutional taking.⁵⁹ The "property" to be taken is the person's money, the "just compensation" is a health insurance plan, and the proffered "public use" would be to keep the current private insurance-based health care system viable.⁶⁰

Even more interestingly, casting the mandate as a classic case of eminent domain need not pass constitutional muster under either the Commerce Clause or the Taxing and Spending Clause.⁶¹ The Supreme Court has been clear that government acts of eminent domain need only satisfy a rational basis test.⁶² Thus, to keep the ACA's health care system viable, the mandate could, itself, be quite readily enforced as a constitutionally proper taking. For better or worse, the idea could expand the public debate in interesting directions.

II. PROPERTY

Per the Fifth Amendment: "[N]or shall private property be taken for public use, without just compensation."⁶³ As emphasized by the Supreme Court over half a century ago, "[t]he Fifth Amendment's guarantee that private property shall not be taken for a public use without just compensation was designed to bar Government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole."⁶⁴

59. See *infra* Part VII.C.

60. See *infra* Part VII.C.

61. See *infra* Part VII.C.

62. See *infra* Part VII.C.

63. U.S. CONST. amend. V.

64. *Armstrong v. United States*, 364 U.S. 40, 49 (1960). Otherwise stated: "[The] State, by *ipse dixit*, may not transform private property into public property without compensation This is the very kind of thing that the Taking Clause of the Fifth Amendment was meant to prevent." *Webb's Fabulous Pharmacies, Inc. v. Beckwith*, 449 U.S. 155, 164 (1980); see also *Lingle v. Chevron U.S.A. Inc.*, 544 U.S. 528, 537 (2005) (citing *Armstrong*, 364 U.S. at 49); *Palazzolo v. Rhode Island*, 533 U.S. 606, 618 (2001) (citing *Armstrong*, 364 U.S. at 49); *E. Enters. v. Apfel*, 524 U.S. 498, 522 (1998) (plurality opinion) (citing *Armstrong*, 364 U.S. at 49); *First English*

A. CONCEPTS OF PROPERTY

The first challenge is to define “property.” The most familiar takings cases, and indeed the bulk of applicable jurisprudence, concern real property.⁶⁵ If a state needs to build a new road through Farmer Brown’s land, the Fifth Amendment permits the state to condemn the land, pay Brown, and build the road.⁶⁶

Still, takings jurisprudence addresses myriad other forms of property. Clearly, money is property.⁶⁷ Financial interest on money has counted as property for Fifth Amendment purposes, such as the interest on a lawyer’s trust account.⁶⁸ Tangible property is likewise encompassed, including fixtures and equipment located on real property,⁶⁹ presidential papers made

Evangelical Lutheran Church of Glendale v. Cnty. of Los Angeles, 482 U.S. 304, 318–19 (1987) (citing *Armstrong*, 364 U.S. at 49); *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 227 (1986) (citing *Armstrong*, 364 U.S. at 49); *Pruneyard Shopping Ctr. v. Robins*, 447 U.S. 74, 83 (1980) (explaining that Takings Clause analysis requires an examination of whether the taking forces an individual to “bear public burdens” that “should be borne” by all); *Penn Cent. Transp. Co. v. New York City*, 438 U.S. 104, 123–24, 148 (1978) (citing *Armstrong*, 364 U.S. at 49) (stating that the Fifth Amendment prevents an individual from taking on more than his or her share of government burdens).

65. See *Lingle*, 544 U.S. at 537 (“The paradigmatic taking requiring just compensation is a direct government appropriation or physical invasion of private property.”).

66. The Fifth Amendment’s provisions regarding government takings are extended to the states via the Fourteenth Amendment. See, e.g., *Pruneyard*, 447 U.S. at 84 (“A State is, of course, bound by the Just Compensation Clause of the Fifth Amendment . . .”); *Penn Cent.*, 438 U.S. at 122 (stating that a Taking “within the meaning of the Fifth Amendment” is applicable to the states “through the Fourteenth Amendment”); *Franklin Mem’l Hosp. v. Harvey*, 575 F.3d 121, 125 (1st Cir. 2009) (“The Takings Clause of the Fifth Amendment, which applies to the states through the Fourteenth Amendment, prohibits the taking of private property . . . without just compensation.”).

67. See *Webb’s Fabulous Pharmacies*, 449 U.S. at 162 (“The principal sum deposited in the registry of the court plainly was private property . . .”).

68. *Brown v. Legal Found. of Wash.*, 538 U.S. 216, 240 (2003); *Phillips v. Wash. Legal Found.*, 524 U.S. 156, 160 (1998); see also *Webb’s Fabulous Pharmacies*, 449 U.S. at 162 (finding interest on an escrow account to be deemed property for Fifth Amendment purposes).

69. *United States v. General Motors Corp.*, 323 U.S. 373, 383–84 (1945).

while in office,⁷⁰ the feathers and body parts of eagles,⁷¹ and alcoholic beverages.⁷²

Intangible property is also included. Contract rights such as a materialman's lien,⁷³ tenure in the academic setting,⁷⁴ lease and rental rights,⁷⁵ and other kinds of contract rights⁷⁶ all are property for Takings Clause purposes.⁷⁷ Intellectual property such as trade secrets likewise qualifies.⁷⁸

70. *Nixon v. United States*, 978 F.2d 1269, 1284 (D.C. Cir. 1992).

71. *Andrus v. Allard*, 444 U.S. 51, 58 (1979).

72. *Everard's Breweries v. Day*, 265 U.S. 545, 563 (1924); *Jacob Ruppert, Inc. v. Caffey*, 251 U.S. 264, 274–75 (1920).

73. *Armstrong v. United States*, 364 U.S. 40, 46–48 (1960) (“The result of this [series of events] was a destruction of all petitioners’ property rights under their liens, although, as we have pointed out, the liens were valid and had compensable value We hold that there was a taking of these liens for which just compensation is due under the Fifth Amendment.”).

74. *Bd. of Regents of State Colls. v. Roth*, 408 U.S. 564, 576–77 (1972); *Perry v. Sindermann*, 408 U.S. 593, 601–03 (1972).

75. *United States v. General Motors Corp.*, 323 U.S. 373, 373, 377–78 (1945).

76. *See Lynch v. United States*, 292 U.S. 571, 579 (1934) (holding that valid contracts for war risk insurance are property within the meaning of the Takings Clause).

77. Other kinds of property rights have also been identified, such as a physician's right to practice medicine. *See Dent v. West Virginia*, 129 U.S. 114, 121–22 (1889); *Lowe v. Scott*, 959 F.2d 323, 334 (1st Cir. 1992); *Keney v. Derbyshire*, 718 F.2d 352, 354 (10th Cir. 1983); *see also Barry v. Barchi*, 443 U.S. 55, 64 (1979) (occupational license is property for due process purposes); *Bell v. Burson*, 402 U.S. 535, 539 (1971) (driver's license is property); *Goldberg v. Kelly*, 397 U.S. 254, 262 n.8 (1970) (welfare payments regarded as property).

78. *Ruckelshaus v. Monsanto Co.*, 467 U.S. 986, 1002–04 (1984).

Trade secrets have many of the characteristics of more tangible forms of property. A trade secret is assignable A trade secret can form the res of a trust, Restatement (Second) of Trusts . . . and it passes to a trustee in bankruptcy This general perception of trade secrets as property is consonant with a notion of “property” that extends beyond land and tangible goods and includes the products of an individual's “labour and invention.” . . . Although this Court never has squarely addressed the question whether a person can have a property interest in a trade secret, which is admittedly intangible, the Court has found other kinds of intangible interests to be property for purposes of the Fifth Amendment's Taking Clause We therefore hold that to the extent that Monsanto has an interest in its health, safety, and environmental data cognizable as a trade-secret property right under Missouri law, that property right is protected by the Taking Clause of the Fifth Amendment.

Id. (citations omitted); *see also Philip Morris, Inc. v. Reilly*, 312 F.3d 24, 32–33 (1st Cir. 2002) (en banc) (“Therefore, it is clear that the tobacco companies have a property interest in their trade secrets . . .”). Somewhat in between

Basic theories of property permeate these analyses.⁷⁹ Particularly central is the right to exclude others, “one of the most essential sticks in the bundle of rights that are commonly characterized as property.”⁸⁰ Regarding intellectual property such as a trade secret, for instance, “the right to exclude others is central to the very definition of the property interest. Once the data that constitute a trade secret are disclosed to others, or others are allowed to use those data, the holder of the trade secret has lost his property interest in the data.”⁸¹

real property and intangible property, the Supreme Court has held that the air space above one’s land has property status. *United States v. Causby*, 328 U.S. 256, 266 (1946). Very low-altitude flights originating in a nearby military airfield caused such great noise that the plaintiffs’ land was rendered completely useless as a chicken farm. *Id.* at 261. The Court held that although flights over private land are not inherently a taking, they can be if “they are so low and so frequent as to be a direct and immediate interference with the enjoyment and use of the land.” *Id.* at 266.

The fact that [the landowner] does not occupy it in a physical sense—by the erection of buildings and the like—is not material. As we have said, the flight of airplanes, which skim the surface but do not touch it, is as much an appropriation of the use of the land as a more conventional entry upon it.

Id. at 264.

79. *See General Motors Corp.*, 323 U.S. at 377–78 (“It is conceivable that [the term ‘property’ in the Takings Clause] was used in its vulgar and untechnical sense of the physical thing with respect to which the citizen exercises rights recognized by law. On the other hand, it may have been employed in a more accurate sense to denote the group of rights inhering in the citizen’s relation to the physical thing, as the right to possess, use and dispose of it. In point of fact, the construction given the phrase has been the latter.” (citation omitted)); *see also* *Bd. of Regents of State Colls. v. Roth*, 408 U.S. 564, 577 (1972) (“To have a property interest in a benefit, a person clearly must have more than an abstract need or desire for it. He must have more than a unilateral expectation of it. He must, instead, have a legitimate claim of entitlement to it. It is a purpose of the ancient institution of property to protect those claims upon which people rely in their daily lives, reliance that must not be arbitrarily undermined.”).

80. *Kaiser Aetna v. United States*, 444 U.S. 164, 176 (1979); *see id.* at 179–80 (“In this case, we hold that the ‘right to exclude,’ so universally held to be a fundamental element of the property right, falls within this category of interests that the Government cannot take without compensation.” (citation omitted)); *see also* *Nollan v. Cal. Coastal Comm’n*, 483 U.S. 825, 831–32 (1987) (quoting *Kaiser Aetna*, 444 U.S. at 176); *Monsanto Co.*, 467 U.S. at 1011; *Loretto v. Teleprompter Manhattan Cable Television Corp.*, 458 U.S. 419, 433 (1982); *Pruneyard Shopping Ctr. v. Robins*, 447 U.S. 74, 82 (1980) (“It is true that one of the essential sticks in the bundle of property rights is the right to exclude others.” (citing *Kaiser Aetna*, 444 U.S. at 176)).

81. *Monsanto Co.*, 467 U.S. at 1011 (citation omitted); *see also Loretto*, 458 U.S. at 435 (“Property rights in a physical thing have been described as the

B. EMTALA PROPERTY ANALYSIS

In EMTALA cases, the property in question is not the hospital as a piece of land with buildings on it. Rather, the hospital as a business entity is the (corporate) “person” whose property is at stake. Hospitals rendering care under EMTALA use two kinds of property—personal and real.⁸² First, EMTALA patients consume large quantities of personal property such as pharmaceuticals, devices and bandages,⁸³ and can include depreciation of equipment and fixtures.⁸⁴ Paid labor can also be included.⁸⁵ Discrete labor services such as physical therapy count if billed separately;⁸⁶ an hour of professional service is just as much consumed as a bandage.

Second, on the real property side, EMTALA patients transiently occupy physical spaces—a cubicle in the ER, an inpatient room, an ICU bed, an OR suite.⁸⁷

rights ‘to possess, use and dispose of it.’ To the extent that the government permanently occupies physical property, it effectively destroys *each* of these rights. First, the owner has no right to possess the occupied space himself, and also has no power to exclude the occupier from possession and use of the space. The power to exclude has traditionally been considered one of the most treasured strands in an owner’s bundle of property rights.”); *see also Philip Morris*, 312 F.3d 24, 31–32 (1st Cir. 2002) (en banc) (discussing how there is a property interest in a trade secret); *Phillips v. Wash. Legal Found.*, 524 U.S. 156, 170 (1998) (citing *General Motors*, 323 U.S. at 378) (“[P]roperty is more than economic value . . . it also consists of ‘the group of rights which the so-called owner exercises in his dominion of the physical thing,’ such ‘as the right to possess, use and dispose of it’”).

82. *See Franklin Mem’l Hosp. v. Harvey*, 575 F.3d 121, 126–27 (1st Cir. 2009) (discussing types of property consumed by emergency room patients).

83. *See, e.g., id* at 127.

84. *See General Motors Corp.*, 323 U.S. at 383–84.

85. *See Franklin Mem’l Hosp.*, 575 F.3d at 127 (discussing labor costs of emergency room care).

86. *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE CLAIMS PROCESSING MANUAL: CHAPTER 12—PHYSICIANS/NONPHYSICIAN PRACTITIONERS (2013), *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf> (describing billing procedures for physical and respiratory therapy under Medicare).

87. *See Franklin Mem’l Hosp.*, 575 F.3d at 127 (discussing the approximate cost of “room and board services” for a patient). Here, labor costs are typically included rather than billed separately. The cost of nursing care is built into the daily price of an ICU bed, and the cost of cleaning up the OR suite after a surgery is built into the cost for using that OR—just as the cost of maid service and furnace maintenance are built into the cost of a night’s stay at a hotel. *See generally* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICARE CLAIMS PROCESSING MANUAL: CHAPTER 1—GENERAL BILLING REQUIREMENTS (2013), *available at* <http://www.cms.gov/Regulations-and-Guidance/Guidance/>

Hospitals' costs in providing both kinds of property to these patients can be enormous. Franklin Memorial Hospital in Maine, for instance, determined that on average each uncompensated inpatient stay (under a Maine law broader than EMTALA)⁸⁸ required "approximately \$1,200 in medical goods, such as medical and surgical supplies, pharmacy drugs, anesthesia gases, and intravenous therapy supplies, about \$1,700 in room and board services, and . . . about \$1,800 for doctors, nurses, and other staff to provide care to the client."⁸⁹ For those without a calculator handy the total is \$4700.

Some EMTALA patients, of course, generate vastly higher costs.⁹⁰ In *Matter of Baby K*, the mother of an anencephalic⁹¹ infant insisted that the hospital use whatever means necessary, including ventilator support in the ICU for as long as necessary, to keep her child alive as long as possible.⁹² After six months the hospital filed suit "to resolve the issue of whether it is obligated to provide emergency medical treatment to Baby K that it deems medically and ethically inappropriate."⁹³

The Fourth Circuit ruled that if Baby K appeared in the ED in respiratory distress—a medical emergency—EMTALA would require the hospital to treat her as long as necessary to stabilize her condition and prevent material deterioration.⁹⁴ "Baby K spent many months in the pediatric intensive care unit at a minimum cost of \$1,450 per day. Nursing home costs

Manuals/Downloads/clm104c01.pdf (describing billing procedures for inpatient hospital stays under Medicare).

88. See *Franklin Mem'l Hosp.*, 575 F.3d at 123–24 (describing a Maine statute under which hospitals were required to provide free medical care to low income patients without adequate compensation).

89. *Id.* at 127 (alteration in original) (internal quotation marks omitted).

90. See, e.g., *In re Baby K*, 16 F.3d 590, 592–93 (4th Cir. 1994) (discussing all the treatment and constant care Baby K received).

91. See *id.* at 592–93, 599 (explaining anencephaly as a condition in which the entire brain and a significant portion of the cranium, except for the brain stem, are missing from a newborn; because the person has no cerebrum, he or she is permanently unconscious).

92. *Id.* at 592–93.

93. *Id.* at 593. The hospital argued on grounds of futility, since no treatment could ever produce consciousness or cognitive function. *Id.* at 597.

94. *Id.* at 594. The court reasoned that if society wishes to limit this sort of aggressive treatment for conditions such as anencephaly, that is for the legislature, not the judiciary, to address. See *id.* at 597–98.

were estimated at over \$100 per day.”⁹⁵ She survived nearly two and a half years.⁹⁶ Baby K’s care was covered by private insurance and Medicaid⁹⁷ but, had she been uninsured, EMTALA would have mandated the full panoply of care for no compensation whatsoever.⁹⁸

Admittedly, EMTALA obligations technically are concluded if the hospital admits the person as an inpatient.⁹⁹ However, the costs generated thereafter are still fundamentally attributable to EMTALA. If it were possible for the hospital simply to transfer a costly indigent patient to a public hospital, as they could pre-EMTALA, then the hospital would not be required to absorb the ongoing high costs of an inherently unstable patient.¹⁰⁰

95. Tricia L. Romesberg, *Futile Care and the Neonate*: In *The Matter of Baby K*, 3 ADVANCES NEONATAL CARE 213, 214 (2003) (citations omitted).

96. *Id.*

97. *Id.*

98. *See supra* notes 10–11 and accompanying text.

99. 42 C.F.R. § 489.24(d)(2)(i) (2012) (“If a hospital has screened an individual under paragraph (a) of this section and found the individual to have an emergency medical condition, and admits that individual as an inpatient in good faith in order to stabilize the emergency medical condition, the hospital has satisfied its special responsibilities under this section with respect to that individual.”); *see also* Lopez v. Contra Costa Reg’l Med. Ctr., No. C 12-03726 LB, 2013 WL 120166, at *6 (N.D. Cal. Jan. 8, 2013) (“[I]f the hospital performs the screening of the emergency medical treatment and admits the individual as an inpatient, either for further treatment or in good faith in order to stabilize the emergency medical condition, then the hospital has satisfied its responsibilities with respect to the individual.” (internal citation omitted)).

100. *E.g.*, Thompson v. Sun City Cmty. Hosp., Inc., 688 P.2d 605, 610 (Ariz. 1984) (describing an Arizona statute that allowed private hospitals to seek reimbursement from public funds for providing emergency treatment to indigent patients). In *Baby K* the district court opined that:

The Hospital would also have an obligation to continue to provide stabilizing medical treatment to Baby K even if she were admitted to the pediatric intensive care unit or other unit of the Hospital and to provide the treatment until she could be transferred back to the Nursing Home or to another facility willing to accept her.

In re Baby K, 832 F. Supp. 1022, 1027 (E.D. Va. 1993). “[The] rationale behind [the] ‘anti-dumping statute is not based upon the door of the hospital through which a patient enters, but rather upon the notion of proper medical care for those persons suffering medical emergencies, whenever such emergencies occur at a participating hospital.” *Id.* (quoting *McIntyre v. Schick*, 795 F. Supp. 777, 781 (E.D. Va. 1992)). The Fourth Circuit affirmed, expressly on the basis of EMTALA. *In re Baby K*, 16 F.3d 590, 598 (4th Cir. 1994).

[S]tabilization of her condition requires the Hospital to provide respiratory support through the use of a respirator or other means necessary to ensure adequate ventilation. In sum, a straightforward

EMTALA thus can place enormous costs on hospitals. Hospitals with special facilities such as newborn intensive care or burn units, for instance, are required to accept transfers of patients needing such facilities, even if such a hospital has no ED.¹⁰¹ Additionally, whole groups of persons can present significant financial challenges under EMTALA. Estimates suggest that nearly eleven million undocumented immigrants live in the United States,¹⁰² many of whom rely on free care—much of which originates in the ER.¹⁰³

application of the statute obligates the Hospital to provide respiratory support to Baby K when she arrives at the emergency department of the Hospital in respiratory distress and treatment is requested on her behalf.

Id. at 594–95 (citations omitted); *see also id.* at 593 (noting the Hospital’s inability, once Baby K was an inpatient, to transfer her to another hospital with a pediatric intensive care unit, when all hospitals in the region refused to accept the patient).

101. 42 C.F.R. § 489.24(f) (2012) (“A participating hospital that has specialized capabilities or facilities (including, but not limited to, facilities such as burn units, shock-trauma units, neonatal intensive care units, or, (with respect to rural areas) regional referral centers which, for purposes of this subpart, mean hospitals meeting the requirements of referral centers found at § 412.96 of this chapter) may not refuse to accept from a referring hospital within the boundaries of the United States an appropriate transfer of an individual who requires such specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.”).

102. Carrie Dann, *By the Numbers: How America Tallies Its 11.1 Million Undocumented Immigrants*, NBC NEWS (Apr. 11, 2013, 4:43 AM), http://nbcpolitics.nbcnews.com/_news/2013/04/11/17691515-by-the-numbers-how-america-tallies-its-111-million-undocumented-immigrants?lite.

103. *See* Deborah Sontag, *Immigrants Facing Deportation by U.S. Hospitals*, N.Y. TIMES, Aug. 3, 2008, <http://www.nytimes.com/2008/08/03/us/03deport.html> (discussing how, in some cases, hospitals incurring high ongoing costs have resorted to repatriating such immigrants and how one hospital, after caring for a severely injured undocumented immigrant, finally chartered a plane and sent the patient to a community hospital in his native Guatemala); Deborah Sontag, *Jury Rules for Hospital that Deported Patient*, N.Y. TIMES, July 28, 2009, <http://www.nytimes.com/2009/07/28/us/28deport.html> (reporting that a Florida jury found the hospital not liable for its actions because it “did not act unreasonably” in repatriating the “severely brain-injured Guatemalan patient against the will of his guardian”); *see also* Alan Zarembo & Anna Gorman, *Citizenship Often Determines Who Gets Medical Care*, L.A. TIMES, Oct. 29, 2008, <http://www.latimes.com/news/printedition/front/la-me-dialysis29-2008oct29,0,2441127.story> (discussing how North Carolina refused to provide some forms of treatment to an illegal immigrant); *U.S. Hospitals Deport Undocumented Patients*, ASSOCIATED PRESS (Apr. 24, 2013), <http://www.advisory.com/Daily-Briefing/2013/04/24/AP-US-hospitals-deport-undocumented-patients> (reporting that estimates suggest over 600 undocumented immigrants have been deported in the past five years,

Add next the U.S. citizens who have a very low income, but who do not currently qualify for Medicaid.¹⁰⁴ In 2011, U.S. hospitals absorbed over \$40 billion in uncompensated care, according to the American Hospital Association.¹⁰⁵ The number of people who cannot pay could soon grow substantially. Originally the ACA required states to expand their Medicaid coverage from a limited range of individuals at or below 100% of the Federal Poverty Line (FPL), to all non-Medicare individuals up to 133% of the FPL—on pain of losing all Medicaid funding.¹⁰⁶ This was the only part struck down in *National Federation of Independent Business v. Sebelius* (*NFIB*): although the federal government can permissibly attach conditions to its disbursements to states, withdrawing all Medicaid funding would be unduly coercive as a means to induce states to expand their programs.¹⁰⁷

in what is being dubbed “medical repatriation”); *U.S. Hospitals Repatriating Sick/Injured Undocumented Immigrants*, UNITED PRESS INT’L (Apr. 24, 2013), http://www.upi.com/Health_News/2013/04/24/US-hospitals-repatriating-sickinjured-undocumented-immigrants/UPI-21001366847321/ (reporting there have been “more than 800 cases of attempted or actual medical deportations in recent years”).

104. See Nat’l Fed’n of Indep. Bus. v. Sebelius (*NFIB*), 132 S. Ct. 2566, 2601 (2012) (“The current Medicaid program requires States to cover only certain discrete categories of needy individuals—pregnant women, children, needy families, the blind, the elderly, and the disabled. There is no mandatory coverage for most childless adults, and the States typically do not offer any such coverage. The States also enjoy considerable flexibility with respect to the coverage levels for parents of needy families. On average States cover only those unemployed parents who make less than 37 percent of the federal poverty level, and only those employed parents who make less than 63 percent of the poverty line.” (citations omitted)).

105. Bruce Japsen, *Unpaid Hospital Bills Rise to \$41 Billion Annually*, FORBES (Jan. 7, 2013, 9:01 AM), <http://www.forbes.com/sites/brucejapsen/2013/01/07/unpaid-hospital-bills-rise-to-41-billion-annually/>.

106. See *NFIB*, 132 S. Ct. at 2582 (“States now cover adults with children only if their income is considerably lower, and do not cover childless adults at all.”); *id.* at 2601 (noting the list will include children, pregnant women, parents, and adults without dependent children who fall between 100% to 133% of the FPL). To encourage states to embrace the Medicaid expansion, the ACA specifies that the federal government will pay 100% of the costs of expansion from 2014–2016, gradually dropping to 90% by 2020. *Id.* (“The Affordable Care Act provides that the Federal Government will pay 100 percent of the costs of covering these newly eligible individuals through 2016. In the following years, the federal payment level gradually decreases, to a minimum of 90 percent.” (citation omitted)).

107. *Id.* at 2604.

The result is that states can choose not to participate in Medicaid expansion.¹⁰⁸ At the same time, eligibility to receive subsidies in states' insurance exchanges under the ACA now requires that one's income be at least 100% of the FPL.¹⁰⁹ As a result, beginning in 2014 in states declining to expand Medicaid, significant numbers of people will effectively be left without insurance coverage options—namely, those who are poor but not eligible for Medicaid.¹¹⁰ Their lone option will be the ER.

Yet another group may increase the ranks of the uninsured. The ACA requires insurance plans to cover a fairly

108. See Benjamin D. Sommers & Arnold M. Epstein, *U.S. Governors and the Medicaid Expansion: No Quick Resolution in Sight*, 368 NEW ENG. J. MED. 496, 498–99 (2013) (discussing wide variations between states regarding their willingness to expand Medicaid and the reasoning behind their decision-making process following the *NFIB* decision).

109. Initially, eligibility to participate in state insurance exchanges began at 133% of the FPL because states were required to include all persons with lesser incomes in expanded Medicaid programs. See *NFIB*, 132 S. Ct. at 2601 (“The Medicaid provisions of the Affordable Care Act, in contrast, require States to expand their Medicaid programs by 2014 to cover *all* individuals under the age of 65 with incomes below 133 percent of the federal poverty line.”). At this point, however, subsidies to participate in state insurance exchanges begin at 100% of the FPL:

The current Medicaid program requires States to cover only certain discrete categories of needy individuals—pregnant women, children, needy families, the blind, the elderly, and the disabled. There is no mandatory coverage for most childless adults, and the States typically do not offer any such coverage. The States also enjoy considerable flexibility with respect to the coverage levels for parents of needy families. On average States cover only those unemployed parents who make less than 37 percent of the federal poverty level, and only those employed parents who make less than 63 percent of the poverty line.

Id. (citations omitted).

110. Sabrina Tavernise & Robert Gebeloff, *Millions of Poor Are Left Uncovered by Health Law*, N.Y. TIMES, Oct. 2, 2013, http://www.nytimes.com/2013/10/03/health/millions-of-poor-are-left-uncovered-by-health-law.html?_r=0; see also Emily Wagster Pettus, *Miss. Says No Thanks to Medicaid Expansion Dollars*, ASSOCIATED PRESS (Oct. 18, 2012, 1:36 PM), <http://bigstory.ap.org/article/miss-says-no-thanks-medicaid-expansion-dollars> (reporting that Mississippi—one of the poorest states with a high level of Medicaid eligibility both currently and under an ACA expansion—has announced that it will decline the option of expanding Medicaid, which will leave substantial numbers of Mississippians with no access to health insurance); see also Reid Wilson, *The Affordable Care Act Won't Help These 5 Million People*, WASH. POST (Oct. 16, 2013, 10:00 AM), <http://www.washingtonpost.com/blogs/govbeat/wp/2013/10/16/the-affordable-care-act-wont-help-these-5-million-people/>.

rich set of “essential health benefits.”¹¹¹ Because this level of coverage is significantly greater than that provided by some pre-ACA insurance plans, subscribers to lesser policies must shift to a higher-benefit policy, typically at higher cost.¹¹² Those who cannot afford the new premium, and who for whatever reason will not receive sufficient subsidy going forward, may well end up uninsured and likewise reliant on the ER.

In sum, EMTALA requires hospitals to provide considerable personal property: pharmaceuticals, bandages, medical devices, laboratory tests, radiographs, enteral and parenteral nutrition, maintenance expenses and depreciation of (high-cost) equipment, and paid staff time. And so long as the EMTALA patient occupies a space—whether in the ED, the OR, the ICU, or a regular hospital room—he or she consumes the “rental value” of that space.

All these are property. And central to what follows, the property in question is not the hospital-as-a-whole. Bricks, mortar, and dirt are not what is given to the patient. The next question is whether these EMTALA-mandated consumptions and invasions of property constitute takings.

III. TAKING

As we have seen, the identification of “property” for EMTALA analysis needs to be precise—bandages and beds, not bricks and mortar. Likewise for a “taking.” Admittedly, takings jurisprudence is not a model of clarity. Per the First Circuit, “the jurisprudence in this area is convoluted and subject to various interpretations.”¹¹³ Nevertheless, the jurisprudence

111. 42 U.S.C. § 18022 (Supp. V 2011).

112. Carter Evans, *Arrival of Obamacare Forcing Insurers to Drop Customers With Low Coverage*, CBS NEWS.COM (Oct. 24, 2013, 7:15 PM), http://www.cbsnews.com/8301-18563_162-57609224/arrival-of-obamacare-forcing-insurers-to-drop-customers-with-low-coverage/; see Anemona Hartocollis, *With Affordable Care Act, Canceled Policies for New York Professionals*, N.Y. TIMES, Dec. 13, 2013, <http://www.nytimes.com/2013/12/14/nyregion/with-affordable-care-act-canceled-policies-for-new-york-professionals.html>.

113. *Philip Morris, Inc. v. Reilly*, 312 F.3d 24, 36 (1st Cir. 2002) (en banc); see also *Lingle v. Chevron U.S.A. Inc.*, 544 U.S. 528, 539 (2005) (“[O]ur regulatory Takings jurisprudence cannot be characterized as unified . . .”).

applicable to EMTALA is plenty clear enough to resolve the key questions.¹¹⁴

A. EVOLUTION OF TAKINGS CLAUSE JURISPRUDENCE

Throughout the nation's early history, the only recognized sort of taking was the classic case in which government completely appropriated the property.¹¹⁵ In 1922 that changed with *Pennsylvania Coal Co. v. Mahon*,¹¹⁶ when regulation of property began to fall within the ambit of takings.

Beginning with *Mahon*, however, the Court recognized that government regulation of private property may, in some instances, be so onerous that its effect is tantamount to a direct appropriation or ouster—and that such “regulatory takings” may be compensable under the Fifth Amendment. In Justice Holmes’ storied but cryptic formulation, “while property may be regulated to a certain extent, if regulation goes too far it will be recognized as a taking.”¹¹⁷

Such “regulatory” takings pose a significant theoretical challenge, because the government does not take or destroy the property outright, but simply restricts its use.¹¹⁸ Human society involves considerable give-and-take. Surely the government cannot be expected to compensate a citizen for every small impact that merely “adjusts the benefits and burdens of economic life to promote the common good.”¹¹⁹ Accordingly, “not every destruction or injury to property by

114. See *Lingle*, 544 U.S. at 538–39 (noting it is *regulatory* takings jurisprudence that particularly exhibits convolution and confusion, rather than the *per se* takings jurisprudence).

115. See *Lucas v. S.C. Coastal Council*, 505 U.S. 1003, 1014 (1992) (summarizing Takings Clause jurisprudence).

116. *Pa. Coal Co. v. Mahon*, 260 U.S. 393 (1922).

117. *Lingle*, 544 U.S. at 537–38 (quoting *Mahon*, 260 U.S. at 415); see also *Tahoe-Sierra Pres. Council, Inc. v. Tahoe Reg'l Planning Agency*, 535 U.S. 302, 323–25 (2002) (discussing the distinction between acquisitions of property and regulations that can be recognized as a taking).

118. See *Lingle*, 544 U.S. at 537–38.

119. *Penn Cent. Transp. Co. v. New York City*, 438 U.S. 104, 124; see also *Lingle*, 544 U.S. at 539 (discussing how examining the adjustment of benefits and burdens is relevant to see if there has been a taking); *E. Enters. v. Apfel*, 524 U.S. 498, 519 (1998) (plurality opinion); *Lucas*, 505 U.S. at 1017; *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211, 225 (1986) (“This interference with the property rights . . . arises from a public program that adjusts the benefits and burdens of economic life to promote the common good and, under our cases, does not constitute a taking requiring Government compensation.”); *Loretto v. Teleprompter Manhattan Cable Television Corp.*, 458 U.S. 419, 426 (1982).

governmental action has been held to be a 'taking' in the constitutional sense."¹²⁰

Nevertheless, government regulation can sometimes be so intrusive that it becomes a taking requiring compensation: "[A] strong public desire to improve the public condition is not enough to warrant achieving the desire by a shorter cut than the constitutional way of paying for the change."¹²¹ Where to draw the line thus became the central question.

The 1978 watershed case of *Penn Central Transportation Co. v. New York City* offered a clearer description of what would constitute a regulatory, as opposed to a traditional ouster-type taking.¹²² Although Grand Central Terminal in New York City had been designated a "landmark" by the city's Landmarks Preservation Commission, the owner of Grand Central—Penn Central Transportation Corporation—requested permission to build a multi-story office building directly above the terminal.¹²³ The Landmarks Commission refused and Penn Central went to court.¹²⁴

The Supreme Court acknowledged that, although the Commission's decision did not deny Penn Central all economic value in the station, it curtailed revenue that might otherwise have been anticipated.¹²⁵ Denying, nevertheless, that Penn Central suffered a taking, the Court offered a nuanced analysis.¹²⁶

120. *Armstrong v. United States*, 364 U.S. 40, 48 (1960); see also *Tahoe-Sierra Pres. Council*, 535 U.S. at 323–24 (contrasting physical takings with regulatory takings); *Andrus v. Allard*, 444 U.S. 51, 65 (1979) ("To require compensation in all such circumstances would effectively compel the government to regulate by *purchase*."); *Mahon*, 260 U.S. at 413 ("Government hardly could go on if to some extent values incident to property could not be diminished without paying for such change in the general law.")

121. *Mahon*, 260 U.S. at 416; see also *Tahoe-Sierra Pres. Council*, 535 U.S. at 354; *E. Enters.*, 524 U.S. at 523 (plurality opinion); *Andrus*, 444 U.S. at 65; *Penn Cent.*, 438 U.S. at 152.

122. See *Penn Cent.*, 438 U.S. 104, 123–28 (1978); see also Glynn S. Lunney, *A Critical Reexamination of the Takings Jurisprudence*, 90 MICH. L. REV. 1892, 1925 (1992) (discussing the *Penn Central* case); William S. Brewbaker, *Health Care Price Controls and the Takings Clause*, 21 HASTINGS CONST. L.Q. 669, 672–73 (1994) (discussing regulatory takings).

123. *Penn Cent.*, 438 U.S. at 116.

124. *Id.* at 117.

125. See *id.* at 136–37.

126. See Lunney, *supra* note 122, at 1925–26.

While conceding *Armstrong v. United States*' fundamental observation that the Takings Clause is "designed to bar Government from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole,"¹²⁷ the Court explained that "this Court, quite simply, has been unable to develop any 'set formula' for determining when 'justice and fairness' require that economic injuries caused by public action be compensated by the government, rather than remain disproportionately concentrated on a few persons."¹²⁸

The Court then described three factors by which to discern whether a regulation is so intrusive as to constitute a taking:¹²⁹ [1] the regulation's economic impact on the claimant; [2] the extent to which it has interfered with investment-backed expectations; and [3] the character of the government action, in particular whether it features a physical invasion.¹³⁰

127. *Penn Cent.*, 438 U.S. at 123 (citing *Armstrong v. United States*, 364 U.S. 40, 49 (1960)).

128. *Id.* at 124; see also *Ruckelshaus v. Monsanto Co.*, 467 U.S. 986, 1005 (1984); *Kaiser Aetna v. United States*, 444 U.S. 164, 174–75 (1979).

129. *Penn Cent.*, 438 U.S. at 124 ("In engaging in these essentially ad hoc, factual inquiries, the Court's decisions have identified several factors that have particular significance. The economic impact of the regulation on the claimant and, particularly, the extent to which the regulation has interfered with distinct investment-backed expectations are, of course, relevant considerations. So, too, is the character of the governmental action. A 'taking' may more readily be found when the interference with property can be characterized as a physical invasion by government, than when interference arises from some public program adjusting the benefits and burdens of economic life to promote the common good." (alteration in original) (citing *United States v. Causby*, 328 U.S. 256 (1946)) (other citations omitted)).

130. See *id.* Prof. Lunney identifies five "takings factors" in *Penn Central*:

- (1) [G]overnment action that deprived the owner of all economically viable use of his physical property;
- (2) government action that physically invaded an individual's physical property;
- (3) government action that was "not reasonably necessary to the effectuation of a substantial public purpose";
- (4) government action that completely destroyed the bundle of rights in a physical thing; and
- (5) government action taken to acquire resources "to permit or facilitate uniquely public functions."

Lunney, *supra* note 122, at 1925. Lunney identifies six factors from *Hodel v. Irving*:

- (1) [T]he ordinance's economic impact on particular individuals;
- (2) its interference with reasonable investment backed expectations;
- (3) its distribution of benefits and burdens (an average reciprocity of advantage);
- (4) the importance of the right affected by the ordinance to our common conception of property ownership;
- (5) the degree of

Takings jurisprudence subsequently evolved to distinguish more clearly between “per se” and “regulatory” takings. Per se takings generally feature either [1] a physical invasion or occupation,¹³¹ or [2] a complete destruction of the property’s economic value.¹³² In contrast, regulatory takings limit the owner’s use of his property short of ouster, as by zoning restrictions, rent control, or other regulation that may adversely affect but does not destroy the value of the property.¹³³

As discussed next, EMTALA requires a per se rather than regulatory takings analysis. In the case of a hospital, a regulatory analysis might be appropriate if, for example, a city’s new zoning regulations permitted an airport to be built very near a hospital, creating such noise that it rendered the hospital far less useable for health and healing.¹³⁴ In this example the property would be the hospital as a whole, and a regulatory analysis would look to [a] the economic impact on the hospital, [b] the hospital’s investment-backed expectations, and [c] the character of the government invasion.¹³⁵

restriction on the right affected by the ordinance; and (6) the ends-means fit of the ordinance.

Id. at 1926. Because subsequent analyses focus on the standard three factors from *Penn Central*, however, those will be the factors emphasized in this Article.

131. See *Loretto v. Teleprompter Manhattan Cable Television Corp.*, 458 U.S. 419, 428 (1982).

132. See *Lucas v. S.C. Coastal Comm’n*, 505 U.S. 1003, 1019 (1992). *Lucas*, along with *Yee v. Escondido*, 503 U.S. 519 (1992), were arguably the first two cases that expressly identified two lines of takings jurisprudence—per se and regulatory. See *Yee v. Escondido*, 503 U.S. 519, 527–32 (1992).

133. Real property is usually, though not always, the target of regulatory takings. See *Penn Cent.*, 438 U.S. at 115. Occasionally, regulatory analysis is properly applied outside of real property. See *E. Enters. v. Apfel*, 524 U.S. 498, 522–24 (1998) (plurality opinion). *Eastern Enterprises v. Apfel* concerned a broad regulation affecting pension benefits in the coal industry. *Id.* at 503–04.

Although takings problems are more commonly presented when “the interference with property can be characterized as a physical invasion by government, than when interference arises from some public program adjusting the benefits and burdens of economic life to promote the common good,” economic regulation such as the Coal Act may nonetheless effect a taking.

Id. at 522–23 (citation omitted).

134. See *Causby*, 328 U.S. at 264–67 (holding the Government’s noisy use of air space for military aircraft flights above the plaintiff’s land rendered his property effectively useless as a chicken farm).

135. See *supra* notes 129–30 and accompanying text.

However, as Part II made plain, the property sacrificed under EMTALA is not the hospital as a whole.¹³⁶ Rather, it is a broad panoply of personal property and the transient invasion of physical spaces within the hospital.¹³⁷ The pharmaceutical is not being regulated; it is being consumed.¹³⁸ The hour of nursing time is not being regulated; it is being spent.¹³⁹ The ICU bed is not being regulated; it is being physically occupied.¹⁴⁰ Accordingly, the next task is to examine per se takings jurisprudence: [1] physical invasion of property;¹⁴¹ and [2] complete destruction of a property's economic value.¹⁴²

1. Per Se Taking: Physical Invasion or Occupation

The lead case regarding physical occupation or invasion is *Loretto v. Teleprompter Manhattan CATV Corp.*¹⁴³ The state of New York had authorized cable television companies to install equipment on the roofs and sides of various buildings, including Plaintiff's apartment building.¹⁴⁴ Although these cable installations were small, the Court held that they "constitute[d] a taking under the traditional test. The installation involved a direct physical attachment of plates, boxes, wires, bolts, and screws to the building, completely occupying space immediately above and upon the roof and along the building's exterior wall . . . [They] permanently appropriate[d] appellant's property."¹⁴⁵ Deeming "a physical intrusion by government to be a property restriction of an unusually serious character for purposes of the Takings Clause,"¹⁴⁶ the Court concluded that when the invasion is permanent, a taking has occurred.¹⁴⁷

136. See *supra* Part II.

137. See *supra* Part II.B.

138. See *supra* Part II.B.

139. See *supra* Part II.B.

140. See *supra* Part II.B.

141. *Supra* note 131.

142. *Supra* note 132.

143. *Loretto v. Teleprompter Manhattan Cable Television Corp.*, 458 U.S. 419 (1982).

144. *Id.* at 421–22.

145. *Id.* at 438 (citation omitted).

146. *Id.* at 426.

147. *Id.*

In these direct physical occupations, size does not matter.¹⁴⁸ The government cannot enter Smith's bank account, for instance, and simply take \$100 to plant a tree in a park—even if Smith is very wealthy and the tree will provide much-needed shade.¹⁴⁹ The “constitutional protection for the rights of private property cannot be made to depend on the size of the area permanently occupied.”¹⁵⁰

Equally important, the physical invasion or occupation need not be permanent.¹⁵¹ In the 2012 *Arkansas Game & Fish Commission v. United States* decision, a unanimous¹⁵² Supreme Court held that intermittent flooding caused by government dam control could constitute a taking.¹⁵³ As the Court observed, “our decisions confirm that takings temporary in duration can be compensable.”¹⁵⁴

148. See *Tahoe-Sierra Pres. Council, Inc. v. Tahoe Reg'l Planning Agency*, 535 U.S. 302, 322 (2002) (“[R]egardless of whether the interest that is taken constitutes an entire parcel or merely a part thereof.”).

149. See *id.* (stating that the government “is required to pay for that share [of the property] no matter how small”).

150. *Loretto*, 458 U.S. at 436. The Court continued: “Indeed, it is possible that in the future, additional cable installations that more significantly restrict a landlord's use of the roof of his building will be made.” *Id.* at 437; see also *Lingle v. Chevron U.S.A. Inc.*, 544 U.S. 528, 538 (“[W]here government requires an owner to suffer a permanent physical invasion of her property—however minor—it must provide just compensation.”). As the *Loretto* court also pointed out:

Finally, whether a permanent physical occupation has occurred presents relatively few problems of proof. The placement of a fixed structure on land or real property is an obvious fact that will rarely be subject to dispute. Once the fact of occupation is shown, of course, a court should consider the *extent* of the occupation as one relevant factor in determining the compensation due. For that reason, moreover, there is less need to consider the extent of the occupation in determining whether there is a taking in the first instance.

Loretto, 458 U.S. at 437–38 (citations omitted).

151. See *Ark. Game & Fish Comm'n v. United States*, 133 S. Ct. 511, 522 (2012).

152. Justice Kagan took no part in the consideration or decision of the case.

153. *Ark. Game & Fish Comm'n*, 133 S. Ct. at 522.

154. *Id.* at 519. The Court went on:

This principle was solidly established in the World War II era, when “[c]ondemnation for indefinite periods of occupancy [took hold as] a practical response to the uncertainties of the Government's needs in wartime.” . . . Notably in relation to the question before us, the takings claims approved in these cases were not confined to instances in which the Government took outright physical possession of the property involved. A temporary takings claim could be maintained as well when government action occurring outside the property gave rise

Ever since [these decisions], we have rejected the argument that government action must be permanent to qualify as a taking. Once the government's actions have worked a taking of property, "no subsequent action by the government can relieve it of the duty to provide compensation for the period during which the taking was effective."¹⁵⁵

2. Per Se Taking: Complete Destruction of Economic Value

The lead case discussing complete destruction of a property's economic value is *Lucas v. South Carolina Coastal Commission*.¹⁵⁶ Plaintiff had purchased land along the South Carolina seashore in anticipation of building a real estate development.¹⁵⁷ Subsequent zoning regulations rendered the land effectively useless for that or any other profitable purpose.¹⁵⁸ "[W]hen the owner of real property has been called upon to sacrifice *all* economically beneficial uses in the name of the common good, that is, to leave his property economically idle, he has suffered a taking."¹⁵⁹ In these cases the government is not simply "adjusting the benefits and burdens of economic life."¹⁶⁰ The act is "functionally equivalent to a

to "a direct and immediate interference with the enjoyment and use of the land."

Id. (alteration in original) (quoting *United States v. Westinghouse Elec. & Mfg. Co.*, 339 U.S. 261, 267 (1950); *United States v. Causby*, 328 U.S. 256, 266 (1946)) (other citations omitted).

155. *Id.* (quoting *First English Evangelical Lutheran Church of Glendale v. Cnty. of Los Angeles*, 482 U.S. 304, 321 (1987)); *see also* *Tahoe-Sierra Pres. Council, Inc. v. Tahoe Reg'l Planning Agency*, 535 U.S. 302, 337 ("[W]e do not hold that the temporary nature of a land-use restriction precludes finding that it effects a taking; we simply recognize that it should not be given exclusive significance one way or the other.").

156. *Lucas v. S.C. Coastal Comm'n*, 505 U.S. 1003 (1992).

157. *Id.* at 1006–07.

158. *Id.* at 1007–09.

159. *Id.* at 1019; *see* *Lingle v. Chevron U.S.A. Inc.*, 544 U.S. 528, 538 (2005) (stating that the regulation "completely deprive[s] an owner of *all* economically beneficial us[e] of her property" (internal quotation marks omitted)); *cf.* *Nollan v. Cal. Coastal Comm'n*, 483 U.S. 825, 834 (1987) (recognizing that land-use regulation does not effect a taking if it does not "den[y] an owner economically viable use of his land" (quoting *Agins v. Tiburon*, 447 U.S. 255, 260 (1980))).

160. *Lucas*, 505 U.S. at 1017 (quoting *Penn Cent. Transp. Co. v. New York City*, 438 U.S. 104, 124 (1978)) (internal quotation marks omitted).

direct appropriation of or ouster from private property,”¹⁶¹ and hence obviates any need for “case-specific inquiry.”¹⁶²

B. EMTALA TAKINGS ANALYSIS

Under an appropriate per se analysis, EMTALA plainly mandates takings.

1. Physical Invasion or Occupation

EMTALA’s effect on real property must be analyzed as a per se taking.¹⁶³ Discrete spaces in the hospital are occupied by an EMTALA patient—a cubicle in the ER, an OR suite during surgery, an ICU bed or inpatient room.

These intermittent invasions are, in essence, an imposed servitude or easement—a recognized genre of taking. *Kaiser Aetna v. United States*, decided just one year after *Penn Central*, concerned a group of Hawai’ian homeowners who built a waterway to connect a pond, around which their homes were built, with a bay that then led to the Pacific Ocean.¹⁶⁴ The federal government insisted that this homeowner-constructed waterway and pond now constituted a “navigable waterway” that must be open to the public at large.¹⁶⁵ Rejecting that position, the Supreme Court held that imposing a navigational servitude would constitute a taking requiring just compensation.¹⁶⁶ “In this case, we hold that the ‘right to exclude,’ so universally held to be a fundamental element of the property right, falls within this category of interests that the Government cannot take without compensation.”¹⁶⁷

Analogously, in *Nollan v. California Coastal Commission*, a California statute required Nollan, the owner of beachfront property, to allow public access to his part of the beach so that citizens could traverse from a public park on one side of his property to another park on the other side.¹⁶⁸ The Court held

161. *Lingle*, 544 U.S. at 529; see *E. Enters. v. Apfel*, 524 U.S. 498, 540 (1998) (Kennedy J., concurring in part, dissenting in part) (citing *Lucas*, 505 U.S. at 1014).

162. *Lucas*, 505 U.S. at 1015.

163. See *supra* Part III.A.1–2.

164. *Kaiser Aetna v. United States*, 444 U.S. 164, 166–67 (1979).

165. *Id.* at 170.

166. *Id.* at 180.

167. *Id.* at 179–80 (citations omitted).

168. *Nollan v. Cal. Coastal Comm’n*, 483 U.S. 825, 828 (1987).

that the statute mandated a physical occupation and thus a taking: "We have repeatedly held that, as to property reserved by its owner for private use, the right to exclude others is one of the most essential sticks in the bundle of rights that are commonly characterized as property."¹⁶⁹

Finally, as discussed above, *Arkansas Game & Fish Commission* similarly held that intermittent flooding caused by the Corps of Engineers' dam control activities could be a taking.¹⁷⁰

In all these cases the outsiders' invasion of private property was intermittent, not continuous. Boats would not be incessantly navigating between the pond and the ocean in *Kaiser Aetna*; beach walkers would not be constantly strolling in front of the private home in *Nollan*; and flooding was not steady in *Arkansas Game & Fish*. Nevertheless, the Court found takings because the possibility of physical occupation was always present.¹⁷¹ The *Nollan* Court deemed the Coastal Commission's act to be more than "a mere restriction on [the property's] use"¹⁷² and concluded:

We think a "permanent physical occupation" has occurred, for purposes of that rule, where individuals are given a permanent and continuous right to pass to and fro, so that the real property may continuously be traversed, even though no particular individual is permitted to station himself permanently upon the premises.¹⁷³

The implication for hospitals' ERs, ORs, ICUs and hospital rooms is obvious. EMTALA does not mean that a hospital will, every minute of every day, be caring for indigent emergency patients or that a defined set of resources or spaces will be used

169. *Id.* at 831–32 (quoting *Loretto v. Teleprompter Manhattan Cable Television Corp.*, 458 U.S. 419, 433 (1982)) (internal punctuation omitted).

170. *Ark. Game & Fish Comm'n v. United States*, 133 S. Ct. 511, 522 (2012); *see supra* Part III.A.1.

171. *See id.* at 518 ("[W]hen the government physically takes possession of an interest in property for some public purpose, it has a categorical duty to compensate the former owner." (quoting *Tahoe-Sierra Pres. Council, Inc. v. Tahoe Regional Planning Agency*, 535 U.S. 302, 322 (2002))).

172. *Nollan*, 483 U.S. at 831 (quoting *id.* at 848 n.3 (Brennan, J., dissenting)).

173. *Id.* at 832. As the *Loretto* Court summarized *Kaiser Aetna*: "The Court emphasized that the servitude took the landowner's right to exclude, 'one of the most essential sticks in the bundle of rights that are commonly characterized as property.'" *Loretto*, 458 U.S. at 433 (quoting *Kaiser Aetna v. United States*, 444 U.S. 164, 176 (1979)). And as *Loretto* added, "constitutional protection for the rights of private property cannot be made to depend on the size of the area permanently occupied." *Id.* at 436–37.

each and every time. Rather, the possibility is ever-present that an indigent patient will appear with potentially very costly emergency needs. Any number of patients may appear—an “intermittent flood” of need. The hospital must provide as much as each such patient needs, for as long as needed, to stabilize whatever emergency condition that patient has.¹⁷⁴ The hospital has lost all right to exclude.¹⁷⁵ It would be no different if government were to mandate that, on cold nights, Hiltons, Ritz Carltons, and all other hotels must provide free lodging to anyone who is homeless and shivering—with no provision whatever to compensate those hotels.

2. Complete Destruction of Economic Value

As discussed in Part II, EMTALA requires hospitals to use personal property such as pharmaceuticals, medical devices, medical and surgical supplies, food, and a host of items that are entirely consumed.¹⁷⁶ Likewise completely consumed will be paid hours of staff time for nursing services, phlebotomy, etc., provided to EMTALA patients.¹⁷⁷ Physician services are also included where physicians are employees rather than independent contractors.¹⁷⁸

174. See *supra* notes 4–6 and accompanying text.

175. The *Loretto* Court stated that:

Property rights in a physical thing have been described as the rights “to possess, use and dispose of it.” . . . To the extent that the government permanently occupies physical property, it effectively destroys *each* of these rights. First, the owner has no right to possess the occupied space himself, and also has no power to exclude the occupier from possession and use of the space. The power to exclude has traditionally been considered one of the most treasured strands in an owner’s bundle of property rights.

Loretto, 458 U.S. at 435 (citations omitted); see also *Lingle v. Chevron U.S.A. Inc.*, 544 U.S. 528, 539 (2005) (“A permanent physical invasion, however minimal the economic cost it entails, eviscerates the owner’s right to exclude others from entering and using her property—perhaps the most fundamental of all property interests.”).

176. See *supra* Part II.B.

177. As noted above, *supra* Parts I, III.B.1, these labor costs are sometimes absorbed into “rental” costs.

178. Matters may be different if the physician is an independent contractor with hospital privileges. See *Burditt v. U.S. Dep’t of Health & Human Servs.*, 934 F.2d 1362, 1374 (5th Cir. 1991) (“[F]ederal law controls the issue of whether a physician is ‘under contract’ with a hospital for purposes of 42 U.S.C. § 1395dd(d)(2).”).

A *per se* takings analysis can apply to personal property, not just real property.¹⁷⁹ The D.C. Circuit addressed the issue squarely in *Nixon v. United States*.¹⁸⁰ When President Richard Nixon resigned from office, he sought exclusive possession of a large mass of documents, tape recordings, and other matters related to his presidency.¹⁸¹ Concerned that the ex-President might destroy important evidence in the Watergate investigation, the government invoked the Presidential Recordings and Materials Preservation Act.¹⁸² President Nixon argued that this represented an unconstitutional taking under the Fifth Amendment.¹⁸³ Specifically responding to the argument that “the *per se* takings doctrine applies only to the physical occupation of *real* property,”¹⁸⁴ the D.C. Circuit countered: “This argument fails for want of authority or logic.”¹⁸⁵

Accordingly, when hospitals’ personal property is consumed for EMTALA services, a taking can occur. The value of the drug, bandage, or food is entirely extinguished.¹⁸⁶ Equally important, the fact that only a small proportion of such property has been taken, relative to the hospital’s overall array of personal property, is irrelevant.¹⁸⁷ Per *Loretto*, “our cases uniformly have found a taking to the extent of the occupation,

179. See *Nixon v. United States*, 978 F.2d 1269, 1284 (D.C. Cir. 1992) (stating that “Supreme Court cases have reaffirmed the *per se* doctrine without mention of any such distinction” between a taking of real or personal property).

180. *Id.*

181. *Id.* at 1270–71.

182. *Id.* at 1271.

183. *Id.* at 1274–75.

184. *Id.* at 1284.

185. *Id.* (noting that while *Loretto* was expressly narrowly tailored, subsequent Supreme Court cases did not focus on real versus personal property).

186. The right to exclude others from these particular properties has been extinguished. See *Ruckelshaus v. Monsanto*, 467 U.S. 986, 1011 (1984) (discussing how once a trade secret has been revealed, the right to exclude ends); *United States v. General Motors Corp.*, 323 U.S. 373, 378 (1945) (“Governmental action short of acquisition of title or occupancy has been held, if its effects are so complete as to deprive the owner of all or most of his interest in the subject matter, to amount to a taking.”); *Philip Morris, Inc. v. Reilly*, 312 F.3d 24, 41–42 (1st Cir. 2002) (discussing tobacco companies’ inability to exclude others if their formulas were disclosed).

187. See *Loretto v. Teleprompter Manhattan Cable Television Corp.*, 458 U.S. 419, 434–35 (1982).

without regard to whether the action . . . has only minimal economic impact on the owner.”¹⁸⁸ Size does not matter.

3. Inapplicability of Regulatory Takings Analysis

At this point it should be evident that regulatory takings analysis does not apply. As the Court made clear in *Tahoe-Sierra Preservation Council*, it is “inappropriate to treat cases involving physical takings as controlling precedents for the evaluation of a claim that there has been a ‘regulatory taking,’ and vice versa.”¹⁸⁹ As observed by the First Circuit, “once a per se rule has been announced, future courts do not have the luxury to consider the public interest, reasonable investment-backed expectations, or economic impact”¹⁹⁰ (the three-factor analysis of regulatory takings). Thus, once we recognize that the takings in question are per se rather than regulatory, it is simply incorrect to inquire whether the hospital “expected” to have its resources depleted by uncompensated emergency care,¹⁹¹ or how badly the hospital has been financially hurt by EMTALA’s cumulative impositions.¹⁹² The schoolboy may expect, even plan for, the fact that neighborhood bullies will regularly take his lunch money. But expectation does not convey legitimacy.¹⁹³

188. *Id.*; see also *Lucas v. S.C. Coastal Council*, 505 U.S. 1003, 1015 (1992) (“We have, however, described at least two discrete categories of regulatory action as compensable without case-specific inquiry into the public interest advanced in support of the restraint. The first encompasses regulations that compel the property owner to suffer a physical ‘invasion’ of his property. In general (at least with regard to permanent invasions), no matter how minute the intrusion, and no matter how weighty the public purpose behind it, we have required compensation.”).

189. *Tahoe-Sierra Pres. Council, Inc. v. Tahoe Reg’l Planning Agency*, 535 U.S. 302, 323 (2002) (citation omitted).

190. *Philip Morris, Inc. v. Reilly*, 312 F.3d 24, 36 (1st Cir. 2002) (en banc).

191. *Cf. Franklin Mem’l Hosp. v. Harvey*, 575 F.3d 121, 128 (1st Cir. 2009) (holding that highly-regulated industries should expect that governments will place constraints on them).

192. See *id.* at 127.

193. Note also how the Court found the taking of IOLTA interest money to be much more akin to the per se taking of *Loretto* than to a regulatory type of taking:

[T]he interest earned in the IOLTA accounts “is the ‘private property’ of the owner of the principal.” [*Phillips v. Wash. Legal Found.*, 524 U.S. 156, 172 (1998).] If this is so, the transfer of the interest to the Foundation here seems more akin to the occupation of a small amount of rooftop space in *Loretto*.

Brown v. Legal Found. of Wash., 538 U.S. 216, 235 (2003).

IV. PUBLIC USE

At first blush, EMTALA easily satisfies the “public use” requirement. It imposes takings on hospitals’ property for the public purpose of ensuring that all persons in a medical emergency, whether or not they can pay, will receive screening and stabilization.¹⁹⁴ It is a protection surely all of us want: in a medical emergency, hospitals should provide immediate care without jeopardizing life and limb while they search the wreckage for an insurance card.

An objection might be posed. In the classic takings cases such as eminent domain used to build a road, the property goes from a private party to the government.¹⁹⁵ In contrast, the property in EMTALA cases ordinarily goes from one private party to another private party.¹⁹⁶

This does not preclude finding the public use required for a proper government taking, as the Court made clear in *Kelo v. City of New London*. In an attempt to revitalize the city’s faltering economy, New London condemned Petitioners’ private property—including waterfront homes that, in some cases, had been in the family for generations¹⁹⁷—mandating that the homeowners sell their land to private developers as part of a

194. The rationale was stated succinctly by the Arizona Court of Appeals in *St. Joseph’s Hospital & Medical Center v. Maricopa County*, 786 P.2d 983, 987–88 (Ariz. Ct. App. 1989). Like EMTALA, an Arizona law required hospitals to provide emergency care regardless of ability to pay. *See id.* at 984 (discussing how Mr. Neu received emergency medical care from a hospital, ended up with a \$50,000 bill but couldn’t pay back most of it so the hospital sought compensation from the county). Although hospitals were forbidden to go after spouses’ assets to pay an otherwise-indigent patient’s bill, the county nevertheless did count spousal assets in determining whether someone was eligible for county assistance. *See id.* at 986. Thus, hypothetically available spousal assets were in fact off-limits for collection. *See id.* at 985. The rationale of the system was to encourage spouses to step up and pay the bill anyway. *See id.* at 988. Per the court: “The aspect of the regulation that denies families county-funded health care if one spouse possesses assets in excess of the statutory limit also benefits the common good, because it encourages families to pay for services rendered for family members rather than allowing that burden to fall on state coffers.” *Id.* at 988. For a useful discussion of EMTALA’s history and somewhat dubious origins, see Hyman, *supra* note 7.

195. *See Webb’s Fabulous Pharmacies, Inc. v. Beckwith*, 449 U.S. 155, 164 (1980) (“[A] State, by *ipse dixit*, may not transform private property into public property without compensation . . .”).

196. Property goes from the hospital to the patient. *See supra* Part II.B.

197. *Kelo v. City of New London*, 545 U.S. 469, 475 (2005).

community revitalization plan.¹⁹⁸ Petitioners protested that forcing private property owners to sell to private developers did not constitute the required “public use.”¹⁹⁹

The Court ruled that, notwithstanding the ultimately private ownership of the condemned land, the city’s decision to take it for economic development did satisfy the Fifth Amendment’s “public use” requirement.²⁰⁰ The Court emphasized its long history of “deference to legislative judgments” as to what government plans serve a “public purpose,”²⁰¹ citing such cases as *Berman v. Parker*²⁰² and *Hawaii Housing Authority v. Midkiff*.²⁰³

As we will now see, the problem is not that EMTALA’s mandate imposes a virtually endless series of takings. The problem, rather, is that hospitals are not always compensated

198. *Id.* at 472.

199. *Id.* at 475.

200. *See id.* at 489–90.

201. *Id.* at 480 (internal quotation marks omitted); *see id.* at 488–89 (reasoning that the legislation had a legitimate purpose and using eminent domain as a means toward that end was not irrational, hence this constitutional requirement was satisfied).

202. *Berman v. Parker*, 348 U.S. 26, 30, 35–36 (1954) (affirming the constitutionality of a redevelopment project in the District of Columbia, in which some of the land on which blighted housing stood went to private parties to build low-cost housing).

203. *Haw. Hous. Auth. v. Midkiff*, 467 U.S. 229, 242–43 (1984) (affirming a land redistribution plan to condemn land owned by long-standing landowners and eventually sell the land to the current lessees, because a high concentration of land was in a few hands and deemed an unhealthy oligopoly).

The mere fact that property taken outright by eminent domain is transferred in the first instance to private beneficiaries does not condemn that taking as having only a private purpose. The Court long ago rejected any literal requirement that condemned property be put into use for the general public. “It is not essential that the entire community, nor even any considerable portion, . . . directly enjoy or participate in any improvement in order [for it] to constitute a public use.”

Id. at 243–44 (alterations in original) (quoting *Rindge Co. v. Los Angeles*, 262 U.S. 700, 707 (1923)). Analogous reasoning appears in *National Railroad Passenger Corp. v. Boston & Maine Corp.*, 503 U.S. 407, 422–23 (1992), which upheld as legitimate “public use” the eminent domain sale of railroad track from one private company to another. Comparably, in *Brown v. Legal Foundation of Washington*, 538 U.S. 216, 240 (2003), the Court held that taking the interest on attorneys’ IOLTA trust accounts to fund legal services for the poor is a valid public purpose. In this phase of the analysis the Court does not consider whether eminent domain is actually an effective means of achieving the public use—the intent alone suffices. *See Lingle v. Chevron U.S.A. Inc.*, 544 U.S. 528, 542 (2005).

for the property taken. EMTALA appears to have been enacted as a politically and economically inexpensive way to broaden access to care without generating any new costs—or at least, no new costs for the government.²⁰⁴ Accordingly, we turn now to the question of whether and when there is “just compensation.”

V. JUST COMPENSATION

Clearly EMTALA mandates systematic takings. Per Part II, the property is not the hospital-as-a-whole, but personal properties and physical spaces. Per Part III, these are per se takings representing either a physical invasion or a complete destruction of economic value, while under Part IV, this is for “public use.” All the elements for a taking are satisfied. All that remains is a fight about the money.

There is nothing inherently wrong with government acts of eminent domain. Indeed, the very existence of the Fifth Amendment’s Takings Clause presupposes that takings can be acceptable. But when they occur, just compensation is imperative.²⁰⁵ As emphasized by Justice Holmes in *Pennsylvania Coal Co. v. Mahon*, “a strong public desire to improve the public condition is not enough to warrant achieving the desire by a shorter cut than the constitutional way of paying for the change.”²⁰⁶

204. See, e.g., Richards *supra* note 7, at 592 n.3 (“Congress imposed its mandate on hospitals receiving federal Medicare funds. As a practical matter, this includes virtually all hospitals. As a constitutional matter, it allows Congress to rely on its broad authority under the Spending Clause. Medical care provided pursuant to these duties is not reimbursed; EMTALA was a political solution that allowed Congress to address inequities in emergency care without increasing federal spending.”).

205. As noted by Justice Holmes in *Pennsylvania Coal Co. v. Mahon*:

We assume, of course, that the statute was passed upon the conviction that an exigency existed that would warrant it, and we assume that an exigency exists that would warrant the exercise of eminent domain. *But the question at bottom is upon whom the loss of the changes desired should fall.*

Pa. Coal Co. v. Mahon, 260 U.S. 393, 416 (1922) (emphasis added).

206. *Id.*; see *Ark. Game & Fish Comm’n, v. United States*, 133 S. Ct. 511, 519 (2012) (“Once the government’s actions have worked a taking of property, ‘no subsequent action by the government can relieve it of the duty to provide compensation for the period during which the taking was effective.’” (quoting *First English Evangelical Lutheran Church of Glendale v. Cnty. of Los Angeles*, 482 U.S. 304, 321 (1987))); *Tahoe-Sierra Pres. Council Inc. v. Tahoe Reg’l Planning Agency*, 535 U.S. 302, 328 (2002).

At first blush we might suppose EMTALA is completely unconstitutional because it mandates systematic takings with no provision for compensation. That would be simplistic, however. Hospitals can be compensated in several ways.

First, because EMTALA is a condition of participation in Medicare, it might be supposed that hospitals' compensation is the privilege of earning revenue by caring for Medicare patients and that, reciprocally, since no hospital is forced to participate in Medicare, a participating hospital should be deemed to accept EMTALA obligations voluntarily—the so-called “voluntariness argument.”

Second, the patients who receive the care can properly be expected under *quantum meruit* to pay for the valuable services the hospital provides, just as the business entities in *Kelo* were required to pay the original landowners.

Third, it might be argued that EMTALA care does in fact receive government compensation. Not-for-profit hospitals, for instance, enjoy reduced tax obligations in exchange for a requirement to provide community service, usually via uncompensated care. Different types of hospitals will be considered separately: for-profit private hospitals, not-for-profit private hospitals, and public hospitals.

Part V shows that all three arguments fail to one degree or another.

A. THE VOLUNTARINESS ARGUMENT: EMTALA AS A MEDICARE CONDITION OF PARTICIPATION

The first argument is that EMTALA is simply a condition of participation for hospitals contracting with Medicare.²⁰⁷ Medicare participation provides nonmonetary compensation, namely, an opportunity to earn money by caring for Medicare beneficiaries.²⁰⁸ On this approach, because a hospital has no obligation to participate, it must accept the responsibilities if it wants the benefits.

207. See 42 U.S.C. § 1395cc(a)(1)(I) (2006 & Supp. V 2011).

208. Cf. Tami Luhby, *Medicare Payment Rates: \$15,000 for One Hospital, \$26,000 for Another*, CNNMONEY (May 22, 2013, 5:55 AM), <http://money.cnn.com/2013/05/22/news/economy/medicare-payments-hospitals/index.html> (stating that for hip replacement surgery, Medicare reimbursed the hospital only about 13% of what was billed).

1. Compensation As "Privilege to Earn Revenue"

The "voluntariness" argument has appeared in several contexts. Outside the health care realm, for instance, attorneys are sometimes required to provide counsel, pro bono, for indigent criminal defendants.²⁰⁹ In *White v. United States Pipe & Foundry Co.*,²¹⁰ the Fifth Circuit found no violation of the Takings Clause when District Courts appoint counsel to serve needy defendants.²¹¹ Citing an earlier case:

"[A]n applicant for admission to practice law may justly be deemed to be aware of the traditions of the profession which he is joining, and to know that one of these traditions is that a lawyer is an officer of the court obligated to represent indigents for little or no compensation upon court order."²¹²

The strongest argument is not that these court appointments are a tradition. Slavery, after all, was "traditional" for hundreds of years in this nation and elsewhere. Nor would it be correct to suppose that there is no taking in the first place. The discussion above shows that of course there is a taking. The attorney's labor is commandeered to serve a client not of her choosing; and the commandeering is for a public use (e.g., criminal defense for indigents). Rather, the best argument would simply be that the opportunity to earn a (sometimes handsome) living by practicing law is a privilege and that, if one wishes to enjoy this opportunity, the price is to donate a few free services now and then. The opportunity to practice is itself the "just compensation."²¹³

209. See generally *Caston v. Sears, Roebuck & Co.*, 556 F.2d 1305, 1309 (5th Cir. 1977) ("While the statute does not require that one be a pauper before counsel may be appointed, a person's financial resources should certainly be considered.").

210. *White v. U.S. Pipe & Foundry Co.*, 646 F.2d 203 (5th Cir. 1981).

211. Cf. *id.* at 205 (identifying three factors courts should consider as "(1) the merits of the complainant's claims of discrimination, (2) the efforts taken by the complainant to obtain counsel on his or her own, and (3) a complainant's financial ability to retain counsel").

212. *Id.* at 205 n.3 (quoting *Dolan v. United States*, 351 F.2d 671, 672 (5th Cir. 1965)).

213. Clearly we could not make a similar argument for the minimum-wage fast-food worker and, for example, require them to donate their labors to soup kitchens. The "opportunity" for a minimum-wage job is not sufficient "compensation" for commandeering such labor. Additionally, as discussed just below, the "compensation" of being permitted to earn income in a particular way cannot be deemed just if the uncompensated services become excessive or oppressive.

Analogous reasoning has arisen regarding physicians' services under EMTALA. Although EMTALA does not directly require physicians to serve emergency patients, hospitals with Medicare contracts are required to ensure that physicians are on call to provide emergency services.²¹⁴ Indirectly, then, hospitals may mandate physicians' services, albeit not necessarily uncompensated services. In *Burditt v. U.S. Department of Health & Human Services*,²¹⁵ a physician with staff privileges at a Medicare-participating hospital argued that his services were being taken without just compensation, in violation of the Fifth Amendment.²¹⁶ The court ruled that, even assuming arguendo that professional services constitute property,²¹⁷ EMTALA binds hospitals, not physicians.²¹⁸ Of particular relevance here, the *Burditt* court went on to explain that, for hospitals, the EMTALA mandate does not effect a taking because participation in Medicare is voluntary.²¹⁹

A number of cases share this view, particularly in the context of complaints that financial compensation from Medicare and Medicaid is so small as to be unjust, thereby violating the Takings Clause.²²⁰ Courts in these cases tend to

214. 42 C.F.R. § 489.24(j) (2012).

215. *Burditt v. U.S. Dep't of Health & Human Servs.*, 934 F.2d 1362 (5th Cir. 1991).

216. *See id.* at 1366.

217. *Id.* at 1376, 1376 n.12, (citing *White v. United States Pipe & Foundry Co.* as holding that "attorney services [are] not protected property under Fifth Amendment's Takings Clause"). As discussed above, this is not precisely what the *White* court found. Rather, the court stated that traditions requiring attorneys to provide pro bono services did not violate the Takings Clause. *See White*, 646 F.2d at 205 n.3. As argued, the most correct, forceful interpretation of *White* is not that professional services are not property or that there was no taking; rather, the appropriate argument would be that, although a mandate to provide uncompensated services does constitute a taking, there is no violation of the Fifth Amendment because the "compensation" is the privilege of earning a living practicing law. *See id.* As discussed below, however, such a mandate must be limited, because this form of "compensation" cannot be relied on to extract endless free labor. *See supra* Part V.A.2.

218. *Burditt*, 934 F.2d at 1376 ("EMTALA imposes no responsibilities directly on physicians; it unambiguously requires *hospitals* to examine and stabilize, treat, or appropriately transfer all who arrive requesting treatment.").

219. *See id.*

220. *See Methodist Hosp. v. Ind. Family & Soc. Servs. Admin.*, 860 F. Supp. 1309, 1335 (N.D. Ind. 1994) ("Whether the new reimbursement rates constitute a taking of the hospital's property without due process of law is a more interesting question.").

find no constitutional problem: "Where a service provider voluntarily participates in a price regulated program or activity, there is no legal compulsion to provide service and thus there can be no taking."²²¹

Accordingly, in *Whitney v. Heckler*²²² physicians argued that a temporary freeze in Medicare payment rates constituted a taking of the physicians' services, given that they could not ask patients to pay extra to make up the difference.²²³ The Eleventh Circuit held that because participation in Medicare was voluntary, there was no taking.²²⁴ Similarly, the Eighth Circuit held that a nursing home rate regulation for Medicaid residents was not a taking because the nursing home was not required to accept Medicaid recipients.²²⁵ Likewise, the First Circuit held that the low payment rates in MaineCare, Maine's Medicaid program, did not constitute a taking because the plaintiff hospital voluntarily participated in the program.²²⁶ More recently the Ninth Circuit issued a similar decision.²²⁷

221. *Id.* (internal quotation marks omitted) (quoting *Garelick v. Sullivan*, 987 F.2d 913, 916 (2d Cir.1993)).

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

223. *Id.* at 972.

224. *See id.* at 974.

225. *Minn. Ass'n of Health Care Facilities v. Minn. Dep't of Pub. Welfare*, 742 F.2d. 442, 445–46 (8th Cir. 1984); *see also In re Health Care Admin. Bd. v. Finley*, 415 A.2d 1147, 1153–54 (N.J. 1980).

226. *Franklin Mem'l Hosp. v. Harvey*, 575 F.3d 121, 123, 130 (1st Cir. 2009). In a separate claim to be addressed below, the hospital also claimed that Maine's mandate to provide completely uncompensated care to indigent patients was a taking. *See infra* Part VI.

227. *Managed Pharmacy Case v. Sebelius*, 705 F.3d 934, 938, 950–51 (9th Cir. 2012). *See Methodist Hospital v. Indiana Family & Social Services Administration*, where a hospital and physicians asked the court to enjoin the state's new Medicaid payment rates. 860 F. Supp. 1309, 1317 (N.D. Ind. 1994). Because the providers were required under EMTALA to see all emergency patients, including Medicaid patients, and because payment rates were lower than the cost of providing care, plaintiffs urged that these inadequate rates were a taking. *Id.* The court invoked a regulatory takings analysis, acknowledging that regulations that go too far could indeed be a taking. *Id.* at 1334. Nevertheless, the court found no taking in this case because "where a service provider voluntarily participates in a price regulated program or activity, there is no legal compulsion to provide service and thus there can be no taking." *Id.* at 1335 (quoting *Garelick v. Sullivan*, 987 F.2d 913, 916 (2d Cir. 1993)); *see also Burditt v. U.S. Dep't of Health & Human Servs.*, 934 F.2d 1362, 1376 (5th Cir. 1991) (ruling against a physician who claimed that EMTALA represented a taking, holding that EMTALA applies to hospitals, not physicians, and that the physician voluntarily served at this hospital, and hence accepted its on-call requirements).

2. Privilege to Earn as Dubious “Compensation”

There are three major reasons to deny that the bare opportunity to participate in Medicare is, in itself, just compensation when EMTALA extracts a taking.

First, it is questionable whether a privilege such as an opportunity to earn is the sort of “currency” that can count as compensation at all. The Supreme Court has been clear that, when the government compensates for a taking, there is no obligation to pay for intangible, consequential damages such as loss of good will or general injury to a business.²²⁸ Compensation is for direct pecuniary losses, not for ancillary, “soft,” non-quantifiable losses.²²⁹

If government need not pay *for* nonpecuniary losses, it is not clear how the government could be permitted, in an odd,

For a broader discussion of underpayment for Medicare and Medicaid services, see generally Daniel Gottlieb, *You Can Take This Health Insurance and . . . Mandate It?*, 33 SETON HALL LEGIS. J. 535, 555–60 (2009) (analyzing whether the ACA’s individual mandate is a taking); Tammy Lundstrom, *Under-Reimbursement of Medicaid and Medicare Hospitalizations as an Unconstitutional Taking of Hospital Services*, 50 WAYNE L. REV. 1243, 1253–55 (2004) (proposing a different test to determine if the underpayment is a taking).

228. In *United States v. General Motors Corp.*, the Court noted that

[t]he rule in such a case is that compensation for that interest does not include future loss of profits, the expense of moving removable fixtures and personal property from the premises, the loss of good-will which inheres in the location of the land, or other like consequential losses which would ensue the sale of the property to someone other than the sovereign [I]t has generally been held that that which is taken or damaged is the group of rights which the so-called owner exercises in his dominion of the physical thing, and that damage to those rights of ownership does not include losses to his business or other consequential damage.

323 U.S. 373, 379–80 (1945). The Court went on to explain that damage to fixtures and equipment and expenses of moving out of the leased space should be considered in determining the market price. *Id.* at 382–84. The Court expressly distinguished between these kinds of readily documentable expenses, which would be compensable, versus “proof of value peculiar to the respondent, or the value of good-will or of injury to the business of the respondent which, in this case, as in the case of the condemnation of a fee, must be excluded from the reckoning.” *Id.* at 383; see also Vickie J. Williams, *Fluconomics: Preserving Our Hospital Infrastructure During and After a Pandemic*, 7 YALE J. HEALTH POL’Y L. & ETHICS 99, 125 (2007) (“[T]he loss to the owner of nontransferable value deriving from a unique need for the property, or a sentimental or illogical attachment to it . . . is not compensable.”). For a further explanation of consequential damages that do not require compensation, see Lunney, *supra* note 122, at 1903–05.

229. See *supra* note 228 and accompanying text.

obverse move, to pay its debts *with* “soft,” nonpecuniary “cash.” That is, if nonpecuniary losses, such as consequential damages, cannot be compensated, surely nonpecuniary “payment” cannot serve as compensation. Simply allowing a physician, attorney or hospital to provide services and earn income should not masquerade as being, in and of itself, a just compensation that could plausibly substitute for money, particularly where enormous costs are routinely being generated. But that is precisely what we are asked to accept, in the “privilege to earn” argument.²³⁰

Second, and more powerfully, it can be argued that Congress’ decision in 1986 to impose vast new financial losses on hospitals, on pain of losing all Medicare funding, was unduly coercive and that the acceptance of unfunded EMTALA obligations is anything but voluntary.

The Supreme Court’s recent discussion of Medicaid expansion in *NFIB*²³¹ is remarkably instructive. The ACA originally required states participating in Medicaid to expand eligibility to include all individuals at or below 133% of the FPL, on pain of forfeiting all Medicaid funding if they did not.²³² This move, ruled the Court, was unconstitutionally coercive.²³³ Although the federal government can properly link conditions to its grants, a complete revocation of Medicaid funds would go too far, given the program’s financial significance to states.²³⁴ This is not a case of “relatively mild encouragement,” said the Court, “it is a gun to the head.”²³⁵ “The threatened loss of over 10 percent of a State’s overall

230. If that is so, then the argument above, *supra* Part V.A.1, in *White*—that it is an acceptable “tradition” to commandeer attorneys’ labor, for the public use and without compensation—must be rejected. “Once the government’s actions have worked a taking of property, ‘no subsequent action by the government can relieve it of the duty to provide compensation for the period during which the taking was effective.’” *Ark. Game & Fish Comm’n v. United States*, 133 S. Ct. 511, 519 (2012) (quoting *First English Evangelical Lutheran Church of Glendale v. Cnty. of Los Angeles*, 482 U.S. 304, 321 (1987)). As argued above, it is to no avail for the government to argue that “we need this labor and we can’t afford to pay for it . . . therefore it is not a taking.” *See supra* notes 108–09 and accompanying discussion.

231. *Nat’l Fed’n of Indep. Bus. v. Sebelius (NFIB)*, 132 S. Ct. 2566 (2012).

232. *Id.* at 2601.

233. *Id.* at 2604.

234. *See id.*

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

budget . . . is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.”²³⁶

Additionally, the Court explained that the imposed Medicaid expansion was “a shift in kind, not merely degree. The original program was designed to cover medical services for four specific categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children.”²³⁷ Expanding the program to encompass every indigent man, woman, and child below a specified income threshold was not a mere alteration or amendment to the program, it was a dramatic transformation.²³⁸ This exceeded Congress’ authority. “As we have explained, [t]hrough Congress’ power to legislate under the spending power is broad, it does not include surprising participating States with post-acceptance or ‘retroactive’ conditions.”²³⁹

As the Court said, “[w]e have repeatedly characterized . . . Spending Clause legislation as much in the nature of a *contract* The legitimacy of Congress’s exercise of the spending power thus rests on whether the State voluntarily and knowingly accepts the terms of the contract,”²⁴⁰ which requires that the State have “a legitimate choice whether to accept the federal conditions in exchange for federal funds.”²⁴¹ In this case, states’ choice would be anything but voluntary.

Admittedly, the Court’s arguments in *NFIB* are embedded in a broader discussion about the importance of maintaining the nation’s federalist system of two governments.²⁴² Still, by

236. *Id.* at 2605; *see id.* at 2604 (“Medicaid spending accounts for over 20 percent of the average State’s total budget, with federal funds covering 50 to 83 percent of those costs.”).

237. *Id.* at 2605–06.

238. *See id.* at 2606.

239. *Id.* (alterations in original) (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 25 (1981)).

240. *Id.* at 2602 (alteration in original) (quoting *Barnes v. Gorman*, 536 U.S. 181, 186 (2002); *Pennhurst*, 451 U.S. at 17) (internal quotation marks omitted).

241. *Id.* at 2602–03 (“In such a situation, state officials can fairly be held politically accountable for choosing to accept or refuse the federal offer. But when the State has no choice, the Federal Government can achieve its objectives without accountability.”).

242. *See id.* at 2602 (“Permitting the Federal Government to force the States to implement a federal program would threaten the political accountability key to our federal system.”).

analogy its arguments can nicely encompass Medicare's EMTALA impositions on private entities such as hospitals. Medicare's relationship with hospitals, like Medicaid's relationship with states, essentially has the nature of a contract: if the hospital wants the opportunity to earn federal payments by caring for Medicare beneficiaries, it must comply with certain conditions.²⁴³ And in our case, just as with the ACA and Medicaid: [1] the addition of the EMTALA mandate to the Medicare program was a change in kind, not merely degree; while [2] the threat of withdrawing all of a hospital's Medicare funding is so huge as to be coercive.

Thus, regarding [1], a change in kind rather than just degree, Medicare as enacted in the mid-1960s was a program in which the federal government would reimburse medical care for the elderly and people with certain disabilities.²⁴⁴ In 1986 with EMTALA, Medicare suddenly exposed hospitals to a flood of emergently ill and injured people who were neither elderly nor disabled—often for no compensation whatsoever.²⁴⁵ This was not a modest alteration, it was a fundamental transformation of Medicare.

Regarding [2], EMTALA's financial coercion of hospitals is considerably stronger than anything the ACA might pose for states. With the possible exception of some boutique facilities, few hospitals can survive without Medicare. The program represents more than 30% of many hospitals' budgets,²⁴⁶ while Medicare and Medicaid together "account for about 55% of hospital revenues."²⁴⁷ People over age sixty-five now comprise 13% of the total population²⁴⁸—a figure that will rise as more Baby Boomers reach retirement age.²⁴⁹ Surely, if threatening a

243. See Lundstrom, *supra* note 227, at 1245 n.20.

244. See *id.*

245. See *supra* notes 4–11.

246. As of 2002, the two programs comprised just over 47% of hospital revenues—approximately 30% from Medicare and 17% from Medicaid. Lundstrom, *supra* note 227, at 1248.

247. Robert Pear, *Administration Offers Health Care Cuts as Part of Budget Negotiations*, N.Y. TIMES, July 4, 2011, <http://www.nytimes.com/2011/07/05/us/05deficit.html?pagewanted=all>.

248. Emily Brandon, *65-and-Older Population Soars*, U.S. NEWS (Jan. 9, 2010), <http://money.usnews.com/money/retirement/articles/2012/01/09/65-and-older-population-soars>.

249. See *id.* ("The 65-and-older population jumped 15.1 percent between 2000 and 2010 . . .").

state with losing 10% of its budget²⁵⁰ is unduly coercive,²⁵¹ it is no less coercive to force hospitals to abandon 30% of their budgets (i.e., all Medicare revenues) to avoid the costs of uncompensated EMTALA services.

In sum, EMTALA hoisted a “gun to the head,”²⁵² imposing on hospitals an “economic dragooning”²⁵³ that gave them little choice: either acquiesce in a major unfunded expansion of their Medicare obligations, or lose not merely some sort of supplemental funds directed toward expanding ED access (there were no such funds), but lose *all* Medicare revenues, and additionally pay penalties and face potential civil liability for failure to comply. “Voluntary” hardly fits such a “choice.”

Third, such coercion, even if dubbed “voluntary” participation, would be very poor health policy. Essentially this argument says to hospitals: “If you don’t want to bear all those unfunded EMTALA costs, then all you need to do is just quit caring for Medicare patients, or close your EDs and shut down all your specialty facilities.” Many hospitals have in fact shuttered EDs, due in part to EMTALA costs.²⁵⁴ Surely the last

250. Nat’l Fed’n of Indep. Bus. v. Sebelius (*NFIB*), 132 S. Ct. 2566, 2605 (2012) (“The threatened loss of over 10 percent of a State’s overall budget . . . is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.”).

251. *Id.* at 2630 (Ginsburg, J., concurring in part and dissenting in part) (“THE CHIEF JUSTICE acknowledges that Congress may ‘condition the receipt of [federal] funds on the States’ complying with restrictions on the use of those funds,’ but nevertheless concludes that the 2010 expansion is unduly coercive.” (alteration in original) (citation omitted)).

252. *Id.* at 2604 (majority opinion) (“In this case, the financial ‘inducement’ Congress has chosen is much more than ‘relatively mild encouragement’—it is a gun to the head.”).

253. *Id.* at 2605.

254. See Renee Y. Hsia, Arthur L. Kellermann & Yu-Chu Shen, *Factors Associated with Closures of Emergency Departments in the United States*, 305 J. AM. MED. ASS’N 1978, 1980 (2011) (finding that from 1990 to 2009, EDs closed at a rate of 27%); Roni Caryn Rabin, *Fewer Emergency Rooms Available as Need Rises*, N.Y. TIMES, May 17, 2011, <http://www.nytimes.com/2011/05/18/health/18hospital.html> (noting that despite there being less EDs, the total number of ER visits increased by 35%); Rand Health, *Why Are Many Emergency Departments in the United States Closing?*, RAND CORP., http://www.rand.org/content/dam/rand/pubs/research_briefs/2011/RAND_RB9607.pdf (last visited Nov. 20, 2013) (“The study revealed that between 1990 and 2009, the number of ERs in nonrural U.S. hospitals declined by 27 percent (from 2,446 to 1,779).”); see also W. Wesley Fields et al., *The Emergency Medical Treatment and Labor Act as a Federal Health Care Safety Net Program*, 8 ACAD. EMERGENCY MED. 1064, 1067 (2001) (reporting that ED

thing the federal government should be doing, just as the Baby Boom generation enters Medicare, is to encourage hospitals to abandon this entire population. Likewise, shuttering more EDs and specialty facilities would hardly be a public health success.²⁵⁵

B. JUST COMPENSATION: PATIENTS

In sum, permitting a hospital to participate in Medicare does not count as “just compensation” for imposing enormous otherwise-uncompensated takings, nor can we dismiss hospitals’ EMTALA costs as simply the product of a “voluntary” choice.

We turn to potential sources of real payment. Imagine that someone is brought unconscious from a motor vehicle wreck to the ER with life-threatening injuries, and the hospital provides appropriate screening and stabilization. This is a per se taking because the policy serves the public use (we all want assurance of such care) and the hospital must provide these services and products with no assurance of payment and no possibility of excluding anyone who might not pay.²⁵⁶ Suppose now that the patient recovers nicely and pays the bill in full. Although there was a taking it was justly compensated, hence not unconstitutional.

But what about the patient who does not pay? To be sure, the patient has an obligation under *quantum meruit* to pay the fair value of services rendered in his time of need—as every first-year law student learns in contracts course.²⁵⁷ Some

closure rates are 27% higher than those for hospitals); Kristofor Husted, *Emergency Room Closures Hit Minorities, Poor Hardest*, NAT’L PUB. RADIO (Nov. 16, 2011, 5:00 PM), <http://www.npr.org/blogs/health/2011/11/16/142392761/emergency-room-closures-hit-minorities-poor-hardest> (“Another recent study by Hsia found a 27 percent decline in nonrural emergency departments across the country from 1990 to 2009.”); Ryan Jaslow, *Emergency Departments are Closing Their Doors: Why?*, CBS NEWS.COM (May 18, 2011), http://www.cbsnews.com/8301-504763_162-20063964-10391704.html.

255. A final count against the “voluntariness” argument comes from the fact that these arguments commonly presuppose that any such taking would be a regulatory rather than per se taking. That is, these cases presume that EMTALA “regulation” simply makes an incremental change in the value of the property. As shown above, *supra* Parts III.A, III.B.3, and discussed just below, a regulatory takings analysis is inappropriate for EMTALA takings.

256. See *supra* Part I.

257. See *Cotnam v. Wisdom*, 104 S.W. 164, 165 (Ark. 1907) (“[A] person utterly bereft of all sense and reason by the sudden stroke of an accident or

courts have insisted that hospitals should force the near-indigent to liquidate their assets.²⁵⁸ But in reality, not everyone can pay, and not everyone who can pay chooses to pay. Some courts suggest that both scenarios should simply be written off as the kind of “bad debt” any hospital must absorb as a part of doing business.²⁵⁹

Those courts are mistaken. If the patient fails to pay, a taking becomes unconstitutional for lack of just compensation. The reason becomes clear when we examine other takings that send property from private party to private party, as in *Kelo v. City of New London*.²⁶⁰ The fact that under eminent domain property can permissibly go from private party to private party does not mean that the transaction could legitimately feature no compensation to the original owners.²⁶¹

Suppose, for instance, that one of the private developers in *Kelo* had simply refused to pay after receiving the property. Although no case law has appeared on the issue, only one conclusion fits with the Fifth Amendment. If the government mandates that a homeowner like Susette Kelo sell her property to a private party like Pfizer Inc., then the government must make sure that Pfizer actually pays Kelo. Government must, in

disease may be held liable, in assumpsit, for necessities furnished to him in good faith while in that unfortunate and helpless condition.”).

258. See, e.g., *Bay Gen. Cmty. Hosp. v. Cnty. of San Diego*, 203 Cal. Rptr. 184, 193 (Cal. Ct. App. 1984) (“In sum, the private hospital will have to seek recovery from the working poor’s assets which elevate them above the Medi-Cal cut off level. This is a harsh divestiture process but the remedy is legislative action.”); see also *Franklin Mem’l Hosp. v. Harvey*, 575 F.3d 121, 129–30 (1st Cir. 2009) (arguing that hospitals may bill the patient directly for any amount remaining after payment by insurer or medical assistance program).

259. See, e.g., *St. Joseph’s Hosp. & Med. Ctr. v. Maricopa Cnty.*, 786 P.2d 983, 988 (Ariz. Ct. App. 1989) (“We do not know what percentage of that figure is expected profit, nor do we know the impact these regulations have had on the hospital’s overall profitability. Presumably, these ‘bad debts’ are absorbed by the hospital as a cost of doing business and are ultimately passed on to the consumer.”).

260. See *Kelo v. City of New London*, 545 U.S. 469, 485–86 (2005) (finding that transfers from one private party to another could satisfy the “public use” requirement).

261. See *Haw. Hous. Auth. v. Midkiff*, 467 U.S. 229, 243–44 (1984) (requiring transfer of large areas of land to be transferred from a few oligopolistic owners to a broader proportion of the population); *Berman v. Parker*, 348 U.S. 26, 31, 33–34 (1954) (requiring owners of commercial as well as residential property to sell to private developers as part of an urban revitalization plan).

effect, be the guarantor of the transaction. And if Pfizer fails to pay,²⁶² then the government must either pay just compensation or return the property to Kelo. The government could then go after Pfizer for reimbursement. The one thing it assuredly may not do is to say to Kelo, "Gosh, Susette . . . looks like you got stiffed . . . sorry 'bout that . . . guess you'd better just chalk it off to bad debt." Such a scenario would clearly create an unconstitutional taking.²⁶³

In emergency care there is no possibility of returning the property to the hospital. The pharmaceuticals, medical devices, nursing time, and ER/OR/ICU space availability have been completely consumed in caring for the EMTALA patient. Economic value has been extinguished and physical space has been invaded.²⁶⁴ If the patient does not pay, the government must do so, a just amount.²⁶⁵ That is, the federal government must either ensure the patient pays or it must pay, itself.²⁶⁶

A related issue concerns the so-called "cost-shifting" by which many hospitals have historically covered costs of indigent care: charge more to paying patients.²⁶⁷ Some courts

262. The example here is purely hypothetical, and there is no reason to think Kelo was not paid the sum designated in the eminent domain transaction.

263. See *Haw. Hous. Auth.*, 467 U.S. at 234 (holding constitutional a takings plan where land prices were set by a condemnation trial or negotiations between the lessors and lessees).

264. See *supra* Part III.

265. See *supra* notes 205–06.

266. In a related question we must consider how to identify which patients should be expected to pay for their care, and who should be deemed indigent. Realistically, the FPL does not help us to identify medical indigency very well. Medical care is so costly, particularly for a serious emergency, that nearly anyone who lacks insurance will be or quickly become medically indigent, i.e., unable to pay the bill out of his or her own pocket. See *St. Joseph's Hosp. & Med. Ctr. v. Maricopa Cnty.*, 635 P.2d 527, 530 (Ariz. Ct. App. 1981). The medical bill can itself send the patient below the poverty line. See *id.* (arguing that the patient became indigent while in the hospital because of the bill). This issue will not be resolved in this Article. As elsewhere in the law, the appropriate analysis will likely focus on the *reasonableness* of what the person should be expected to pay, given his means and other necessary expenses. See, e.g., *Franklin Mem'l Hospital v. Harvey*, 575 F.3d 121, 129–30 (1st Cir. 2009).

267. See, e.g., Lester C. Thurow, *Medicine Versus Economics*, 313 NEW ENG. J. MED. 611, 612 (1985) ("Overtly (by having insurance systems contribute to a pool to pay for the costs of the uninsured) or covertly (by charging paying patients more than their costs and using the extra funds to subsidize those no insured), funds are being extracted from the current system to pay for the uninsured.").

find “nothing invidious in the notion that to establish (a just and reasonable return on equity) the [nursing] home may have to charge its paying patients sufficient to enable it to carry a reasonable number of [under-paying] Medicaid patients.”²⁶⁸

Applied to EMTALA, however, under this reasoning the government effects payment to the hospital by taking it from another innocent party who clearly does not owe the money. Instead of wrongly forcing the hospital to absorb the cost of EMTALA-mandated care, the government would now wrongly force other patients and their insurers to absorb it—expenses that are thereafter, of course, transferred yet again to still other people who pay either via higher insurance costs or via lower wages. The fact that the costs of the initial taking have now been diffused onto a broader variety of parties does not render it any less a taking, nor does it mean that the dearth of government compensation has somehow become “just.”

Even if cost-shifting is so successful that the hospital becomes wealthy and can “afford” the EMTALA losses, the government must still pay.²⁶⁹ If the government may not take \$100 from a millionaire to plant a tree in a public park because “he can afford it,” then neither may it take assets from affluent hospitals or from their paying patients, even for a worthy cause.

If the government replies that it simply must ordain such cost-shifting, lest society lose this important benefit, the Supreme Court has a reply. In *Arkansas Game & Fish Commission* the government insisted that, if the Court were to

268. *St. Joseph's Hosp.*, 635 P.2d at 535 (alteration in original) (quoting *N.J. Ass'n of Health Care Facilities v. Finley*, 402 A.2d 246, 254 (N.J. Super. Ct. App. Div. 1979)) (internal punctuation marks omitted). In a different case featuring the same Arizona hospital and county, the Arizona Court of Appeals held that a hospital could not seek reimbursement from the county because the patient did not meet the legal standards for being an indigent. *St. Joseph's Hosp. & Med. Ctr. v. Maricopa Cnty.*, 786 P.2d 983, 989 (Ariz. Ct. App. 1989). The county's formula for identifying indigency included spousal assets—even though the hospital would be forbidden to go after spousal assets to pay the hospital bill in question. *See id.* at 985–86. Per the court: “The aspect of the regulation that denies families county-funded health care if one spouse possesses assets in excess of the statutory limit also benefits the common good, because it encourages families to pay for services rendered for family members rather than allowing that burden to fall on state coffers.” *Id.* at 988. While we may or may not wish to oppose requirements for spouses to support one another, the reality is that “cost-shifting” spreads the costs of uncompensated care far beyond the borders of the family unit.

269. *See supra* notes 205–06.

deem its intermittent flooding a taking, then this could disrupt a broader public good, namely, its efforts toward flood control.²⁷⁰ The Court flatly rejected the argument:

The slippery slope argument, we note, is hardly novel or unique to flooding cases. Time and again in Takings Clause cases, the Court has heard the prophecy that recognizing a just compensation claim would unduly impede the government's ability to act in the public interest . . . We have rejected this argument when deployed to urge blanket exemptions from the Fifth Amendment's instruction. While we recognize the importance of the public interests the Government advances in this case, we do not see them as categorically different from the interests at stake in myriad other Takings Clause cases.²⁷¹

C. JUST COMPENSATION: FEDERAL PAYMENTS TO HOSPITALS

1. For-Profit Private Hospitals

As discussed, the patient who receives an EMTALA benefit can be expected to pay fair market value (FMV) for his care, whether out of pocket or through an insurer. However, when the patient cannot or does not pay, it becomes essential to explore other avenues for just compensation. We have seen that the federal government that mandates this taking cannot provide just compensation by extracting (taking) it from someone else—whether from the hospital, a local municipality, the state, or, as noted just above, from other patients. As the feds incur the debt, the feds must pay the debt. Still, there may be existing avenues by which this is already being done. To these we now turn.

The paradigmatic scenario in which an EMTALA taking is unconstitutional is the for-profit private hospital that pays a full load of taxes and has no Hill-Burton obligations—hence has no obligations to render uncompensated care as a community benefit²⁷²—and which then provides emergency care for a medically indigent patient. This sort of case typically represents a taking with no compensation at all, a clear violation of the Fifth Amendment.

Immediately the question arises, how much compensation is “just.” While it is not the purpose of this Article to delve into this question, a few remarks may be useful. From *United States*

270. See *Ark. Game & Fish Comm'n v. United States*, 133 S. Ct. 511 (2012).

271. *Id.* at 521 (citations omitted).

272. See *supra* note 19.

v. General Motors Corp., FMV appears to be key.²⁷³ Also important, compensation should focus on what the property owner lost, not on what the government gained.²⁷⁴

Admittedly, identifying “market value” for health care services can be difficult. On one hand, hospitals should ordinarily be able to monetize reasonably well the actual costs of any given episode of emergency care. They can compute the per-unit cost they pay for pharmaceuticals and devices; the per-hour salaries they pay physicians, nurses, and allied providers; and the per-hour or per-day value of ER, OR, ICU, and inpatient bed time. Compared with more nuanced questions about, for example, real estate value,²⁷⁵ hospital services should pose fewer problems of proof.²⁷⁶

On the other hand, we also need to factor in a reasonable rate of return over the bare costs to the institution. In health care this question can be uniquely complicated. The prices charged for various products and services often have little connection with the cost of providing them. Hospitals commonly identify their “rack-rate” prices via a “Charge Master” that lists the hospital’s official prices for thousands of goods and services. Those charges may have little relationship with the cost of providing the service.²⁷⁷

273. See *United States v. General Motors Corp.*, 323 U.S. 373, 379 (1945) (“[T]he compensation to be paid is the value of the interest taken. Only in the sense that he is to receive such value is it true that the owner must be put in as good position pecuniarily as if his property had not been taken. In the ordinary case, for want of a better standard, market value, so called, is the criterion of that value.”).

274. See *Brown v. Legal Found. of Wash.*, 538 U.S. 216, 236 (2003) (holding that just compensation is measured according to the owner’s loss); *United States v. Causby*, 328 U.S. 256, 261 (1946) (holding the value is determined by “the owner’s loss, not the taker’s gain”); *General Motors Corp.*, 323 U.S. at 378 (holding the deprivation of the former owner constitutes the taking).

275. In *Midkiff’s* land transfers, prices for the properties were to be set either by a condemnation trial or by negotiation between the parties themselves. *Haw. Hous. Auth. v. Midkiff*, 467 U.S. 229, 229 (1984).

276. See *Loretto v. Teleprompter Manhattan Cable Television Corp.*, 458 U.S. 419, 437–38 (1982) (pointing out that per se takings tend to present fewer problems of proof, compared with regulatory takings).

277. Charge Masters have historically been adjusted frequently and kept confidential. See, e.g., E. Haavi Morreim, *High-Deductible Health Plans: New Twists on Old Challenges from Tort and Contract*, 59 VAND. L. REV. 1207, 1253 (2006). They are known to include considerable internal cost-shifting, as the price for one common service or product might be raised substantially to cover the cost of an essential but costly service that could not otherwise pay for itself. *Id.* at 1254. Charge Master prices vary widely, sometimes wildly,

At the same time, many payors' actual payments to hospitals are based, not on Charge Master prices, but on a pre-negotiated payment structure. Many insurers, from Medicare to private insurers, use a lump-sum approach, whether a per-diem fee or a diagnosis-based amount calculated according to the patient's diagnosis and other factors.²⁷⁸ Ultimately, therefore, the initial price of a product or service often has only a limited relationship to either the hospital's costs or to a putative FMV.²⁷⁹

from one hospital to another. See Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME, Feb. 20, 2013, at 16, 22 ("No hospital's chargemaster prices are consistent with those of any other hospital . . ."). And even within a hospital, the price charged to one patient can be very different from that charged to another, depending on the specific discounts negotiated with each patient's insurer. See *id.* at 23 (discussing how despite one patient's bill being high, the hospital spokesman insisted "most people never pay those rates"). Cost-shifting also is spread across various types of payers, for example, as private payers tend to pay more for a given service than government insurers such as Medicare and Medicaid. See Williams, *supra* note 228, at 105 ("As part of this system, one payor group (usually private health insurers) may systematically pay substantially higher prices to offset lower prices paid by another payor group (usually the federal and state governments, or patients paying out-of-pocket).").

278. See Williams, *supra* note 228, at 108–09. Medicare established its Diagnosis-Related Group (DRG) payment system in the early 1980s as an alternative to traditional fee-for-service. See Bruce C. Vladeck, *Medicare Hospital Payment by Diagnosis-Related Groups*, 100 ANNALS INTERNAL MED. 576, 576 (1985). Instead of paying the hospital more, the longer the patient stayed and the more services he received, the DRG payment would be fixed according to the patient's main diagnosis and related factors. See *id.* at 577–81. Here, the incentive is to achieve efficient service and prompt discharge, rather than to maximize services. See, e.g., Williams, *supra* note 228, at 108.

279. Nevertheless, hospitals are increasingly asked to provide transparency regarding the cost and value of their services. See generally Brill, *supra* note 277 (discussing how difficult the author found it to ask a hospital for its prices and find out why one patient's bill was so high). Individuals facing ever-rising deductibles are much more likely to ask about costs and to engage in price-shopping, even as businesses try to obtain greater control over this important cost. It is likely that in the future, to the extent that the health care system still relies on a fee-for-service approach to paying providers, the price of a service will more closely correlate with the actual cost of providing it. At the same time, to the extent that health care is increasingly compensated via "bundled" payments that cover a broad episode of care rather than each individual Band-aid and blood-draw, it will be necessary to find some reasonable way to monetize the value of EMTALA-mandated care. See David M. Cutler & Kaushik Ghosh, *The Potential for Cost Savings Through Bundled Episode Payments*, 366 NEW ENG. J. MED. 1075, 1077 (2012) (analyzing cost savings under different bundled-payment systems); Robert

We need not resolve that tangle here.²⁸⁰ Suffice it to say that EMTALA takings must be compensated in a way that fairly captures market value in some way that reasonably exceeds the bare cost of providing the care.²⁸¹

Plainly too, it would be incorrect to consider the hospital's overall financial condition and conclude that, if the hospital is fiscally sound, then it can "afford" to care for indigent emergency patients.²⁸² If the federal government takes, then the federal government, not someone else, must pay.

Mechanic & Christopher Tompkins, *Lessons Learned Preparing for Medicare Bundled Payments*, 367 NEW ENG. J. MED. 1873, 1875 (2012) (discussing variations on payments); William Weeks et al., *The Unintended Consequences of Bundled Payments*, 158 ANNALS INTERNAL MED. 62, 63 (2013) (explaining that care must be taken to avoid encouraging hospitals to treat "healthy" patients over "sick" patients to keep costs below bundled payments).

280. For recent cases concerning the reasonableness of hospitals' charges, see *Allen v. Clarian Health Partners, Inc.*, 955 N.E.2d 804, 809–10 (Ind. Ct. App. 2011), *rev'd*, 980 N.E.2d 306 (Ind. 2012) (discussing the difficulty in determining the reasonable value of medical services); *St. Francis Med. Ctr. v. Reeves*, 356 S.W.3d 813, 815–16 (Mo. Ct. App. 2012) (holding that customary charges in the industry for services rendered could be proof of reasonableness). For further discussion of the "reasonableness" of hospital charges, see generally Morreim, *supra* note 277, at 1258–59 (discussing the difficulty in determining what constitutes a reasonable fee).

281. See generally Lundstrom, *supra* note 227, at 1246–47 (explaining that reimbursements must meet the fair standard test by allowing hospitals to operate successfully and compensate investors for risk assumed). It should be noted that, although regulatory takings jurisprudence permits the "give and take" of life in society to impair the value of one's property without actually rendering that impairment a taking, EMTALA cases are per se takings, not regulatory takings. See, for example, *Andrus v. Allard*, 444 U.S. 51, 65 (1979), where the court held that "the denial of one traditional property right does not always amount to a taking;" and *Yee v. Escondido*, 503 U.S. 519, 522–23 (1992), where the court held that a regulation is a taking only if it unfairly singles out the property owner to bear a public burden. It is therefore imperative that just compensation be identified and paid for each such taking.

282. In a case like *Arkansas Game & Fish Commission*, it would be irrelevant whether the Commission could "afford" to repair the damage of the federal government's intermittent flooding. If the government caused the damage, the government must pay for the damage. In the same vein it did not matter whether General Motors could "afford" to absorb the damage caused by a federal usurpation of its leased space and damaged fixtures, or had other ways to pay for the damage. See *United States v. General Motors Corp.*, 323 U.S. 373, 379 (1945) (holding that compensation paid is to be "the value of the interest taken").

2. Not-For-Profit Private Hospitals

The challenge to define “just compensation” is more complex for tax-exempt hospitals.²⁸³ Not-for-profit (NFP) hospitals are spared substantial tax payments in exchange for an obligation to provide charity care or other community benefits.²⁸⁴ These could include emergency services.

This Article will make no attempt to determine what a “just” level of EMTALA compensation is,²⁸⁵ nor to determine how much, or by what formula, a tax exempt hospital’s indigent care obligations should be calculated, or how they should be allocated between EMTALA versus other kinds of services. Nevertheless, it will be useful to note significant complexities attending this task. Since EMTALA carries no direct compensation²⁸⁶ we will distinguish between the indirect compensation that *can* properly count toward the federal EMTALA obligation, and that which cannot be counted.

i. What the Federal Government Can Count Toward EMTALA Debt

Exemption from federal taxes²⁸⁷ obviously can count so long as the value of tax savings equals or exceeds the total

283. Hill-Burton obligations should be considered alongside tax exemption, but they will not be expressly discussed here. Funding under the Act ceased in 1997 and, at present, only around 200 hospitals in the United States still have Hill-Burton obligations. *Hill-Burton Free and Reduced-Cost Health Care*, HEALTH RESOURCES & SERVICES ADMIN., <http://www.hrsa.gov/gethealthcare/affordable/hillburton/> (last visited Sept. 4, 2013); *see also* Am. Hosp. Ass’n v. Schweiker, 721 F.2d 170, 172–75 (7th Cir. 1983) (describing the obligations hospitals must fulfill if they receive Hill-Burton funding); Richards, *supra* note 7, at 597–98 (describing how the Hill-Burton Act’s lack of punitive measures made it ineffective).

284. *See What Is the Difference Between Nonprofit Hospitals and For-Profit Hospitals?*, MEDICARE NEWSGROUP (Sept. 21, 2013), <http://www.medicarenewsgroup.com/news/medicare-faqs/individual-faq?faqId=31a98723-ad91-4801-9bd8-1f968a7c0f1b>.

285. Identifying fair compensation for hospitals might, for example, be determined according to the “fair return on investment” approach used for public utility price regulation. *See* Thomas W. Merrill, *Constitutional Limits on Physician Price Controls*, 21 HASTINGS CONST. L.Q. 635, 653–56 (1994) (proposing that fair return on investment be used to set payment for physician services under Medicare and Medicaid).

286. *See supra* Part I. The lone exception, of course, would be Medicare patients’ ER visits, assuming that compensation for these is “just.”

287. To the extent a tax-exempt hospital also is relieved of state and/or local taxes, those government entities, and not the federal government, would

FMV of EMTALA services. Of note, it can be difficult to discern just how much indigent care an NFP hospital actually provides, whether for ER patients or more broadly. Some hospitals purportedly fail to make energetic collection efforts, then improperly identify this bad debt as charitable care.²⁸⁸ In response to this problem, the ACA places new requirements on tax-exempt hospitals.²⁸⁹

Additionally, the federal government makes a variety of payments to hospitals that could theoretically be applied to EMTALA debt. Any time government payment for Medicare beneficiaries exceeds the FMV of those particular services, any “excess” could theoretically count toward EMTALA debt. This Article makes no attempt to determine whether hospitals²⁹⁰ are “overpaid” for Medicare services. Suffice it to say the issue is controversial, but that any such overpayments could, in principle, apply to EMTALA.

have authority to determine what kinds of service will count as the community benefit the hospital is expected to provide.

288. Reciprocally, others are said to have engaged in aggressive collection tactics, even for patients reasonably deemed medically indigent. *See, e.g.*, Nina Bernstein, *Hospitals Flout Charity Aid Law*, N.Y. TIMES, Feb. 12, 2012, http://www.nytimes.com/2012/02/13/nyregion/study-finds-new-york-hospitals-flout-charity-rules.html?_r=1&ref=health (describing hospitals in New York state that appear to be pursuing aggressive debt-collection tactics, even after receiving significant payments from a state-sponsored fund to cover charity care); Jessica Silver-Greenberg, *Debt Collector Is Faulted for Tough Tactics in Hospitals*, N.Y. TIMES, Apr. 24, 2012, http://www.nytimes.com/2012/04/25/business/debt-collector-is-faulted-for-tough-tactics-in-hospitals.html?_r=2&nl=afternoonupdate&emc=edit_au_20120424.

289. Each tax-exempt hospital will be required to maintain a financial assistance policy (FAP) and an emergency medical care policy, under which the hospital will limit the amounts that will be charged to eligible individuals. 26 U.S.C. § 501(r) (2012). Hospitals must refrain from extraordinary collections efforts until after making reasonable efforts to determine that person’s FAP eligibility. *Id.* § 501(r)(6). These hospitals must also conduct community health needs assessments on a regular basis. *Id.* § 501(r)(3). On April 5, 2013 the IRS issued proposed regulations to address this requirement under section 501(r)(3) of the Internal Revenue Code (Code). *See* Community Health Needs Assessments for Charitable Hospitals, 78 Fed. Reg. 20,523 (proposed Apr. 5, 2013) (to be codified at 26 C.F.R. pts. 1, 53) (providing guidance on assessment, tax, and reporting requirements and consequences for failing to meet them).

290. The question whether Medicare “overpays” for physician services is irrelevant in this setting, since EMTALA does not bind physicians. *See* *Burditt v. U.S. Dep’t of Health & Human Servs.*, 934 F.2d 1362, 1376 (5th Cir. 1991) (holding that “physicians only voluntarily accept responsibilities under EMTALA”).

Medicare also helps pay for physician training via Direct Graduate Medical Education (DGME) payments to teaching hospitals.²⁹¹ Where the paid labor of these physicians-in-training is spent caring for emergency patients, it could count toward EMTALA debt. Conversely, when the trainee is caring for a nonemergency patient, then that portion of the DGME payment is not legitimately credited.

Medicare also makes "disproportionate share hospital" (DSH) payments to hospitals providing a disproportionate share of uncompensated care, some portion of which could count toward EMTALA.²⁹² However, these payments are slated to decrease by up to 75% under the ACA, based on the Act's presumption that the number of un- and under-insured people would fall dramatically.²⁹³

Across these funding sources, dollars must not be counted twice. If \$1000 is designated for John Doe, a Medicare beneficiary with an elective hip replacement, and if the Medicare payment barely covers the FMV of Doe's care, then the same \$1000 cannot also count toward EMTALA debt. Obvious as this point seems, it could nevertheless be tempting for the government to say "we pay you all this money . . . surely it is enough to cover EMTALA takings." The accounting must

291. See, e.g., *Medicare Direct Graduate Medical Education (DGME) Payments*, ASS'N AM. MED. CS., https://www.aamc.org/advocacy/gme/71152/gme_gme0001.html (last updated May 31, 2012) (describing how DGME payments compensate teaching hospitals for training costs incurred treating Medicare patients).

292. The Medicaid DSH program was initiated in 1981 to help defray the costs for hospitals serving particularly large numbers of low-income patients. ROBERT E. MECHANIC, NAT'L HEALTH POLICY FORUM, MEDICAID'S DISPROPORTIONATE SHARE HOSPITAL PROGRAM: COMPLEX STRUCTURE, CRITICAL PAYMENTS 3 (2004), available at http://www.nhpf.org/library/background-papers/BP_MedicaidDSH_09-14-04.pdf. Payments are made to states, which in turn distribute the funds to hospitals. CHRISTIE PROVOST PETERS, NAT'L HEALTH POLICY FORUM, MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS 1 (2009), available at http://www.voryshcadvisors.com/files/2012/04/Basics_DSH_06-15-09.pdf. In 2011 these payments totaled \$11.59 billion. JOHN R. JACOB ET AL., THE MEDICARE DSH ADJUSTMENT 4 (2012), available at http://www.healthlawyers.org/Events/Programs/Materials/Documents/MM12/papers/M_jacob_et_al_slides.pdf. The Medicare DSH program, established in 1986, paid out \$10.8 Billion in 2010. See *id.*

293. See John A. Graves, *Medicaid Expansion Opt-Outs and Uncompensated Care*, 367 NEW ENG. J. MED. 2365, 2365 (2012). The impact of these reductions is expected to be particularly great in states opting to forego Medicaid expansion in 2014. *Id.*

be specific, and the burden falls upon the government that incurred the debt.

ii. What the Federal Government Cannot Count Toward EMTALA Debt

This is the more interesting question. As explained above, the hospital's overall fiscal health, including any budget surpluses via "excess" (more than FMV) payments from private insurers, cannot count toward EMTALA debt. Likewise the federal government can only count those Medicaid²⁹⁴ payments directed toward Medicaid beneficiaries' emergency care. Per

294. Lundstrom provides a useful description of Medicare and Medicaid. See Lundstrom, *supra* note 227, at 1250 n.53.

Both Medicare and Medicaid were created in 1965 under the Social Security Act of 1965. Lundstrom, *supra* note 227, at 1245 n.20. Medicare extended health coverage to almost all Americans aged sixty-five and over. *Key Milestones in CMS Programs*, CENTERS FOR MEDICARE & MEDICAID SERVICES, <http://cms.hhs.gov/About-CMS/Agency-Information/History/Downloads/KeyMilestonesinCMSPrograms.zip> (last updated June 13, 2013, 11:20 AM). In 1972, amendments expanded coverage to include the disabled and those with end-stage renal disease. *Id.* Medicare is administered by the federal government and reimbursement rates are set by statute. See 42 U.S.C. § 1395 (2006 & Supp. V 2011) ("Nothing in the provisions of, or amendments made by, this Act . . . shall result in a reduction of guaranteed benefits under [Medicare].").

On the other hand, Medicaid, a program that pays for health-related services for certain groups of needy individuals, is a combined federal/state program administered by the states. See 42 U.S.C. § 1396a(a) (2006 & Supp. V 2011) (authorizing an appropriation to help the States pay for medical care for the poor and disabled). Under this program, "each State for the most part has broad discretion in determining the payment methodology and payment rate for services." BARBARA S. KLEES ET AL., *CTRS. FOR MEDICARE & MEDICAID SERVS., BRIEF SUMMARIES OF MEDICARE & MEDICAID 27* (2010), available at <http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MedicareProgramRatesStats/downloads/MedicareMedicaidSummaries2010.pdf>.

Payments to hospitals for the Medicare program are calculated utilizing a complicated formula that takes into account a Base Rate per DRG, wage index, and geographic location (large urban or other). See Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates, 68 Fed. Reg. 45,346, 45,348 (proposed Aug. 1, 2003) (to be codified at 42 C.F.R. pts. 412, 413); see also Medicare Program; Changes to the Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates; Correction, 68 Fed. Reg. 57,732 (Oct. 6, 2003) (to be codified at 42 C.F.R. pts. 412, 413) (listing corrections to previously published wage index information). "Since hospital rates for Medicaid are determined by the states with federal approval, and hospital rates for Medicare are determined by statute, reimbursement rates for the two programs may differ, even for the same patient condition or DRG." Lundstrom, *supra* note 227, at 1250 n.53.

many hospitals' experience, Medicaid payments are insufficient even to cover their intended use,²⁹⁵ hence are unlikely to generate overages applicable to EMTALA debt.

The upshot for present purposes is simply that, if an NFP institution's uncompensated EMTALA expenditures exceed its obligation to provide free EMTALA care, and if government funding properly counted toward EMTALA debt is inadequate, then any excess hospital costs for EMTALA patients are not merely a taking, they now represent a taking without just compensation and are unconstitutional.

3. Public Hospitals

Public hospitals (other than federally funded hospitals such as Veterans Administration facilities) are funded by state or local governments with the specific mission to serve designated state or local populations.²⁹⁶ EMTALA mandates that these institutions serve all who come to their EDs, without providing funds and regardless of whether the patient is a member of the designated service population.²⁹⁷ The above

295. For instance, in *Franklin Memorial Hospital v. Harvey*, Plaintiff Franklin Memorial Hospital (FMH), in one of Maine's poorest counties, received on average about \$2645 for the care of each indigent inpatient, while the average expense was nearly \$5000. See *Franklin Mem'l Hosp. v. Harvey*, 575 F.3d 121, 124 (1st Cir. 2009). For 2008 the hospital gave away nearly \$900,000 in uncompensated care. *Id.*

In 2001, 57% of hospitals were paid less than what is [sic] cost them to care for Medicare patients. Also, according to an analysis by the Lewin Group, hospitals received only 84 cents in Medicaid revenue and tax appropriations for every dollar it cost them to care for Medicaid and charity patients.

Lundstrom, *supra* note 227, at 1254 (internal citations and quotation marks omitted). A number of authors have discussed the question of whether inadequate compensation constitutes an unconstitutional taking. See Lunney, *supra* note 122, at 1924–35 (providing an overview of compensation in recent case law); Merrill, *supra* note 285, at 665–66 (discussing what limits the constitution places on price controls on physicians). *But see* Brewbaker, *supra* note 122, at 702–07 (arguing that the courts will probably uphold price controls).

296. See *Funding Essential Care*, NAT'L ASS'N PUB. HOSPS., <http://www.naph.org/Main-Menu-Category/Our-Work/Safety-Net-Financing.aspx> (last visited Sept. 17, 2013) ("Hospitals . . . rely on payments from federal, state, and local governments to successfully care for low-income patients and preserve essential services for the entire community.").

297. *EMTALA*, AM. C. EMERGENCY PHYSICIANS, <http://www.acep.org/content.aspx?id=25936> (last visited Sept. 17, 2013) ("[EMTALA] is a federal law that requires anyone coming to an emergency department to be stabilized and treated, regardless of their insurance status or ability to pay

arguments regarding NFP hospitals apply equally well to public hospitals. The federal government cannot properly count others' payments toward its own debts.

The Supreme Court has emphasized that the federal government generally cannot commandeer states to do its business.²⁹⁸ As the Court underscored in *NFIB*, the Constitution's Spending Clause permits Congress to condition its grants to states "to secure compliance with federal objectives."²⁹⁹ However, to preserve the Constitution's two-government system, the Court will "strike down federal legislation that commandeers a State's legislative or administrative apparatus for federal purposes."³⁰⁰ Arguably EMTALA, applied to state or locally-funded public hospitals, oversteps its bounds if it usurps those public hospitals to serve federal rather than state goals.

The specifics of whether this-or-that particular dollar of funding will count toward an EMTALA debt are left to be debated elsewhere. The important point for present purposes is that wherever an indigent EMTALA patient's care is not paid for *by the patient or by the federal government*, the taking is left uncompensated, and hence is unconstitutional.

[Medicare-participating hospitals must] treat the emergency medical conditions of patients in a non-discriminatory manner to anyone . . .").

298. See *Printz v. United States*, 521 U.S. 898, 933 (1997) (holding that the federal government cannot commandeer a states' resources to implement the Brady Handgun Violence Prevention Act). "The Framers' experience under the Articles of Confederation had persuaded them that using the States as the instruments of federal governance was both ineffectual and provocative of federal-state conflict . . . [T]he Framers rejected the concept of a central government that would act upon and through the States . . ." *Id.* at 919.

The great innovation of this design was that "our citizens would have two political capacities, one state and one federal, each protected from incursion by the other"—"a legal system unprecedented in form and design, establishing two orders of government, each with its own direct relationship, its own privity, its own set of mutual rights and obligations to the people who sustain it and are governed by it."

Id. at 920 (quoting *U.S. Term Limits, Inc. v. Thornton*, 514 U.S. 779, 838 (1995) (Kennedy, J., concurring)).

299. *Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB)*, 132 S. Ct. 2566, 2602 (2012).

300. *Id.* (citing *Printz*, 521 U.S. at 933). In addition, the Court made clear that if the Federal Government's mandate leaves a state with no real choice, then "the Federal Government can achieve its objectives without accountability . . . [T]his danger is heightened when Congress acts under the Spending Clause, because Congress can use that power to implement federal policy it could not impose directly under its enumerated powers." *Id.* at 2603.

VI. CONFUSED JURISPRUDENCE

As noted in Part I, the U.S. Supreme Court has never addressed the constitutionality of EMTALA, nor have any circuit courts. A few courts have addressed somewhat comparable issues arising from state mandates to serve indigent patients.³⁰¹ In some of these cases the state pays for the care, but the hospital alleges the amount is inadequate.³⁰² Other cases feature no payment at all and allege an unconstitutional taking on that basis.³⁰³ The latter are spotlighted here, as courts' errors in addressing these cases are particularly instructive.

As this Part will show, the pivotal error these courts make is to assume that when a government requires a hospital to provide uncompensated care to indigent patients, it is an instance of land use regulation in which the government regulates the hospital-as-a-whole. Courts then invoke *Penn Central's* three factors to discern whether the regulation impairs the value of the hospital-as-a-whole, or harms its overall financial viability.³⁰⁴

This entire framework is mistaken. The hospital is not the property. The hospital is the (corporate) "person" whose property is being taken. The Supreme Court has no difficulty recognizing that takings can be imposed upon corporate

301. See *Franklin Mem'l Hosp. v. Harvey*, 575 F.3d 121, 129 (1st Cir. 2009) (ruling that Maine's "free care" laws did not constitute a taking); *St. Joseph's Hosp. & Med. Ctr. v. Maricopa Cnty.*, 786 P.2d 983, 986, 988 (Ariz. Ct. App. 1989) (holding that the state has the authority to determine what qualifies as "indigent," and such qualifications, even when coupled with the obligations imposed on the hospital to treat all emergency patients, does not constitute a taking).

302. See *Franklin Mem'l Hosp.*, 575 F.3d at 124 ("FMH recovers some of the costs it incurs in treating certain low income patients through reimbursements from the MaineCare program. Yet reimbursements through MaineCare fall well short of FMH's actual costs in treating patients.").

303. See *id.* at 124 ("Maine provides no payment for the medical services rendered in compliance with its free care laws . . .").

304. As the reader will recall, the *Penn Central* factors are: [1] the regulation's economic impact on the claimant; [2] "the extent to which it has interfered with investment-backed expectations;" and [3] the character of the government action, particularly whether it features a physical invasion. *Penn Cent. Transp. Co. v. City of New York*, 438 U.S. 104, 124 (1978).

persons just as upon individual human beings.³⁰⁵ EMTALA imposes precisely this sort of taking.

The leading example is *Franklin Memorial Hospital v. Harvey*.³⁰⁶ Although the First Circuit did address the alleged inadequacy of Maine's reimbursements under its Medicaid MaineCare program,³⁰⁷ it primarily focused on Maine's separate statute requiring all hospitals in the state to provide free medical care to the indigent, regardless of eligibility for MaineCare.³⁰⁸ The latter statute commonly resulted in no payment whatsoever to the hospital.³⁰⁹

Similarly, in *St. Joseph's Hospital & Medical Center v. Maricopa County*,³¹⁰ the county mandated that hospitals care for the indigent, yet defined its own payment responsibilities so narrowly that hospitals were forced to treat many people gratis who clearly could not pay for their care.³¹¹ The Court of Appeals of Arizona held that the county is authorized to determine who is eligible for assistance.³¹² Therefore, although the hospital could bill the patient, it could not collect from the county.³¹³

305. See, e.g., *Ruckelshaus v. Monsanto Co.*, 467 U.S. 986, 1003–04 (1984) (finding to the extent that a company has a trade-secret property right, such right is protected by the Takings Clause of the Fifth Amendment).

306. *Franklin Mem'l Hosp.*, 575 F.3d at 121.

307. See *id.* at 129–30.

308. See *id.* at 125–29. MaineCare is Maine's version of Medicaid.

309. *Id.* at 129 (“Maine’s free care laws merely require that hospitals not refuse to treat patients based on their ability to pay and that they provide those services freely to those with incomes at or below 150% of the federal poverty level.”); see Jessica Hall, *Maine Hospitals’ Free Care Doubled*, MORNING SENTINEL, May 7, 2012, http://www.onlinesentinel.com/news/maine-hospitals-free-care-doubled_2012-05-06.html?pagenum=full (discussing the difficulties facing hospitals when dealing with the extra costs and that “charity care” under the statute doubled from 2006 to 2011).

310. *St. Joseph’s Hosp. & Med. Ctr. v. Maricopa Cnty.*, 786 P.2d 983 (Ariz. Ct. App. 1989).

311. See *id.* at 984. In the instant case, the county determined that the patient was not indigent because his spouse had enough money to overcome the “indigent” classification. *Id.* At the same time, all parties agreed that when the bill came due, the hospital would not be allowed to go after the spouse’s assets. *Id.* at 985. Thus, the very same separate spousal assets that rendered the otherwise-indigent patient unqualified for financial assistance were expressly off limits for collection purposes. See *id.* at 985–86.

312. See *id.* at 986 (“[T]he legislature may and must draw financial eligibility lines somewhere.”).

313. *Id.* at 989–89. See *Bay General Community Hospital v. County of San Diego*, 203 Cal. Rptr. 184, 185–95 (Cal. Ct. App. 1984), where a somewhat

Both these courts presumed they were addressing a case of land use regulation, then assumed that the property in question was the hospital-as-a-whole and invoked *Penn Central's* three-factor regulatory takings analysis.³¹⁴ Although both hospitals argued that personal property such as “services, facilities, and supplies” was taken,³¹⁵ both courts focused solely on realty. Per the Arizona appellate court:

Traditional eminent domain cases shed some light on the question. The typical eminent domain case involves the taking or regulation of real property which diminishes or destroys the value of that property to the owner and provides a direct benefit to the state [T]he eminent domain analysis provided in property-use-regulation cases will be our guide.³¹⁶

The Arizona Court initially determined that a per se taking did not occur, since the county’s actions were not “tantamount to a complete condemnation of the hospital,”³¹⁷ or

similar Catch-22 situation emerged in California. A state appellate court left in place a complex situation in which a private hospital was required to provide emergency care to indigent residents and non-resident patients, even though: [a] payment for hospital care was only made to one county-approved hospital (i.e., University Hospital), *id.* at 187; [b] the private hospital was not allowed to transfer this patient to University Hospital, *id.* at 190–92; and [c] in any event, no compensation would be available for the treatment of undocumented aliens, even though the hospital was required to provide the emergency care. *Id.* at 193–94.

314. The regulatory takings analysis generally applies to real property but has occasionally been used outside of real property. *See, e.g.,* E. Enters. v. Apfel, 524 U.S. 498, 529–37 (1998) (plurality opinion) (applying regulatory takings analysis to pension plan obligations).

315. *St. Joseph's Hosp.*, 786 P.2d at 987; *Franklin Mem'l Hosp. v. Harvey*, 575 F.3d 121, 126 (1st Cir. 2009) (“FMH stresses that Maine’s free care laws require it to give away its personal property to the extent that it must purchase and freely provide expensive medicines and medical supplies to low income patients.”).

316. *St. Joseph's Hosp.*, 786 P.2d at 987. The Court noted that:

This case is atypical because the benefit—emergency health care—inures to the patient directly. The only fiscal benefit the state enjoys is that it does not have to pay for the patient’s care, unless the patient qualifies as indigent. There is some authority for the proposition that the government must pay for an unconstitutional taking of property, even if it is another who derives the benefit.

Id. (citing *Ivey v. United States*, 88 F. Supp. 6, 8 (E.D. Tenn. 1950)). As discussed above, this patient was in fact indigent even though he did not qualify as such because of spousal assets that, themselves, were statutorily unavailable to the hospital. As a result the hospital was required to shoulder the burden for his care. *See supra* note 311.

317. *St. Joseph's Hosp.*, 786 P.2d at 988.

a denial of all “economically viable use of the land.”³¹⁸ The Court then delved into the first two *Penn Central* criteria, namely economic impact and investment-backed expectations, finding that “these ‘bad debts’ are absorbed by the hospital as a cost of doing business that is ultimately passed on to the consumer.”³¹⁹ Per *Penn Central*’s third factor, the character of the government action, the Court found that this was not a “physical invasion by government,”³²⁰ but rather was simply a requirement, as a condition of doing business in the state, that the hospital ask the patient to pay if he or she does not qualify as indigent³²¹—the so-called “voluntariness argument” discarded above.³²²

Franklin Memorial primarily focused on Maine’s mandate that hospitals serve low income patients for no payment at all.³²³ The law is enforced by a system of fines and lawsuits,³²⁴

318. *Id.* at 987 (quoting *Corrigan v. City of Scottsdale*, 730 P.2d 528, 535 (Ariz. Ct. App. 1985)); *see id.* at 988 (relying on the fact that St. Joseph’s failed to provide sufficient information to determine the economic hardship resulting from the hospital’s uncompensated care obligations).

319. *Id.* at 988.

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

321. *Id.* at 988; *see also In re Health Care Admin. Bd. v. Finley*, 415 A.2d 1147, 1154 (N.J. 1980) (“Restrictions on the use of property, if in furtherance of a valid governmental purpose, serve the public interest and are considered a proper exercise of the police power even though they may result in some economic disadvantage. Local rent control is a prime example of such police power regulation.”).

322. *See supra* Part V.A. The reader will recall that the “Voluntariness Argument” cannot survive since (1) the opportunity to earn is not actual compensation; (2) congressional imposition of financial burdens on hospitals in 1986 hardly make the choice to join the program “voluntary;” and (3) such coercion is bad health policy since it is causing hospitals to stop offering emergency care services.

323. *See Franklin Mem’l Hosp. v. Harvey*, 575 F.3d 121, 125–29 (1st Cir. 2009).

324. *Id.* at 123–24 (“[T]he state obtains compliance with its free care requirement through a system of fines and enforcement suits brought by the state’s attorney general or any affected patient.”). The Court also noted that Rhode Island has a similar statute. *Id.* at 124 n.2; *see also* Gayland Oliver Hethcoat II, Note, *Free Hospital Care and the Takings Clause: Franklin Memorial Hospital v. Harvey in a Changing Health-Care Landscape*, 65 U. MIAMI L. REV. 169, 179–80 (2010) (discussing the applicable Maine statute, which states that “[n]o hospital shall deny services to any Maine resident solely because of the inability of the individual to pay for those services,” and defines “services” as “all medically necessary inpatient and outpatient

permitting exception only for cases where the obligation causes financially ruinous consequences.³²⁵ The First Circuit rejected the hospital's argument that this statute represented an unconstitutional taking.³²⁶ Presuming the property to be the hospital-as-a-whole, the court undertook a regulatory analysis,³²⁷ invoked the three *Penn Central* factors,³²⁸ and found none sufficient for a taking.³²⁹ First, indigent care did not consume an inordinately high proportion of the hospital's gross revenues,³³⁰ and the statute permitted hospitals to stop providing free care if their economic viability were jeopardized.³³¹ Second, although NFP hospitals can have "investment-backed expectations," the hospital knew quite well that it was in a highly regulated industry, and hence must expect and plan for the fact that financial burdens of this sort might be imposed.³³² Finally, the First Circuit held that this was not a physical invasion, but rather was simply a public

services" (alterations in original) (citations omitted) (quoting 10-144-150 ME. CODE R. §§ 1.01(A), 1.03 (LexisNexis 2007))).

325. *Franklin Mem'l Hosp.*, 575 F.3d at 124. Specifically, the statute permits hospitals to avoid liability if "economic viability would be jeopardized by compliance." ME. REV. STAT. ANN. tit. 22 §1715(2)(D) (2013).

326. *Id.* at 129.

327. *Id.* at 125 ("Here, the challenged government action, which does not directly appropriate FMH's property but rather regulates how FMH may use it, is properly analyzed under the law of regulatory takings, not the law of physical takings."). As the court noted, "[a] physical taking occurs either when there is a condemnation or a physical appropriation of property," whereas "[a] regulatory taking transpires when some significant restriction is placed upon an owner's use of his property for which 'justice and fairness' require that compensation be given." *Id.* (quoting *Phillip Morris Inc., v. Reilly*, 312 F.3d 24, 33 (1st Cir. 2002) (en banc)).

En passant the court acknowledged the two kinds of per se taking: a permanent physical invasion of the property, and deprivation of all economically beneficial use of the property. *Id.* at 125–26. However, the court opined that neither of these applied in the instant case. *Id.* at 126. First, if a hospital does not wish to serve indigent patients it is free to use its property in some other way instead of as a hospital (the familiar voluntariness argument). *Id.* at 126. Second, there was no allegation that this hospital had somehow lost all economic value—as a hospital—by being forced to provide some free care. *See id.* Hence, said the court, there was no per se taking here. *Id.*

328. They are: economic impact, investment-backed expectations, and the character of the government's invasion. *Id.* at 126.

329. *See, e.g., Franklin Mem'l Hosp.*, 575 F.3d at 129.

330. *Id.* at 124.

331. *Id.* at 127.

332. *See id.* at 128 ("FMH's investment-backed expectations are tempered by the fact that it operates in a highly regulated hospital industry.").

program that “adjust[s] the benefits and burdens of economic life to promote the common good.”³³³

By now it should be clear that these analyses completely misunderstand the Takings Clause. Although Franklin Memorial Hospital expressly argued that it was required to “give away its personal property,”³³⁴ and that it “must purchase and freely provide expensive medicines and medical supplies to low income patients,”³³⁵ the court responded that the hospital had the option to stop being a hospital.³³⁶ Such a non sequitur is puzzling at best. If the state commandeers my car, how does it help that I am still free to use my garage for something other than sheltering a car? They still took my car. At no point does the First Circuit take seriously the possibility that some of the alleged takings were of costly personal property.

And yet, that is precisely what happens in EMTALA cases. As argued above, EMTALA does not take (or regulate) bricks, mortar, and dirt—the real estate. Rather, it mandates per se takings: complete destruction of personal property such as pharmaceuticals and medical devices, and physical occupation of hospital spaces (ER, OR, ICU, inpatient beds). The Supreme

333. *Id.* at 128–29 (internal quotation marks omitted) (quoting *Penn Cent. Transp. Co. v. New York*, 438 U.S. 104, 124 (1978)).

334. *Id.* at 126.

335. *Id.*

336. *Id.* (“FMH is not required to serve low income patients; it may choose to stop using its property as a hospital, which makes it subject to Maine’s free care laws.”). The court compared the hospital’s option to that of the owner of a mobile home park in *Yee v. City of Escondido*, who had the option to stop renting land to mobile homes if he did not like the rent control to which his property was subjected. *Id.* at 126 (citing *Yee v. City of Escondido*, 503 U.S. 519, 527–28 (1992)); see Gary E. Jones, *Regulatory Takings and Emergency Medical Treatment*, 47 SAN DIEGO L. REV. 145, 178 (2010) (discussing the *Franklin Memorial* trial court and appellate court decisions). The trial court evinced an apparently greater grasp of the issue as it deemed the personal property to be an “investment” that the hospital made, but that such an investment had to have been made in the “expectation” that the hospital would be obliged to provide a significant amount of free care. *Franklin Mem’l Hosp. v. Harvey*, No. 07-125-B-S, 2008 WL 4416412, at *4 (D. Me. Sept. 24, 2008). Thus, the trial court discussed the personal property issue in the context of *Penn Central*’s “investment-backed expectations.” See *id.* at *4–9. The trial court’s analysis suffers from the same flaw as the other analyses: it presumes that this is about real estate, and that the proper analytic framework is as a regulatory taking. This, as discussed herein, is simply a misconstruction of the issue.

Court does not require that the entire property be invaded,³³⁷ nor that invaders be physically present at every moment of every day.³³⁸ Like other cases of eminent domain discussed here, the ever-present prospect of high-cost indigent emergency patients imposes a servitude or easement on the hospital, an “intermittent flood”³³⁹ of EMTALA patients.

Borrowing the Supreme Court’s own words in *Brown v. Washington Legal Foundation*, the whole EMTALA process resembles a “Robin Hood Taking”:

Perhaps we are witnessing today the emergence of a whole new concept in Compensation Clause jurisprudence: the Robin Hood Taking, in which the government’s extraction of wealth from those who own it is so cleverly achieved, and the object of the government’s larcenous beneficence is so highly favored by the courts (taking from the rich to give to indigent defendants) that the normal rules of the Constitution protecting private property are suspended. One must hope that that is the case. For to extend to the entire run of Compensation Clause cases the rationale supporting today’s judgment—what the government hath given, the government may freely take away—would be disastrous.³⁴⁰

VII. POLICY IMPLICATIONS: AN OMINOUS PREDICTION . . . AND A TWIST

We turn now to policy implications and a story of two statutes on a collision course.

A. EMTALA THE FIG LEAF

Over the years, the first statute, EMTALA, has become a “fig leaf” of sorts. As we rushed to help the poor soul who lies crushed and bleeding before our very eyes, it became easier to

337. *Loretto v. Teleprompter Manhattan Cable Television Corp.*, 458 U.S. 419, 438 (1982) (holding that the placement of cable boxes, wires, and bolts on part of the roof of a building constituted a physical invasion).

338. *Nollan v. Cal. Coastal Comm’n*, 483 U.S. 825, 831–32 (1987) (holding that the condition imposed on the approval of a rebuilding permit, which required owners to provide access for the public to pass over their land, constituted a physical invasion); *see also Jones, supra* note 336, at 179–80 (citing the *Nollan* case as holding that “mandated public access on a continued basis constitutes a physical occupation even if no one person has a right to remain on the premises”).

339. *See Ark. Game & Fish Comm’n v. United States*, 133 S. Ct. 511, 522 (2012) (holding that there can be a taking for a temporary but substantial invasion).

340. *Brown v. Legal Found. of Wash.*, 538 U.S. 216, 252 (2003) (Scalia, J., dissenting).

lose sight of the many ill-but-uninsured people whose names we never learned because they never appeared in emergency rooms. We have helped “identified lives” much more readily than “statistical lives,” even though the latter are far more numerous.³⁴¹ We have consoled ourselves in the knowledge that, even if someone could not go to a doctor, he could always go to the ER.

B. EMTALA THE ENABLER

Nearly a quarter-century after EMTALA the second statute was born. On March 23, 2010, President Barack Obama signed the ACA into law.³⁴² The law attempts to ensure near-universal health care coverage for citizens and legal residents.³⁴³ After constitutional challenges in four circuit courts,³⁴⁴ the U.S. Supreme Court largely upheld the ACA in June 2012, in *NFIB*.³⁴⁵

To render health insurance more affordable the ACA requires each state to have an “insurance exchange”³⁴⁶ that can marshal the buying power traditionally enjoyed by large businesses.³⁴⁷ Individuals and small business employees will be able to choose from a variety of options in that marketplace.³⁴⁸ Subsidies will be provided, on a sliding scale, to anyone between 100%–400% of the FPL.³⁴⁹ All health plans in the

341. The distinction between identified and statistical lives is discussed, for example, in Randall F. Moore, *Caring for Identified Versus Statistical Lives: An Evolutionary View of Medical Distributive Justice*, 17 *ETHOLOGY & SOCIOBIOLOGY* 379, 380–92 (1996).

342. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

343. See, e.g., 42 U.S.C. § 18032(a) (Supp. V. 2011).

344. These were the Fourth, Sixth, Eleventh, and D.C. Circuits. See Nat’l Fed’n of Indep. Bus. v. Sebelius (*NFIB*), 132 S. Ct. 2566, 2580–81 (2012).

345. The only portion the Court struck down was a provision requiring states to expand Medicaid coverage to cover all citizens up to 133% of the FPL. *Id.* at 2601–07. This portion was found to exceed Congress’ powers under the Spending Clause as applied to 42 U.S.C. § 1396c of the Medicaid Act. See *id.* at 2601–27.

346. 42 U.S.C. § 18031(b) (Supp. V 2011). If the state does not comply, 42 U.S.C. § 18041(c) requires that the federal government set up and operate the exchange in that state.

347. Cf. Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 *HEALTH AFF.* (Supp. 1) 24, 25 (1993).

348. Selections are to be assisted by “navigators.” See 42 U.S.C. § 18031(i).

349. 42 U.S.C. § 18071 (Supp. V 2011); *NFIB*, 132 S. Ct. at 2673.

exchange must cover “essential health benefits.”³⁵⁰ To ensure that plans are affordable even for those with preexisting conditions, the law requires both “guaranteed issue,” forbidding insurers to deny coverage to persons with preexisting conditions,³⁵¹ and “community rating,” precluding insurers from charging higher rates for these persons.³⁵²

These requirements on insurers could encourage healthy people to wait until they are ill or injured to buy insurance, thereby creating the classic economic problems of adverse selection. Accordingly, a third provision is an “individual mandate” requiring citizens and legal aliens to maintain minimum essential health insurance coverage.³⁵³ Anyone who declines to purchase insurance must pay a “shared responsibility payment”³⁵⁴ to the IRS, which “shall be assessed and collected in the same manner” as tax penalties.³⁵⁵ Although the Supreme Court held that the Mandate could not be sustained under the Commerce Clause,³⁵⁶ it was upheld under the Taxing and Spending Clause.³⁵⁷

And now the two statutes begin to clash. On one hand, the mandate’s penalty for noncompliance was upheld as a tax partly because, since it is considerably less costly than insurance, it could legitimately be dubbed a tax and not really a penalty.³⁵⁸ However, this very price difference can encourage healthy people to pay the tax rather than spend considerably more for insurance.³⁵⁹ Indeed, the Congressional Budget Office and the Joint Committee on Taxation estimated that some six million Americans—50% more than initially anticipated—will

350. 42 U.S.C. § 18022 (Supp. V 2011).

351. *NFIB*, 132 S. Ct. at 2613 (citing 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4(a) (2006)).

352. *Id.* (citing 42 U.S.C. § 300gg (Supp. IV 2010)).

353. 26 U.S.C. § 5000A (2012).

354. *Id.* § 5000A(b)(1).

355. *Id.* § 5000A(g)(1).

356. *NFIB*, 132 S. Ct. at 2585–91.

357. *Id.* at 2594–600.

358. *Id.* at 2595–96 (citation omitted) (“[F]or most Americans the amount due will be far less than the price of insurance, and, by statute, it can never be more. It may often be a reasonable financial decision to make the payment rather than purchase insurance, unlike the ‘prohibitory’ financial punishment in *Drexel Furniture*.”).

359. *See id.* at 2595–96.

opt to pay rather than play.³⁶⁰ This number could rise further. Smokers—currently about 20% of the adult population—can be charged up to 50% percent higher premiums, for instance, and age likewise can raise premiums.³⁶¹ Hence for a 55-year old smoker, the uptick in insurance premiums could reach over \$4000 per year.³⁶²

Moreover, a failure to pay the penalty-tax will not be treated as a crime, but rather will simply trigger a letter from the IRS stating that money is owed.³⁶³ The IRS is not permitted to place liens or levies on property to collect the tax.³⁶⁴ The Mandate is thus only minimally enforceable. Accordingly, the number of people choosing not to buy insurance could rise far beyond current estimates as the law is implemented.³⁶⁵

360. CONG. BUDGET OFFICE, PAYMENTS OF PENALTIES FOR BEING UNINSURED UNDER THE AFFORDABLE CARE ACT (2012), available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/09-19-12-Indiv_Mandate_Penalty.pdf; see also Russ Britt, *Six Million Will Pay Health Law Penalty: Study*, MARKET WATCH (Sept. 19, 2012), http://www.marketwatch.com/story/six-million-will-pay-health-law-penalty-study-2012-09-19?link=MW_latest_news (“Six million Americans . . . will end up paying a penalty for failing to have health insurance . . .”); Paige Winfield Cunningham, *CBO Raises Estimate of Those Hit by Obama Health Care Tax*, WASH. TIMES, Sept. 19, 2012, <http://www.washingtontimes.com/news/2012/sep/19/cbo-raises-estimate-those-hit-obama-health-care-tax/> (“[S]ix million Americans . . . are expected to pay a tax penalty . . .”).

361. Ricardo Alonso-Zaldivar, *Smokers May Not Be Able to Afford Obamacare*, SEATTLE TIMES, Jan. 25, 2013, http://seattletimes.com/html/health/2020208512_healthcaresmokersxml.html.

362. *Id.*

363. See 26 U.S.C. § 5000A(g)(2)(A) (2012).

364. *Id.* § 5000A(g) (instructing the Secretary on the tools he may use to collect the penalty); *id.* § 5000A(g)(2)(B) (prohibiting the Secretary from using notices of lien and levies); *NFIB*, 132 S. Ct. at 2584; see also 26 U.S.C. § 5000A(g)(2)(A) (barring criminal prosecutions). At most, the IRS can extract the penalty-tax from whatever tax refund is due the taxpayer, and the right to collect a given sum can extend over 10 years’ refunds. See Lisa Scherzer, *The Obamacare Penalty: Yes, It Can Be Avoided*, YAHOO FINANCE (Oct. 25, 2013), <http://finance.yahoo.com/news/does-the-obamacare-penalty-actually-have-teeth-144740030.html>. However, a taxpayer could in principle avoid much of the penalty-tax by adjusting the amount withheld each year so that she receives little or no refund at the end of the year.

365. See Philip Klein, *Higher Health Care Premiums Could Cause Obamacare to Death Spiral*, WASH. EXAMINER (Jan. 8, 2013), <http://washingtonexaminer.com/higher-health-care-premiums-could-cause-obamacare-to-death-spiral/article/2517939#.UPC-5o5BoeF> (predicting a “death spiral”).

Beyond this, many of those whose incomes are just a little too high to receive a government subsidy may be unable to afford coverage. Although employers with more than fifty employees must offer affordable coverage,³⁶⁶ the ACA defines "affordable" as costing no more than 9.5% of income.³⁶⁷ For someone earning \$21,000 per year, that figure could mean premiums of almost \$2000, not counting whatever else would be owed, for example, in a high annual deductible.³⁶⁸ It would not be surprising to find many such lower-income workers opting to forego health insurance in favor of other household expenses. Add next: undocumented immigrants, persons whose income is below the FPL in states that declined to expand Medicaid, and who thus are too poor to qualify for the insurance exchanges; and those who, though previously insured, can no longer afford suddenly costlier health plans that now include "essential health benefits."³⁶⁹

The temptation for relatively healthy people to forego health insurance grows because, after all, EMTALA assures emergency care and, per the ACA, someone who then discovers ongoing healthcare needs can buy insurance, with at most a ninety-day waiting period for full coverage.³⁷⁰ In essence, one can wait until the house is on fire before buying homeowner's insurance.

If enough healthy people refrain from buying it, insurance is likely to become significantly more costly. Indeed, as Justice Ginsburg pointed out in her opinion:

In the 1990's, several States—including New York, New Jersey, Washington, Kentucky, Maine, New Hampshire, and Vermont—enacted guaranteed-issue and community-rating laws without requiring universal acquisition of insurance coverage. The results were disastrous. "All seven states suffered from skyrocketing

366. See 42 U.S.C. § 18024(b) (Supp. V 2011).

367. Robb Mandelbaum, *It's the Affordable Care Act. But What Is Affordable?*, N.Y. TIMES (Aug. 12, 2013, 7:00 AM), http://boss.blogs.nytimes.com/2013/08/12/its-the-affordable-care-act-but-what-is-affordable/?_r=0.

368. See Ricardo Alonso-Zaldivar, *Obamacare Glitch Could Make Coverage Unaffordable For Low-Wage Workers*, HUFFINGTON POST (June 13, 2013), http://www.huffingtonpost.com/2013/06/13/obamacare-glitch-unaffordable_n_3435735.html?utm_hp_ref=business&ir=Business.

369. See *supra* Part II.B.

370. 42 U.S.C. § 300gg-7 (Supp. V 2011).

insurance premium costs, reductions in individuals with coverage, and reductions in insurance products and providers.”³⁷¹

If insurance costs thus rise, small businesses currently providing health coverage may decide instead to pay a penalty and send their workers to the Insurance Exchanges.³⁷² At that point workers who were previously insured will have the choice whether to buy insurance or to pay the penalty-tax. If a significant number of these people, too, forego insurance, the result will further erode the risk-shifting that is essential to a successful insurance market, and likely cause additional increases in the cost of health insurance.

The result could be a financial crisis threatening the viability of the ACA. In the process, EMTALA would stand as a key enabler by shielding millions of people from the immediate consequences of a decision to forego insurance. Although some people will be genuinely unable to afford insurance even with a subsidy, many others will forego it as a calculated risk-benefit decision. That decision is made easier by EMTALA’s guarantee that emergency needs will be met, regardless of ability to pay. Indeed, during the 2012 presidential election campaign, republican candidate Governor Mitt Romney’s criticism of the ACA emphasized that even the uninsured can count on

371. Nat’l Fed’n of Indep. Bus. v. Sebelius (*NFIB*), 132 S. Ct. 2566, 2614 (2012) (Ginsburg, J., concurring in part and dissenting in part) (citing Brief for American Association of People with Disabilities et al. as *Amici Curiae* at 9, Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012) (No. 11–398)); see also Brief for Governor of Washington Christine Gregoire as *Amicus Curiae* at 11–14, Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012) (No. 11–398) (discussing what happened in Washington when it had an individual insurance market).

372. *NFIB*, 132 S. Ct. at 2674 (joint opinion of Scalia, Kennedy, Thomas & Alito, JJ., dissenting):

The employer responsibility assessment provides an incentive for employers with at least 50 employees to provide their employees with health insurance options that meet minimum criteria Unlike the Individual Mandate, the employer-responsibility assessment does not require employers to provide an insurance option. Instead, it requires them to make a payment to the Federal Government if they do not offer insurance to employees and if insurance is bought on an exchange by an employee who qualifies for the exchange’s federal subsidies.

Id. (citation omitted). See also Stacy Cowley, *Dropping Health Plans, to Pick Better Coverage*, N.Y. TIMES, Dec. 11, 2013, <http://www.nytimes.com/2013/12/12/business/smallbusiness/changing-the-health-insurance-equation-for-small-employers.html?gwh=5CCEBFA6D882A54BD0D1BAF0458A3152>.

emergency care as a safety net.³⁷³ His remark echoed former President George W. Bush's statement that "people have access to health care in America. After all, you just go to an emergency room."³⁷⁴

C. THE TWIST: EMINENT DOMAIN TO REVITALIZE THE MANDATE

In closing, there is a twist. We cannot expect a health care system based on private insurance to survive if citizens are permitted to wait until the house is on fire to buy their home insurance, and then buy it for the same price as everyone else. At some point, if the ACA is to survive, the Mandate needs real teeth.³⁷⁵ This statement is not intended to endorse either the Mandate or the ACA, but simply to trace out the direct financial implications of the foregoing financial scenario and to identify an avenue that could, logically, meet the challenge.

So here is the twist. If Congress so chose,³⁷⁶ the insurance mandate could be implemented, not as an easily avoidable "tax,"³⁷⁷ but as a bona fide act of eminent domain. That is, the very same Fifth Amendment principles discussed above could be used, in a very different direction, to make sure that everyone is insured. A detailed explication is reserved for another occasion, but the basics are these:

373. See Andis Robeznieks, *Groups Criticize Romney Over Comment on Care for Uninsured*, MOD. HEALTH CARE (Sept. 24, 2012), <http://www.modernhealthcare.com/article/20120924/NEWS/309249951/groups-criticize-romney-over-comment-on-care-for-uninsured>; Elise Viebeck, *Romney: Uninsured Can Seek Care in ER*, THE HILL (Sept. 24, 2012, 12:07 PM), <http://thehill.com/blogs/healthwatch/politics-elections/251249-romney-uninsured-can-seek-care-in-the-er>; cf. Jeffrey Young, *Mississippi's GOP Governor Says No American Lacks Health Care*, HUFFINGTON POST (Jan. 23, 2013), http://www.huffingtonpost.com/jeffrey-young/phil-bryant-health-care-r_b_2534962.html (discussing a similar comment by Mississippi Governor Bryant).

374. Remarks to the Greater Cleveland Partnership and a Question-and-Answer Session in Cleveland, Ohio, 2007 WEEKLY COMP. PRES. DOC. 920, 922 (July 10, 2007).

375. This Article offers no opinion regarding whether it would be good, or not good, to preserve the ACA. Rather, the point is simply that Community Rating plus Guaranteed Issue are financially unsustainable in the absence of some sort of mandate ensuring that enough people will buy insurance to spread risk adequately.

376. Such a choice is admittedly quite unlikely, but the exercise has interest, given the potential financial challenges if insurance costs spiral upward as described.

377. See *supra* notes 363–65 and accompanying discussion.

(1) The public use: preserving the viability of a health care system financed by individual insurance policies;

(2) The property to be taken: the individual person's money;³⁷⁸

(3) The just compensation: a health plan for that individual—one that includes all the essential health benefits required by the ACA.³⁷⁹

Of particular interest, this approach to the ACA's mandate, unlike the current version, would not have to pass muster under either the Commerce Clause³⁸⁰ or the Taxing and Spending Clause.³⁸¹

As recently as 2005 the Supreme Court re-emphasized that, when it comes to government exercises of eminent domain, the courts will be highly deferential under a rational basis review.³⁸² In *Kelo v. City of New London*³⁸³ the Court was asked to determine whether a legislatively mandated transfer of land from one private party to another comported with the Constitution's requirement that a taking be for public use.³⁸⁴

378. See *Brown v. Legal Found. of Wash.*, 538 U.S. 216, 220, 240 (2003); *Phillips v. Wash. Legal Found.*, 524 U.S. 156, 160 (1998); *Webb's Fabulous Pharmacies, Inc. v. Beckwith*, 449 U.S. 155, 164 (1980). These cases show us that money has long been deemed a type of property for purposes of the Takings Clause. Here, the amount of money would be determined, per the ACA, according to the person's wealth, with sliding-scale assistance for those between "100 and 400 percent" of the FPL. See *Nat'l Fed'n of Indep. Bus. v. Sebelius (NFIB)*, 132 S. Ct. 2566, 2673 (2012).

379. See 42 U.S.C. § 18022 (Supp. V 2011). Although it would be somewhat unusual to provide something other than money as compensation under the Takings Clause, nothing prevents the use of a monetary equivalent such as a health plan to serve as the compensation afforded to the individual from whom property has been taken. The only requirement is that it be "just" under the Fifth Amendment. Moreover, in a strong sense the compensation is still monetary, albeit with strings: the citizen whose money has been taken would be given, in essence, a monetary-equivalent voucher that can be "spent," albeit only in one marketplace, namely the health insurance market as the person chooses from available health plans. See *id.* §18022(d) (identifying the ACA's tiered levels of coverage).

380. U.S. CONST. art. I, § 8, cl. 3.

381. U.S. CONST. art. I, § 8, cl. 1; *NFIB*, 132 S. Ct. 2594–600 (holding that the ACA's "mandate" to purchase health insurance was not constitutionally sustainable under the Commerce Clause, but that the "penalty" for failing to buy insurance could be upheld as a tax).

382. *Kelo v. City of New London*, 545 U.S. 469, 490 (2005) (Kennedy, J., concurring).

383. *Id.* at 469.

384. *Id.* at 472.

“Without exception, our cases have defined that concept broadly, reflecting our longstanding policy of deference to legislative judgments in this field.”³⁸⁵ The Court’s scope of review for eminent domain is thus limited.³⁸⁶ “When the legislature’s purpose is legitimate and its means are not irrational, our cases make clear that empirical debates over the wisdom of takings—no less than debates over the wisdom of other kinds of socioeconomic legislation—are not to be carried out in the federal courts.”³⁸⁷ This deference extends to Congress.³⁸⁸

In the final analysis, several competing factors must somehow be reconciled. Surely those who are emergently ill or injured should receive care, without delaying for financial

385. *Id.* at 480. The Court went on to cite *Berman v. Parker*, 348 U.S. 26 (1954), *Hawaii Housing Authority v. Midkiff*, 467 U.S. 229 (1984), and other cases affirming judicial deference to legislative decisions. See *Kelo*, 545 U.S. at 480–82.

386. *Id.* at 484.

387. *Id.* at 488 (internal quotation marks omitted) (citing *Haw. Hous. Auth.*, 467 U.S. at 242–43). The Court also wrote:

Viewed as a whole, our jurisprudence has recognized that the needs of society have varied between different parts of the Nation, just as they have evolved over time in response to changed circumstances. Our earliest cases in particular embodied a strong theme of federalism, emphasizing the “great respect” that we owe to state legislatures and state courts in discerning local public needs.

Id. at 482. Prior decisions were equally clear:

This Court has declared that a taking should be upheld as consistent with the Public Use Clause, U.S. Const., Amdt. 5, as long as it is “rationally related to a conceivable public purpose.” . . . This deferential standard of review echoes the rational-basis test used to review economic regulation under the Due Process and Equal Protection Clauses . . .

Id. at 490 (Kennedy, J., concurring) (internal citations omitted).

388. See *Ruckelshaus v. Monsanto Co.*, 467 U.S. 986, 1014 (1984) (“So long as the taking has a conceivable public character, ‘the means by which it will be attained is . . . for Congress to determine.’” (alteration in original) (internal citation omitted)).

Subject to specific constitutional limitations, when the legislature has spoken, the public interest has been declared in terms well-nigh conclusive. In such cases the legislature, not the judiciary, is the main guardian of the public needs to be served by social legislation, whether it be Congress legislating concerning the District of Columbia . . . or the States legislating concerning local affairs Once the object is within the authority of Congress, the right to realize it through the exercise of eminent domain is clear. For the power of eminent domain is merely the means to the end.

Berman v. Parker, 348 U.S. 26, 32–33 (1954) (citations omitted).

questions that should be addressed later.³⁸⁹ At the same time, the Constitution forbids this public burden to be foisted on a limited number of private parties.³⁹⁰

The remedy is not at all clear, nor does this Article purport to show the way. Suffice it to say, if somehow we succeed in broadening insured access to care for a much larger proportion of our citizens, it will follow that far fewer instances of EMTALA care will be uncompensated and thereby unconstitutional. The Catch-22 challenge is that EMTALA may, itself, obstruct that path by continuing to encourage people to avoid becoming insured.

Stay tuned . . . the conversation is likely to become quite interesting.

389. See 42 U.S.C. § 1395dd (2006 & Supp. V 2011).

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