A-16-24

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Plaintiffs-Petitioners,

COOPER UNIVERSITY HOSPITAL; HACKENSACK MERIDIAN HEALTH PASCACK VALLEY MEDICAL CENTER; JFK MEDICAL CENTER; OUR LADY OF LOURDES MEDICAL CENTER; LOURDES MEDICAL CENTER OF BURLINGTON COUNTY; HACKENSACK MERIDIAN HEALTH MOUNTAINSIDE MEDICAL CENTER,

Plaintiffs

v.

SUPREME COURT OF NEW JERSEY
DOCKET NO. 089696 (A-16-24)

On Appeal From:
SUPERIOR COURT OF NEW JERSEY APPELLATE DIVISION
DOCKET NO. A-2767-21

Sat Below:
Hon. Lisa Rose, J.A.D.
Hon. Morris G. Smith, J.A.D.
Hon. Lisa Perez Friscia, J.A.D.

# PLAINTIFFS-PETITIONERS' BRIEF IN RESPONSE TO JOINT BRIEF OF *AMICI CURIAE* LEGAL SERVICES OF NEW JERSEY & DISABILITY RIGHTS NEW JERSEY

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SUPREME COURT
OF NEW JERSEY

THE STATE OF NEW JERSEY; THE STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES; SARAH ADELMAN IN HER CAPACITY AS COMMISSIONER OF THE DEPARTMENT OF HUMAN SERVICES; THE STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES; MEGHAN DAVEY IN HER CAPACITY AS DIRECTOR OF THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES; STATE OF NEW JERSEY, DEPARTMENT OF HEALTH; DR. KAITLAN BASTON IN HER CAPACITY AS COMMISSIONER OF THE DEPARTMENT OF HEALTH

Defendants-Respondents.

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## PROCEDURAL HISTORY AND STATEMENT OF FACTS

Petitioners (the "Hospitals") incorporate by reference the procedural histories and statements of facts set forth in their other submissions, adding that by Order of March 13, 2025, the Court granted leave for Legal Services of New Jersey and Disability Rights New Jersey to submit a joint amicus brief. That Order provided that the parties, including the Hospitals, could submit a brief in response on or before March 24, 2025.

## LEGAL ARGUMENT

### POINT I

### COUNTERBACKGROUND STATEMENT

The joint amicus brief submitted by Legal Services of New Jersey and Disability Rights New Jersey has a section entitled Background. [Ab-4 to 18.] While detailed, some aspects of this Background statement are incomplete or misleading.

The State of New Jersey has long promised its citizens that basic healthcare services will be available. The fulfillment of that promise, however, has not yet been realized. Amici describe in detail the importance of having health care available to our communities and for poor and uninsured individuals. This is not a proposition that is in dispute or controversial. In support of the partial summary judgment motion, the Hospitals had submitted the medical and healthcare administrative report of Louis D'Amelio, M.D. [Pa-458 to 469.] Dr. D'Amelio explained:

> Charity Care and Medicaid patients have poor social determinants of health including malnutrition, inadequate shelter, psychosocial problems and substance abuse. Most significantly, they lack access to primary and preventive care. This is most evident with chronic conditions such as diabetes or hypertension, lack of preventive care results in delay in diagnosis and treatment. This, in turn, culminates in emergency presentations with advanced stages of illness. The cycle continues with worse outcomes and higher cost of care.
>
> ...
>
> The deleterious impact of inadequate health coverage is not limited to emergency conditions. Women without insurance do not receive screening for breast cancer to the same extent as those who are insured. They present at advanced stages of malignancy. ... Uninsured patients and those covered by Medicaid presented with more advanced disease than did privately insured patients. Survival was worse for uninsured patients and those with Medicaid coverage than for privately insured patients with local disease and regional spread. The adjusted risk of death was 49 percent higher for uninsured patients and 40 percent higher for Medicaid patients than for privately insured patients. ... The medical literature is replete with current citations that uninsured and Medicaid cancer patients present with more advanced disease and worse outcomes. [Pa-465 to 467 (citations omitted).]

Earlier in his report, Dr. D'Amelio observed:

> All New Jersey hospitals have historically provided care to unfunded and underfunded patients without legal compulsion. Such care rendered in accordance with the traditional medical ethic, allows hospitals discretion to consider their capabilities and resources so as to provide the greatest good to the greatest number of people. In contrast, the requirement legally mandated by the Take All Comers Statute is without any limit on the amount of care to be provided or a hospital's ability to provide the care. Stated another way, under this law, a hospital must take all comers at all times at any cost. [Pa-458.]

In various legislative pronouncements over decades in the latter part of the 20th Century, the State of New Jersey has declared it to be "the public policy of the State that hospital and related health care services of the highest quality, of

demonstrated need, efficiently provided and properly utilized at a reasonable cost are of vital concern to the public health." P.L. 1971, ch. §1; P.L. 1978, ch. 83, §1. Contrary to the suggestion by Amici [Ab-16], neither of these enactments established a program of charity care. The term "charity care" is not used in the statute. Rather the Legislature addressed "uncompensated care," which it defined as "inpatient and outpatient care provided to medically indigent persons and bad debt." P.L. 1986, ch. 204, §2(g). This 1986 legislation established the Uncompensated Care Trust Fund pursuant to which all payers of healthcare services would share in payment for uncompensated care. The Legislature proceeded to declare that

> access to quality health care shall not be denied to residents of the State because of their inability to pay for the care; there are many residents of the State who cannot pay for needed hospital care and **in order to ensure that these persons have equal access to hospital care it is necessary to establish a mechanism which will ensure payment of uncompensated hospital care; to protect the fiscal solvency of the State's general hospitals**. [Id. §1 (emphasis added).]

This approach was fortified with P.L. 1989, ch. 1, §1a which stated that it was "necessary that all payers of health care services share equally in the payment of uncompensated care on a Statewide basis" so that quality health care would not be denied to New Jersey residents because of their inability to pay for the care, especially those with incomes below the federal poverty level, and to protect the fiscal solvency of the State's general hospitals. It was reiterated in P.L. 1991, ch. 187, §1.

With the 1978 legislation, known in the industry as Chapter 83, the State implemented not only certificate of need requirements concerning health planning but also a rate-setting system. This was thought to be "a way both to control rising costs and to provide access to health care for the uninsured." Kevin G. Volpp & Bruce Siegel, State Model: New Jersey. Long-Term Experience With All-Payer State Rate Setting, 12 Health Affairs 59, 59 (1993). The cost of uncompensated care was an "allowable financial element" to be used in the rate-setting process. Id. These authors, which included the then current Commissioner of Health, wrote:

> It was believed that without equity among payers and the explicit recognition of bad debt and charity care, large-scale cost shifting would result in an untenable position for disenfranchised patients and for the hospitals that treated them, as well as for commercial payers, who were bearing an increasing share of these costs through rising hospital charges. [Id.]

Accordingly, New Jersey had created "a state-operated system of rate regulation that encompasses all payers and all hospitals while **assuring that these hospitals receive reimbursement for all uncompensated care.**" Bruce Siegel, Anne Weiss & Dianne Lynch, Setting New Jersey Hospital Rates: A Regulatory System Under Stress, 14 U. Puget Sound L. Rev. 601, 601 (1991) (emphasis added).

This Court took notice that in establishing payer reimbursement rates, the Legislature directed that there be consideration of "the costs involved in providing health care to indigent patients" and that with the Uncompensated Care Trust Fund, "through the equitable collection and distribution of monies generated by increasing

the rates charged to payers at all New Jersey hospitals, seeks to spread the costs of indigent health care across the state." Saint Barnabas Med. Ctr. v. Cty. of Essex, 111 N.J. 67, 76 (1988). This is distinctively different than the current Charity Care Program which places the burden of uncompensated care – charity care – squarely on hospitals alone with no assurance that even the basic costs of providing the care will be recovered.

The functioning of Chapter 83 and the Uncompensated Care Trust Fund was challenged by a group of unions claiming that surcharges for charity care placed on hospital bills paid by the self-insured health and welfare funds forced them to pay for health care for people who were not union members. This was alleged to be an unconstitutional taking and a violation of ERISA. United Wire, Metal & Mach. Health & Welfare Fund v. Morristown Mem'l Hosp., 793 F. Supp. 524 (D.N.J. 1992), aff'd in part, rev'd in part, 995 F.2d 1179 (3d Cir. 1993). The District Court ruled that ERISA preempted Chapter 83 but rejected the takings claim as involving only money and not property. 793 F. Supp. at 536, 540. The Third Circuit affirmed the takings ruling but held that Chapter 83 did not trigger ERISA preemption. 995 F.2d at 1190-91.

By the time the appeal was concluded, however, Chapter 83 was dismantled and the Legislature had deregulated health care with the elimination of rate-setting and the enactment of the Health Care Reform Act of 1992. In P.L. 1992, ch. 160, the

Legislature adhered to its declaration of the "paramount public interest for the State to take all necessary and appropriate actions to ensure access to and the provision of high quality and cost-effective hospital care to its citizens" and declared that "[a]ccess to quality health care shall not be denied to residents of this State because of their inability to pay for the care." Id. §1. In light of this public interest, the Legislature deemed it "necessary to provide disproportionate share hospitals with a charity care subsidy supported by a broad-based funding mechanism."

Stated more directly, the responsibility for health care for those who cannot pay for it is a societal obligation to be discharged by the State of New Jersey and not shouldered exclusively by the State's hospitals.

There is a perception that non-profit hospitals have an obligation to provide charity care because of their tax-exempt or preferential tax treatment status. That is a misconception. Federal tax exemption, while beneficial to hospital organizations, is not predicated on a hospital providing charity care.

The Federal law standard for exempt organizations requires the entity to be organized and operated exclusively for religious, charitable, and scientific purposes. In 1956, the IRS published Revenue Ruling 56-185, which for the first time set forth affirmative requirements which a nonprofit hospital had to meet in order to qualify for charitable exemption under section 501(c)(3). Douglas M. Mancino, Income Tax Exemption of the Contemporary Nonprofit Hospital, 32 St. Louis U. L.J. 1015, 1040

(1988). It required that to obtain or maintain its tax-exempt status, a nonprofit hospital, "must be operated to the extent of its financial ability for those not able to pay for the services rendered, and not exclusively for those who are able and expected to pay." This standard was changed, however, with the publication of Revenue Ruling 69-545, which modified the prior Revenue Ruling "to remove therefrom the requirements relating to caring for patients without charge or at rates below cost" to qualify for the federal tax exemption. Rev. Rul. 69-545, 1969-2 C.B. 117 (1969). Rather, it set forth a "community benefit test" for determining whether a nonprofit hospital is operated to serve a public rather than private interest and thus qualifies for tax-exempt status as a 501(c)(3) charitable organization. The community benefit test is "a flexible . . . test based upon a variety of indicia." Geisinger Health Plan v. C.I.R., 985 F.2d 1210, 1217 (3rd Cir. 1993). While providing free care to indigents may satisfy the community benefit test, the standard can be met in numerous other ways including, but not limited to, "serving those who pay their bills through public programs such as Medicaid or Medicare." Id. "Hospitals are not required to provide any specified level of free or below-cost medical care in order to qualify for tax exempt status." McCoy v. East Texas Medical Center Regional Healthcare System, 388 F.Supp.2d 760, 769 (E.D. Tex. 2005).

Tax exempt hospitals annually file I.R.S. Form 990, including Schedule H to demonstrate they meet the enhanced community benefit standard. The non-profit tax-exempt Hospitals are in compliance with federal exempt organization law.

Similarly, the provision of charity care is not a *quid pro quo* for state tax exemption. Presbyterian Home at Pennington, Inc. v. Pennington Borough, 409 N.J. Super. 166, 184 (App. Div. 2009), certif. denied, 201 N.J. 143 (2010). The court stated there is "no basis in either the plain language of the statute or its legislative history to impose an additional charitable [sic] component." 409 N.J. Super. at 185. Indeed, from the inception of the exemption statute "hospital purposes were distinguishable from charitable ones and countenanced the value of each as worthy of exemption from taxation." Id. at 188. Rather, the statutory criteria for tax exemption in the State of New Jersey is that the non-profit be organized and operated for charitable, educational and scientific purposes and no part of the net earnings inures to the benefit of private persons. N.J.S.A. 54:4-3.6. The non-profit Petitioner Hospitals are in compliance with state requirements.

Amici invoke the Hill-Burton Act, which provided federal funding for construction of community hospitals starting in 1947, as a precedent for an obligation by hospitals to serve the public good by providing free or reduced cost care. [Ab-17 to 18]. The Hill-Burton Act required that a hospital receiving federal construction funding must "furnish needed services for persons unable to pay

therefor," 42 U.S.C.A. § 291c(e), until the loan amounts were repaid or for a twenty-year period. Lile v. Univ. of Iowa Hosps. & Clinics, 886 F.2d 157, 158 (8th Cir. 1989). In exchange for the construction funding, the hospitals provided the free care. Cook v. Ochsner Found. Hosp., 559 F.2d 968, 972 (5th Cir. 1977). This has nothing to do with tax exempt status and is irrelevant in the circumstances of this case. None of the Hospitals have obligations under the Hill-Burton Act. The only general hospital in New Jersey that is obligated under the Act is Jersey City Medical Center. https://www.hrsa.gov/get-health-care/affordable/hill-burton/facilities.

Finally, in their brief, Amici state that "nowhere in their complaint do the hospitals elaborate on the basis for these costs (i.e., whether 'costs' denote out-of-pocket expenditures, Medicaid reimbursement rates, full sticker price, or perhaps another measure." [Ab-2 to 3]. While such information may not have been in the Hospitals' Complaint, it is clearly set forth in the expert reports in the record before this Court. [Pa510-Pa647]. "Costs" refer to the "expenses, whether direct or indirect, incurred by a provider or hospital to deliver healthcare services to a patient." [Pa514]. The costs are developed using "the cost apportionment methodology, and the cost per diem and ratio of cost-to-charge ("RCC") methodologies" developed and adopted by the Medicare program. [Pa515]. Thus, "costs" refer to the actual expenses incurred in providing services to charity care patients, without regard to any profit the Hospitals might otherwise be entitled to.

## POINT II

## UNDER NEW JERSEY LAW, THE HOSPITALS RETAIN A RIGHT TO EXCLUDE IN THEIR BUNDLE OF PROPERTY RIGHTS. THE ANALYSIS UNDER CEDAR POINT NURSERY IS FULLY APPLICABLE.

Amici argue that the principles concerning *per se* physical takings in Cedar Point Nursery v. Hassid, 594 U.S. 139 (2021) are inapplicable because the property rights of New Jersey hospitals do not include the right to exclude patients. That is a grossly exaggerated statement. To begin with, this proposition was not accepted or employed by the Appellate Division. It explicitly stated: "Unlike the cable installation law in Loretto v. Teleprompter Manhattan CATV Corp., 458 U.S. 419 (1982)], N.J.S.A. 26:2H-18.64 does not limit the right to exclude individuals from their premises." [App Div Op at 19.] The Attorney General embraced that ruling in its opposition to the Petition for Certification. [DLb-9.] In its supplemental brief, the Attorney General acknowledged a somewhat modified position that "to be clear, charity care does not disturb hospitals' right to exclude for reasons unrelated to nonpayment." [DSb-25.]

But more fundamentally, the proposition advanced by Amici ignores the common law concerning hospitals and the right of a patient to medical treatment. Hospitals have a common law right to exclude individuals from their premises. In McDonald v. Massachusetts General Hospital, 120 Mass. 432, 435 (Mass. 1876), the

court stated that "no person has individually a right to demand admission" to a hospital. There is substantial case law and academic writings supporting the recognition of this common law right to exclude. See e.g., Van Campen v. Olean Gen. Hosp., 205 N.Y.S. 554, 558 (N.Y. App. Div. 1924), aff'd, 147 N.E. 219 (N.Y. 1925); Birmingham Baptist Hosp. v. Crews, 157 So. 224, 225 (Ala. 1934); Costa v. Regents of Univ. of Cal., 254 P.2d 85, 95 (Cal. App. 1953); Le Juene Rd. Hosp., Inc. v. Watson, 171 So. 2d 202, 203 (Fla. Dist. Ct. App. 1965) ("[A] private hospital is under no obligation to admit any patient that it does not desire. Harsh as this rule may sound, it is permissible for a private hospital to reject for whatever reason, or no reason at all, any applicant for medical and hospital services."); Fabian v. Matzko, 344 A.2d 569, 571 (Pa. Super. 1975) ("Although never considered by a Pennsylvania appellate court, the general rule in other jurisdictions is that a private hospital is under no duty to accept patients that it considers undesirable and it may reject or accept patients for admission as it sees fit."); Walling v. Allstate Ins. Co., 455 N.W.2d 736, 738 (1990) ("The original rule at common law was that a private hospital did not have a duty to treat any patient not accepted by it.")

Under the common law, physicians also had the right to refuse to provide care for any reason. In Hurley v. Eddingfield, 59 N.E. 1058 (Ind. 1901), the court stated that having obtained a state license – that is, permission – to practice medicine, "the State does not require, and the licensee does not engage, that he will practice at all

or on other terms than he may choose to accept." To similar effect is Buttersworth v. Swint, 186 S.E. 770, 772 (Ga. App. 1936). The consensual nature of the physician-patient relationship before there is a duty to treat has long been recognized in New Jersey law. Young v. Crescente, 132 N.J.L. 223, 227 (E.&A 1944); see also Velazquez v. Jiminez, 172 N.J. 240, 248 (2002). Although Amici refer to the Code of Medical Ethics promulgated by the American Medical Association found in 1847 as recognizing a physician's duty to provide free care [Ab-15], they do not recognize or acknowledge that the series of AMA codes of ethics promulgated since 1912 have had a provision that "except in emergencies," a physician is "free to choose whom to serve and the environment to render service." Chalmers C. Clark, In Harm's Way: AMA Physicians and the Duty to Treat, 30 J. Med. & Phil. 65 (2005).

Academic writers have explained the origins of this common law right to exclude and refuse to treat. As stated in Jane Reister Conard, Granny Dumping: The Hospital's Duty to Care to Patients Who Have Nowhere to Go, 10 Yale L. & Pol'y Rev. 463 (1992):

> Common law imposes no explicit duty upon physicians or hospitals to rescue or treat those in need of emergency care. The "no-duty" rule arises from tort theory which distinguishes between nonfeasance and malfeasance. Nonfeasance, or failure to provide care, normally will not trigger liability. [Id. at 457.]

To similar effect are Leonard S. Powers, Hospital Emergency Service and the Open Door, 66 Mich. L. Rev. 1455, 1459 (1968); Karen Rothenberg, Who Cares?:

The Evolution of the Legal Duty to Provide Emergency Care, 26 Hous. L. Rev. 21, 25 (1989); James P. McHugh, Emergency Medical Care for Indigents: All Hospitals Must Provide Stabilizing Treatment or Pay the Price, 93 W. Va. L. Rev. 165, 168 (1990).

A germane comment appears in Levin v. Sinai Hosp. of Baltimore City, 46 A.2d 298, 301 (Md. 1946), where the court stated: "A private hospital is not under a common law duty to serve everyone who applies for treatment or permission to serve. **In the absence of statute**, it may accept some applicants and reject others." (Emphasis added.) The mandate in N.J.S.A. 26:2H-18.64 to not deny care based on the ability to pay is such a statute. To reiterate what the Hospitals have been saying throughout this litigation: they are not challenging the obligation to provide care as within the police power of the State. But a duty to treat is not the equivalent of an obligation to treat without just compensation and it does not eliminate the right to exclude.

This Court has recognized a property owner's right to exclude as one of the most fundamental elements in the bundle of rights recognized as "property." See, e.g., Gardner v. New Jersey Pinelands Comm'n, 125 N.J. 193, 215 (1981). The seminal New Jersey Supreme Court decisions cited by Amici of State v. Shack, 58 N.J. 297 (1971), Doe v. Bridgeton Hosp. Ass'n, 71 N.J. 478 (1976), cert. denied, 433 U.S. 914 (1977), and Uston v. Resorts International Hotel, Inc., 89 N.J. 163 (1982)

**limit** the exercise of a property owner's fundamental right to exclude but **do not eliminate** that right.

The overreading and distortion of the effect of Stack, Uston, and Doe by Amici is readily demonstrated.

In State v. Shack, a Legal Services staff attorney and a field worker for a non-profit organization providing health services to migrant workers sought to meet with a migrant farm worker at a camp site owned by the employer. The migrant worker needed medical aid for the removal of 28 sutures. The owner's offer to locate the worker was declined as the attorney and field worker wanted to go on to the property themselves. As a result of this confrontation, a criminal trespass complaint was filed by the owner. 58 N.J. at 300-01. The Court began its analysis with this statement: "Property rights serve human values. They are recognized to that end, and are limited by it." Id. at 303. The Court limited the traditional common law property rights of owners to exclude by holding that trespass as defined in the New Jersey statute did not include the right to bar access to governmental services to migrant workers housed on private property. Id. at 307-08. But more importantly in the context of the Hospitals' takings claim, the Court did not require the property owner to provide or pay for the medical care that the migrant worker needed.

It further stated:

> A man's right in his real property of course is not absolute. It was a maxim of the common law that one should so use his property as not to injure the rights of others. ... Although hardly a precise solvent of actual controversies, the maxim does express the inevitable proposition that rights are relative and there must be an accommodation when they meet. Hence it has long been true that necessity, private or public, may justify entry upon the lands of another. [Id. at 305.]

The ruling in Shack is fully consistent with Cedar Point Nursery and its recognition of "background principles of property law" that limit the scope of physical takings arising from a governmental requirement for access to private property. As Chief Justice Roberts wrote: "[M]any government-authorized physical invasions will not amount to takings because they are consistent with longstanding background restrictions on property rights. ...These background limitations also encompass traditional common law privileges to access private property." 594 U.S. at 160-61. See also State v. Dargon, 165 N.J. Super. 500, 501 (App. Div. 1978) (contention that defendants cannot be guilty of trespass because the hospital building is quasi-public in nature and defendants initially entered the premises for legitimate purposes rejected as "without merit.")

The Court refined the application of the Shack no-trespass rule in State v. Schmidt, 84 N.J. 535 (1980). The Court adopted a multi-part test that restricted the trespass offense depending on the nexus between the nature of the property and expressional activity. Although made in the context of free expression, the first two standards reflected in this ruling are germane here. These include assessing (1) the

nature, purposes, and primary use of such private property, generally, what constitutes its "normal" use, (2) the extent and nature of the public's invitation to use that property as not necessarily involving unfettered access to an entire property, and (3) the purpose of the expressional activity undertaken upon such property in relation to both the private and public use of the property. [Id. at 563.] This multi-faceted test can be applied to recognize the distinction between the public space to which access is allowed and the non-public areas in a hospital where access is not allowed without specific permission. The Court emphasized that even when important rights of speech, assembly, petition for redress and the like are involved, "private property itself remains protected under due process standards from untoward interference with or confiscatory restrictions upon its reasonable use. ... The constitutional protection of private property against undue interference or 'taking' is secured by our own Constitution." Id. at 561.

Likewise, Amici misread the Uston decision in which the Court held that a casino operator could not exclude from the blackjack table an individual who used card counting to increase his chances of winning. In Uston, the casino owner claimed "that it could exclude [the card counter] because it had a common law right to exclude anyone at all for any reason." 89 N.J. at 170. The court rejected this claim and held that property owners have "no right to exclude people unreasonably" when they otherwise "open their premises for public use." Id. at 173. However, while

concluding that both Resorts and the Casino Commission had incorrectly interpreted the impact of the Casino Control Act, the Court emphasized that "the act has **not completely divested** Resorts of its common law right to exclude." Id. at 170 (emphasis added). It added that "[w]hether a decision to exclude is reasonable must be determined from the facts of each case." Id. at 174.

Amici assert that Uston "makes clear that under New Jersey law, businesses can't exclude members of the public simply because they know they will not make money from them (and even if they know they will lose money)." [Ab-25.] They make this assertion without pointing to any particular passage in the opinion. Moreover, it is an inaccurate description of the process of card counting in the game of Blackjack or 21. Card counters keep track of the playing cards as they are dealt and adjust their betting patterns when the odds appear to be in their favor. Hoagburg v. Harrah's Marina Hotel Casino, 585 F. Supp. 1167, 1170 n. 4 (D.N.J. 1984). Even assuming one has skill as a card counter, however, the element of chance remains. A skilled card counter appears to have a 0.5% to 1.5% advantage over the house but with a decrease in that small advantage if multiple decks are used or the pack of cards are reshuffled. Anthony Cabot & Robert Hannum, Advantage Play and Commercial Casinos, 74 Miss. L.J. 681, 693 (2005). There is no assurance such a customer will not lose, let alone that the customer will win with such regularity that the casino knows that it will not make money and will even lose money.

The Court clearly identified limits on the scope of the Uston open-to-the-public approach in Marzocca v. Ferone, 93 N.J. 509 (1983). It pointed to the earlier decision in Garifine v. Monmouth Park Jockey Club, 29 N.J. 47 (1959), in which the Court had held that the owner of a racetrack had a common law right of exclusion that was unimpaired by the Civil Rights Act so long as the exclusion was not based on race, creed, color, national origin or ancestry. It found "no force" in the contention that the defendant had no right to exclude "because as a licensee 'it has secured the advantage of a State monopoly.'" Id. at 56-57. In the current case before it, which also involved a racetrack having excluded a horse owner from racing at the Freehold Raceway, the Appellate Division relying on Uston held that the racetrack no longer had an unfettered right to exclude. The Court "disagree[d] with that holding in the factual context of this case." 93 N.J. at 515. It also disagreed that Uston had overruled Garifine sub silentio. Id. at 512. In Garifine, the right of exclusion had been applied to a patron suspected of being a bookmaker and was not based on race, creed, color, national origin or ancestry. In Marzocca, the Court described a comment in Uston as *dicta* that the common law right of an amusement owner to exclude unwanted patrons was not absolute in light of the competing interest of the patron in reasonable access to the premises once the property owner has opened them for public use. Parting company with the Appellate Division, it held that "the racetrack's **common law right to exclude exists** in the context of this case."

Marzocca, 93 N.J. at 516. It stated that the ruling in Uston "was not intended to reach beyond concerns for the general public." Id. The Appellate Division had incorrectly added the bracketed material in this quoted passage from Uston: "'[p]roperty owners have no legitimate interest in unreasonably excluding particular members of the public [*and, inferentially, those otherwise entitled to use the public facilities*] when they open their premises for public use.'" The Court responded: "We do not draw the inference suggested by the court below." 93 N.J. at 517. It clarified that the ruling only "limit[ed] the common law doctrine by proscribing exclusions that violate public policy." Id.

The last case relied on by Amici is Doe v. Bridgeton Hospital Association. Two women and their physicians, who were on staff at the defendant hospitals, sought to compel the hospitals to make their facilities available for elective abortions during the first trimester. The hospitals had the facilities to perform therapeutic abortions with the same type of equipment and facilities that would be used for elective abortions. 71 N.J. at 483-84. The Court invoked the principle established in Greisman v. Newcomb Hosp., 40 N.J. 389, 403-04 (1963) that institutions such as hospitals were quasi-public entities with an obligation to serve the public good. Accordingly, it refused to permit property rights to interfere with a woman's right to reproductive choice, holding that a private non-sectarian hospital could not refuse on moral grounds to permit its facilities to be used for abortions. 71 N.J. at 489-90.

In both Griesman and Doe, the Court used the common law obligations of an innkeeper to illustrate the nature, scope, and limitations that were applicable. 40 N.J. at 397; 71 N.J. at 487-88. An innkeeper "was bound by common law to receive and lodge all comers in the absence of a reasonable ground of refusal. ... A valid refusal had to be related to the inn's operations as an inn."

There is nothing in the common law obligation of an innkeeper or the "public calling" doctrine used in Griesman that allowed a visitor to go into non-public areas or receive lodging and food for free. Notwithstanding a hospital's responsibilities to refrain from arbitrary and unreasonable actions, nothing in Greisman or Doe precludes the invocation of the analogy to an innkeeper at common law in the circumstances of this matter.

Furthermore, in Griesman, while analyzing the application of the common law to regulation of private businesses and professions for the common good through the analogy to innkeepers and common carriers, the Court referred to the early case of Messenger v. Pennsylvania R. Co., 37 N.J.L. 531 (1874), which emphasized the need to avoid discrimination in the availability of the service while preserving the right to be compensated for it:

> Many considerations may properly enter into the agreement for carriage or the establishment of rates, such as the quantity carried, its nature, risks, the expense of carriage at different periods of time, and the like; but he has no right to give an exclusive advantage or preference, in that respect, to some over others, for carriage, in the course of his business. For a like service, the public are entitled to a like price. [Id. at 536.]

These cases do not establish that a right of access is equivalent to a right of access with entitlement to free services from the property owner. The case law makes clear that the Hospitals retain at least a right of exclusion concerning non-public areas that have restricted public access. It is not the providing of services to individuals regardless of their ability to pay that is the takings problem. It is the governmental requirement that one must allow such people to enter the premises and receive services without there being an obligation on someone's part to make payment for the services, thus depriving the Hospitals of the right to reimbursement of the expenses. The Federal EMTALA law requires hospitals to provide emergency evaluation and care without regard to an individual's ability to pay. However, nothing in the Act prohibits a subsequent attempt to collect compensation. Emergency Physicians Integrated Care v. Salt Lake Cnty., 167 P.3d 1080, 1086 (Utah 2007).

It is self-evident that several of the Hospitals have deep roots in their communities and have long embraced a mission to provide quality health care. For some that sense of mission originates from religious principles. However, in satisfying that obligation of public trust, a hospital is not converted from an eleemosynary organization into an altruistic one. It still has an economic identity in order to survive and continue its work of providing quality healthcare.

In that regard, it should be repeated that the Charity Care Program not only requires a hospital to allow entry onto its property and into various non-public areas of its facility but to utilize its resources, whether medications, supplies, equipment or staff rendering medical care, to provide services to the patient. In this situation, there would be a common law entitlement to compensation for the services provided. Whether based on an implied-in-fact contract or the quasi-contract of quantum meruit, a medical provider or hospital is entitled to recover the cost of treatment. See, e.g., St. Barnabas Med. Ctr. v. Essex County, 111 N.J. 67, 79-80 (1988). While the extent of the recovery may be determined on the basis of the reasonable value of the services rendered, Hackensack Hosp. v. Tiajoloff, 85 N.J. Super. 417, 419 (App. Div. 1964), as explained by the Seventh Circuit in Cosgrove v. Bartolotta, 150 F.3d 729 (7th Cir. 1998):

> When one person confers a benefit on another in circumstances in which the benefactor reasonably believes that he will be paid--that is, when the benefit is not rendered gratuitously, as by an officious intermeddler, or donatively, as by an altruist or friend or relative--then he is entitled to demand the restitution of the market value of the benefit if the recipient refuses to pay. [Id. at 734.]

By virtue of N.J.A.C. 10:52-11.14, however, the Hospitals are barred from pursuing any collection action. More simply stated, the right of the Hospitals to pursue a common law cause of action for compensation has been taken away from them. The common law entitlement to bring such a legal claim is a chose in action. The New Jersey Legislature included choses in action within the definition of

"property" in N.J.S.A. 1:1-2. See also Shelton v. Restaurant.com, Inc., 214 N.J. 419, 430 (2013). And the Supreme Court has stated that a chose in action "is a constitutionally recognized property interest." Phillips Petroleum Co. v. Shutts, 472 U.S. 797, 807 (1985).

Accordingly, the Hospitals have property interests that are adversely impacted by the application of the statute and the administrative regulation.

## POINT III

## AMICI'S ATTEMPT TO DISTINGUISGH HORNE IS MISPLACED. REGARDLESS OF THE DIFFERENCES BETWEEN THE AGRICULTURE AND HEALTHCARE INDUSTRIES, THE PHYSICAL APPROPRIATION OF THE HOSPITALS' PERSONAL PROPERTY ENTITLES THEM TO JUST COMPENSATION

Amici contend "[t]he hospitals place great reliance on the holding in Horne, without, however, addressing the many crucial ways in which providing health care at hospitals differs from growing and selling raisins, and that owning a hospital differs from owning a farm." [Ab-29]. While there are undoubtably differences between these industries, none of those differences matter. Hospitals, just like farmers, are not required to forfeit their Fifth Amendment right to just compensation when their property is physically taken from them. Indeed, each of the cases relied upon by Amici addresses situations where there have been restrictions placed on the use of property, as opposed to the physical appropriation of property at issue in Horne and here. More analogous cases involving physical appropriations of property in the healthcare industry can be found in the recent decisions in Teva Pharmaceuticals v. Weiser, 709 F.Supp.3d 1366 (D. Colo. 2023), appeal pending, and Pharmaceutical Research and Manufacturers of America v. Williams, 715 F.Supp.3d 1175 (D. Minn. 2024), aff'd, 728 F.Supp.3d 986 (D. Minn. 2024), cited in Petitioners' submissions to this Court but not addressed by Amici.

The court in Teva Pharmaceutical evaluated the constitutionality of the Colorado Epinephrine Affordability Act enacted to deal with the affordability crisis regarding EpiPens to be used in treating anaphylactic shock. The statute required the manufacturer to provide the device to pharmacies at no cost which would then make them available to the public. Citing Horne as well as Cedar Point Nursery, the court held that requiring possession of property to be transferred from its owner to another was all that was required to trigger the Taking Clause and resulted in an unconstitutional taking unless just compensation was provided. 709 F.Supp.3d at 1377.

Similarly, Pharmaceutical Research involved a statute limiting the price that a pharmacy could charge a patient to fill an insulin prescription and requiring insulin manufacturers to provide a replacement supply to the pharmacy which could be given to patients free of charge. Relying on both Horne and Cedar Point Nursery, the court struck the State of Minnesota's defense based on granting a license to sell pharmaceutical products. The court found a physical taking and stated that the statute "takes the manufacturers' property and gives it away free of charge to certain Minnesota residents." 715 F.Supp.3d at 1189.

Both the Teva Pharmaceutical and Pharmaceutical Research holdings are germane here and support a conclusion that there has been an unconstitutional taking of the Hospitals' property.

In opposition, Amici also argue that Hospitals are quasi-public institutions that owe a fiduciary duty to serve the public. However, none of the cases cited for this proposition supports the conclusion that because hospitals may fall into the category of quasi-public institutions, they have forfeited their constitutional protection against having their private property taken for a public use without just compensation. Often referred to as a "metaphor," the concept of "[f]iduciary obligation is one of the most elusive concepts in Anglo-American law." Deborah A. DeMott, Beyond Metaphor: An Analysis of Fiduciary Obligation, 1988 Duke L.J. 879, 879 (1988). Used in a variety of contexts, it developed through "a jurisprudence of analogy rather than principle." Id.

Amici advance a loose usage of the concept of quasi-public entities and fiduciary obligations. They rely on cases presenting a more limited question of when a hospital can preclude a physician from performing services at their facilities, Comprehensive Neurosurgical, P.C. v. Valley Hospital, 257 N.J. 33 (2024) and Berman v. Valley Hospital, 103 N.J. 100 (1986), and the even more obscure issue of whether and how a county medical society can limit its membership. Falcone v. Middlesex County Medical Society, 34 N.J. 582 (1961). Amici's attempt to rely on case law relating to the reasonableness and validity of a hospital's administrative decisions regarding their staff are wholly inapplicable to the case before this Court. Here, the Hospitals have made no administrative decisions regarding who to treat at

their facilities. Rather, they have been deprived of the right to make such decisions through the strict mandates of N.J.S.A. 26:2H-18.64 and N.J.A.C. 10:52-11.14. The cases cited by Amici do not lead to the deprivation of the right to just compensation.

Hospitals, whether non-profit or for profit, exist to furnish vital health care services with funding coming from public sources as well as private charitable contributions. Activities that are affected with a public interest have been variously described as public callings, quasi-public entities, or public utilities. A public utility may be defined as "a business engaged in providing goods or services so essential to communal and economic life that securing their adequate supply is ultimately a government responsibility." William P. Barr et. al., The Gild That Is Killing the Lily: How Confusion over Regulatory Takings Doctrine Is Undermining the Core Protections of the Takings Clause, 73 Geo. Wash. L. Rev. 429, 439 (2005). This definition certainly fits the circumstances of a New Jersey hospital operating under the mandate of the Take All Comers Statute. Hospitals, like other public utilities, provide integral community services, often exercise monopoly-like reach over a certain geographic area, invest significant capital on fixed infrastructure, and function under extensive regulation. Treating hospitals required to provide care to uninsured or poor people as utilities has support in the academic literature. Gayland Oliver Hethcoat II, Free Hospital Care and the Takings Clause: Franklin Memorial Hospital v. Harvey in A Changing Health-Care Landscape, 65 U. Miami L. Rev. 169,

194–97 (2010); Tammy Lundstrom, Under-Reimbursement of Medicaid and Medicare Hospitalizations As an Unconstitutional Taking of Hospital Services, 50 Wayne L. Rev. 1243, 1254 (2005). The congruence of the concept of public utility and the function of hospitals calls for recognition of the "fair rate of return" standard used in public utility rate cases.

Public utilities are subject to rate-setting to determine the prices to be charged for their services. Amici inappropriately rely on a number of cases where courts have upheld restrictions on the price a business may charge for its products and services. Such regulations may limit the amount of profits a business may earn but they do not physically appropriate the business' property for use by others. This case, however, is not about price controls as N.J.S.A. 26:2H-18.64 does not restrict the prices hospitals may charge for the services they provide, rather, it compels hospitals to physically turn their property over to third parties and then N.J.A.C. 10:52-11.14 prohibits the hospitals from even billing charity care patients for property used in their treatment. This is consistent with Pharmaceutical Research, where the court rejected the attempt by the State to characterize the statute as placing a limit on the price an insulin manufacturer could charge Minnesota residents. "Rather, it takes the manufacturers' property and gives it away free of charge." 715 F.Supp. 3d at 1189. Nor should this Court treat the confiscation of hospital property as a price control regulation.

. Even in the context of heavily regulated rate-setting industries, courts apply what is referred to as the "fair return" standard. Under this standard, to be constitutional, regulated rates must be "just and reasonable" meaning they must provide not only for a company's cost, but also for a fair return on investment. Tenoco Oil Co. v. Dept. of Consumer Affairs, 876 F.2d 1013, 1020 (1st Cir. 1989). When this Court held in New Jersey Ass'n of Health Care Facilities v. Finley, 83 N.J. 67 (1980), cert. denied, 449 U.S. 944 (1980), that nursing homes could be required to provide a limited number of beds without receiving full compensation to meet the needs of their communities, the Court still insisted on there being a "just and reasonable rate on equity" but with that determination to be made in an as applied constitutional challenge rather than in the facial attack then before it. 83 N.J. at 81-82.

A fair return is "something more than survival." State Farm Mut. Auto. Ins. V. State of New Jersey, 124 N.J. 32, 46 (1991). In determining whether the compensation paid is constitutional, the rate set must be within a "zone of reasonable outcomes," and it must, at a minimum, permit a business to: (1) operate successfully, (2) maintain financial integrity, (3) attract capital, and (4) compensate its investors for the risk assumed. See generally Fed. Power Comm'n. v. Hope Natural Gas Co. 320 U.S. 591, 601-605 (1944). In the context of public utility rate setting, a 6.5%

return on investment has been considered constitutional under a Takings analysis. Id.

Here, far from a 6.5% return on investment, the Hospitals suffer significant financial losses from the compelled treatment of charity care patients. The mandates of N.J.S.A. 26:2H-18.64 and N.J.A.C. 10:52-11.14 require the Hospitals to turn their real, personal and service property over to an unlimited number of third parties, prohibit the hospitals from billing those third parties for the property commandeered, and limit any compensation for the property taken to whatever subsidy the State may deem appropriate in a given year. The undisputed factual record demonstrates that each of the Hospitals has suffered millions of dollars in losses each year as the result of the mandate of the Take All Comers Statute. [Pa-629 to 642.] Under no circumstances can these substantial losses be considered a "fair return." Thus, the price fixing cases relied upon by Amici are inapposite.

Amici also rely on a series of cases upholding rent control ordinances which are similarly inapplicable. Notably absent from Amici's discussion is any acknowledgement that even when upholding such rent control ordinances this Court has recognized that the rates set must be "just and reasonable" and not "confiscatory." Hutton Park Gardens v. Town Council of West Orange, 68 N.J. 543, 568-569 (1975). While "[t]he rate of return need not be as high as prevailed in the industry prior to regulation nor as much as an investor might obtain by placing his

capital elsewhere . . . the return should be commensurate with returns on investments in other enterprises having comparable risks." Id. at 569-570. Here, the rate of return the Hospitals received in the years at issue for the statutorily mandated treatment of charity care patients was negative resulting in losses of millions of dollars each year. The confiscatory nature of such negative returns cannot, under any rate of return analysis, meet constitutional muster.

Amici's reliance on beach access cases for the proposition that background principles of property law preclude the Hospitals' claim is similarly misplaced. Regardless of any principles of property law regarding beach access, as discussed in Point II supra, Hospitals have a common law right to exclude individuals from their facilities and are under no obligation to provide treatment in non-emergent situations. There are no background principles of property law precluding the Hospitals' claims. Consistent with the decision in Pharmaceutical Research that "public nuisance law does not apply to 'pricing of a legal, beneficial medicine'", it similarly does not apply to the legal beneficial healthcare services provided by the Hospitals. 728 F.Supp.3d at 991.

Finally, Amici's reliance on case law declining to find a taking in the context of attorney's *pro bono* requirements is similarly misplaced. As an initial point, this is not a universally accepted proposition. See, e.g., DeLisio v. Alaska Superior Ct., 740 P.2d 437, 442 (Alaska 1987); Arnold v. Kemp, 813 S.W.2d 770, 775 (Ark. 1991);

cf. Williamson v. Vardeman, 674 F.2d 1211, 1216 (8th Cir. 1982) (requiring attorney to advance funds for investigatory services, deposition fees, etc. is a taking).

More to the point, when this Court last addressed the issue, it declined to require the government pay attorneys for *pro bono* services "at least for now." Madden v. Township of Delran, 126 N.J. 591, 594 (1992). In coming to its conclusion, the Court based its decision "on [its] belief that more municipalities will join those who have appointed public defenders to represent indigent defendants (or who pay designated counsel to do so) thereby . . . relieving the bar of this burden." Id. at 595.

Implicit in this observation is the Court's recognition that the *pro bono* burden placed on attorneys could reach a level where it becomes unconstitutional. At the time of its decision, the Madden Court estimated that an attorney "could expect to be assigned only one municipal court case every four-and-half years." Id. at 602. Here, the burden on the Hospitals is far more significant. The Charity Care program requires the Hospitals to treat hundreds or thousands of patients at the cost of millions of dollars each year. No doubt, a similar *pro bono* burden on an attorney (or law firm) would have changed the Madden Court's holding.

None of the cases relied upon by Amici addresses the physical appropriations of private property, and therefore, Horne is controlling, and the Hospitals are entitled

to just compensation for the private property they are compelled to provide charity care patients.

## CONCLUSION

The joint amicus submission does not alter the conclusion that the manner in which the New Jersey Charity Care Program is applied to the Plaintiff-Petitioner Hospitals results in a physical taking of property that is unconstitutional unless just compensation is paid to them.

Respectfully submitted,

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