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NOTES

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GAYLAND OLIVER HETHCOAT II*

I. INTRODUCTION

With the strokes of twenty-two pens, President Barack Obama on March 23, 2010, signed into law the Patient Protection and Affordable Care Act (PPACA),[1] ushering in a legislative overhaul of the U.S. health-care system unseen in decades.[2] At the signing ceremony, the President cherished the historical value of the event, speaking wondrously about the legislative victory. "The bill I'm signing will set in motion reforms that generations of Americans have fought for and marched for and hungered to see," the President said. "Today, we are

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

2. Sheryl Gay Stolberg & Robert Pear, *Obama Signs Health Care Overhaul Bill, With a Flourish*, N.Y. TIMES, Mar. 23, 2010, http://www.nytimes.com/2010/03/24/health/policy/24health.html?_r=1.

affirming that essential truth, a truth every generation is called to rediscover for itself, that we are not a nation that scales back its aspirations."[3]

For opponents of the legislation, the President's rhetorical grandeur was not enough to sustain even a moment of national unity or nonpartisanship. Only minutes after the President's signing, more than a dozen state attorneys general, with Attorney General Bill McCollum of Florida at the helm, filed suit in federal court to challenge the PPACA.[4] Alleging that the Act exceeds the scope of Congress's Article I powers and violates the Tenth Amendment,[5] the pending lawsuit constructs the Constitution, which courts have disavowed as a guarantor to an affirmative right to health care,[6] as a tool to preclude the statutory formation of a universal health-care system. Although this construction is debatable, the attorneys' general attack on the PPACA is nevertheless a formidable one, which eventually could make its way before the U.S. Supreme Court.

In the meantime, smaller-scale battles in the courts suggest that the Constitution is not such a complete bar to statutory rights to health care. In one novel federal appeals case, *Franklin Memorial Hospital v. Harvey*,[7] the U.S. First Circuit Court of Appeals was tasked with a two-fold inquiry under the Takings Clause of the Fifth Amendment: whether Maine statutes that require all hospitals to provide free medical services to the indigent, particularly in conjunction with the state's reimbursement rate under its Medicaid program, amounted to uncompensated takings of a hospital's private property.[8] Responding in the negative, the court affirmed the district court's granting of summary judgment for the defendant, Maine Department of Health and Human Services Commissioner Brenda M. Harvey, on the free-care claim and also affirmed dismissal of the Medicaid claim.[9] The court's holding is notable because it suggests that, to the extent that the Fifth Amendment forecloses takings claims once some other source of law gives life to a basic right to health care, the Constitution indeed, albeit indirectly, may authorize this right.[10]

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3. *Id.*

4. *See* Complaint, Florida *ex rel.* McCollum v. U.S. Dep't of Health and Human Servs., No. 3:10-cv-91 (N.D. Fla. Mar. 23, 2010).

5. *Id.* at 15–20.

6. *See, e.g.*, Wideman v. Shallowford Cmty. Hosp., Inc., 826 F.2d 1030, 1032 (11th Cir. 1987) ("[W]e can discern no general right, based upon either the Constitution or federal statutes, to the provision of medical treatment and services by a state or municipality.").

7. 575 F.3d 121 (1st Cir. 2009).

8. *Id.* at 123.

9. Franklin Mem'l Hosp. v. Harvey, 575 F.3d 121 (1st Cir. 2009), *aff'g* No. 07-125-B-S, 2008 WL 4936403 (D. Me. Nov. 14, 2008).

10. The right to health care for purposes here is the right to medically necessary inpatient and

Franklin Memorial is notable, furthermore, because of the backdrop against which the First Circuit adjudicated. As the first decade of the new millennium drew to a close, the very notion of a right to health care was up for debate as Congress deliberated whether to drastically expand health-insurance coverage before finally passing the PPACA.[11] Meanwhile, the severe current downturn in the U.S. economy has only amplified the stakes in federal and state reform efforts. And, at the same time, the recent recession has placed some health-care providers, particularly hospitals like Franklin Memorial Hospital, the plaintiff in *Franklin Memorial*, at an uncertain crossroads. "[H]ospital investment portfolios have lost value like everyone else's, donors are scaling back their philanthropy, patients are deferring expensive elective procedures that normally provide a big chunk of revenue, and an increasing number of unemployed, uninsured patients is showing up in emergency rooms needing free or discounted care."[12] The situation, by all appearances, is a "perfect storm."[13]

The conditions for hospitals across the country have been equally precarious in Maine, the so-called "Charlie Brown of health care" because of the shortcomings of its reform measures, which have included the creation of a state-sponsored health insurance plan and expanded Medicaid eligibility.[14] Primarily at issue in *Franklin Memorial* were Maine's recently liberalized laws that mandate free hospital care,

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outpatient care at a hospital. This right is dissimilar from, but subsumes, the more fundamental right to emergency care at a hospital. Courts have protected statutory schemes that guarantee this latter right (and, inversely, that impose a duty of care on health-care providers) from takings claims, thus supporting the conclusion that the Takings Clause is not necessarily a limitation on statutory rights to health care. *See* Burditt v. U.S. Dep't of Health and Human Servs., 934 F.2d 1362, 1376 (5th Cir. 1991) (upholding the Emergency Medical Treatment and Active Labor Act against a takings claim); St. Joseph's Hosp. & Med. Ctr. v. Maricopa Cnty., 786 P.2d 983, 987–89 (Ariz. 1989) (rejecting the notion that an indigency calculation pursuant to a state statute, together with a state statutory requirement that hospitals provide emergency treatment to patients regardless of ability to pay, constituted a taking under the U.S. and Arizona Constitutions); *see also* Gary E. Jones, *Regulatory Takings and Emergency Medical Treatment*, 47 SAN DIEGO L. REV. 145 (2010).

11. For a timeline of developments leading up to the passage of the PPACA, see Elisabeth Goodridge & Sarah Arnquist, *A History of Overhauling Health Care*, N.Y. TIMES (July 19, 2010), http://www.nytimes.com/interactive/2009/07/19/us/politics/20090717_HEALTH_TIMELINE.html?ref=health_care_reform.

12. Kyla Jones, *Economy Takes Toll on Charity Care*, AAMC REP. (Ass'n of Am. Med. Colls., Wash., D.C.), Nov. 2009, *available at* http://www.aamc.org/newsroom/reporter/nov09/economy.htm.

13. *Id.*

14. Gardiner Harris, *Maine Finds a Health Care Fix Elusive*, N.Y. TIMES, Nov. 10, 2009, http://www.nytimes.com/2009/11/11/health/policy/11maine.html?scp=1&sq=maine%20finds%20a%20health%20care%20fix%20elusive&st=cse. Despite these reforms, Maine continues to grapple with health-insurance premiums that are unaffordable for many, high health-care spending per person, and crowded emergency rooms. *Id.*

which is medical treatment that a hospital or other health-care organization provides without the expectation of payment.[15] Many states have some variation of free-care laws,[16] but as the First Circuit noted,

> Maine's free care laws are unique in that (1) the laws mandate that a hospital provide free/uncompensated care to persons deemed eligible by the state through a penalty enforcement scheme, (2) the hospital is not reimbursed any amount for the provision of free care, [and (3)] the provision of free care is not a license condition [and] is not linked to the state's certificate of need process.[17]

Pursuant to these laws, the hospital in *Franklin Memorial* watched the ranks of free-care patients increase[18] concurrent with adverse developments in the economy, much as hospitals across the country have faced a greater demand for costly care by patients who are unable to pay for their treatment.[19]

In this context, Franklin challenged its burden to care for Maine's poorest residents by seeking a declaratory judgment that the state's free-care laws and Medicaid payment scheme contravened the Fifth Amendment's protection against uncompensated takings of private property.[20] The hospital thus evoked *Penn Central Transportation Co. v. City of New York*[21] and subsequent Supreme Court case law governing regulatory-takings claims. In characterizing Franklin Memorial Hospital's free-care takings claim in particular, the *Franklin Memorial* court said that "in FMH's view, Maine's free care laws are not a form of price control but instead direct the transfer of property from the hospitals to low-income patients."[22]

This casenote agrees with most of the First Circuit's analysis under the *Penn Central* regime. It further concludes that, even if the court had scrutinized Maine's free-care laws under a price-control analysis, it would have reached the same result. Moreover, this note maintains that

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15. *See* CMTY. CATALYST, NOT THERE WHEN YOU NEED IT: THE SEARCH FOR FREE HOSPITAL CARE 23 (2003) [hereinafter SEARCH FOR FREE HOSPITAL CARE].

16. *See* CMTY. CATALYST, FREE CARE: A COMPENDIUM OF STATE LAWS (2003) [hereinafter COMPENDIUM] (summarizing free-care laws and regulations in the United States).

17. Franklin Mem'l Hosp. v. Harvey, 575 F.3d 121, 124 (1st Cir. 2009).

18. Franklin Mem'l Hosp. v. Harvey, No. 07-125-B-S, 2008 WL 4416412, at *2 (D. Me.), *aff'd*, No. 07-125-B-S, 2008 WL 4936403 (D. Me. Nov. 14, 2008), *aff'd*, 575 F.3d 121 (1st Cir. 2009).

19. *See* AM. HOSP. ASS'N, THE ECONOMIC CRISIS: THE TOLL ON THE PATIENTS AND COMMUNITIES HOSPITALS SERVE 3 (2009) [hereinafter ECONOMIC CRISIS] (reporting that seventy percent of respondent community hospitals saw an increase in uncompensated care as a percent of total gross revenues from March of 2008 to March of 2009).

20. *Franklin Mem'l*, 575 F.3d at 123.

21. 438 U.S. 104 (1978).

22. *Franklin Mem'l*, 575 F.3d at 127.

some of the policy concerns about free care underlying *Franklin Memorial* will continue to exist even in the wake of the PPACA.

The structure of this note is five-part. Part II introduces free care and overviews *Penn Central* and other regulatory-takings case law, which forms a framework for understanding the First Circuit's decision in *Franklin Memorial*. Part III details the facts, procedure, holding, and reasoning of the case. Part IV elaborates on the court's discussion of the role of a hospital's nonprofit status under *Penn Central*. Offering an alternative analysis of *Franklin Memorial*, Part V lays out the reasons why Franklin's free-care takings claim would have been untenable even if it had argued that Maine's free-care laws paralleled a price control. Finally, Part VI comments on the supply of and demand for free care in light of Congress's historical stride toward securing health-insurance coverage for millions of Americans with the passage of the PPACA.

II. PUTTING *FRANKLIN MEMORIAL* IN PERSPECTIVE

A. *The Purpose and Origins of Free Care*

Also known as charity care, free care is medical treatment for which a hospital or other health-care provider does not expect to be paid.[23] "Bad debt," in contrast, reflects services for which a hospital expects to be paid but, for one reason or another, usually a patient's inability to pay, the hospital does not receive payment.[24] Aggregately, free care and bad debt make up "uncompensated care."[25] A consumer-watchdog group, which supports wider free-care availability, stresses that characterization of money owed for medical treatment "makes an *enormous* difference to the uninsured or underinsured person" because an expectation of payment invariably leads to efforts to collect money or assets that seldom exist.[26] The American Hospital Association, however, calls this divide "arbitrary at best," stating that hospitals have practical

23. SEARCH FOR FREE HOSPITAL CARE, *supra* note 15, at 23.

24. *Id. Franklin Memorial* illustrates how a hospital may garner expectations of payment. The hospital there had a billing process whereby an expectation of payment formed depending on where a patient fell between 150 percent and 250 percent of the Federal Poverty Guidelines. Franklin Mem'l Hosp. v. Harvey, No. 07-125-B-S, 2008 WL 4416412, at *2 (D. Me. Sept. 24, 2008). If a patient fell below the lowest percentage, the hospital would have no expectation of payment for care; in other words, the hospital would regard such care as "free care" as this casenote uses the phrase. Contrastingly, if a patient fell anywhere above the lowest percentage, the hospital still might supply some level of free care; but, depending on where the patient fell along the spectrum, the hospital would expect some degree of payment. Any nonpayment would be "bad debt." In the fiscal year ending June 30, 2006, Franklin Memorial Hospital reported $2,899,056 in bad debt. *Id.*

25. AM. HOSP. ASS'N, UNCOMPENSATED HOSPITAL CARE COST FACT SHEET 1 (2009) [hereinafter UNCOMPENSATED HOSPITAL CARE].

26. SEARCH FOR FREE HOSPITAL CARE, *supra* note 15, at 23.

difficultly in splitting bad debt from charity care because the medically indigent and underinsured generate both bad debt and charity-care costs.[27]

The primary beneficiaries of free care nevertheless are mostly undifferentiated: the uninsured.[28] As the economic recession that began in late 2007 has shed jobs and, with them, health-insurance coverage, this group grew from 46.3 million people in 2008 to 50.7 million people in 2009.[29] Characteristically, the majority of today's uninsured are poor or near poor nonelderly adults, who are usually at higher risk of serious illnesses than the general population.[30] Most of these people are ineligible for public health-insurance coverage under Medicaid because, for example, they are without dependent children.[31] With few other options, the uninsured are left to fall back on free care as their "ultimate safety net."[32]

The institutions and individuals that comprise the safety net vary. They include public and nonprofit hospitals, community health centers, public health-department clinics, rural health clinics, free clinics, and some physician practices.[33] Of these, community-health centers and public hospitals are two of the "largest and most visible elements."[34] These latter two establishments serve largely uninsured and publicly insured people and provide a range of inpatient and outpatient services.[35] Whereas community health centers tend to offer their low-income populations diverse medical and non-medical services, such as interpreter and

27. UNCOMPENSATED HOSPITAL CARE, *supra* note 25, at 2.

28. SEARCH FOR FREE HOSPITAL CARE, *supra* note 15, at 23. The underinsured also add to the demand for free care. This group, which comprises people whose health insurance does not adequately cover their medical expenses, numbered 25 million people in 2007, up sixty percent from 2003. Cathy Schoen et al., *How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, HEALTH AFFAIRS (2008), http://content.healthaffairs.org/cgi/reprint/hlthaff.27.4.w298v1?ijkey=rhRn2Tr4HAKZ.&keytype=ref&siteid=healthaff. Maine's free-care laws appear to address the problem of underinsurance by instructing that "any amount remaining due after payment by the insurer or medical assistance program will be considered free care." 10-144-150 ME. CODE R. § 1.05(B)(2) (LexisNexis 2007).

29. CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, P60-238, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, at 22 (2010).

30. KAISER COMM'N ON MEDICAID AND THE UNINSURED, HENRY J. KAISER FAMILY FOUND., THE UNINSURED: A PRIMER 4 (2009).

31. *Id.* at 19. Medicaid is a hybrid state and federal public health-insurance program for certain low-income groups, such as the disabled and pregnant. *Medicaid Program—General Information*, CENTERS FOR MEDICAID AND MEDICAID SERVICES, https://www.cms.gov/MedicaidGenInfo/ (last modified Mar. 29, 2010).

32. SEARCH FOR FREE HOSPITAL CARE, *supra* note 15, at 23.

33. Bruce Siegel, Marsha Regenstein & Peter Shin, *Health Reform and the Safety Net: Big Opportunities; Major Risks*, 32 J.L. MED. & ETHICS 426, 426 (2004); *see id.* (discussing various conceptions of the "safety net").

34. *Id.*

35. *Id.* at 427.

child-care services, public and other safety-net hospitals tend to supply emergency-department services and high-cost specialized care to their large proportion of Medicare patients.[36]

A variety of sources may obligate or incentivize these hospitals and others to offer this safety net. Perhaps most fundamentally, hospitals' traditional role as caregivers may goad them to supply free care. Until the twentieth century, hospitals catered to the poor, who were unable to afford physician visits at home.[37] Today, these historical underpinnings may live on in hospitals' stated principles of corporate social responsibility.[38]

Externally, as *Franklin Memorial* exemplifies, a state may require hospitals to provide a minimum threshold of free care by statute or regulation.[39] State laws of this sort differ across many factors, such as terminology, eligibility requirements, and funding source (if any). Among other approaches, states may distribute "earmarked" funds from public uncompensated care pools to hospitals;[40] attach a duty to provide free

36. *Id.* Medicare is a federal public health-insurance program with various components regarding hospital, medical, and prescription-drug coverage. *Medicare Program—General Information*, CENTERS FOR MEDICAID AND MEDICAID SERVICES, https://www.cms.gov/MedicareGenInfo/ (last modified Dec. 14, 2005). It chiefly covers people age sixty-five and older. *Id.*

37. *See* Randall R. Bovbjerg et al., *U.S. Health Care Coverage and Costs: Historical Development and Choices for the 1990s*, 21 J.L. MED. & ETHICS 141, 141 (1993).

38. More than 4200 hospitals have committed to the American Hospital Association's Statement of Principles and Guidelines regarding hospital billing and collection practices for the uninsured and underinsured. *See* BD. OF TRS., AM. HOSP. ASS'N, HOSPITAL BILLING AND COLLECTION PRACTICES (2003).

39. Free-care laws are related to, but not synonymous with, federal and state emergency-care laws. *See supra* note 10. The Emergency Medical Treatment and Active Labor Act, for example, requires that Medicare-participating hospitals provide a medical screening examination to any individual seeking treatment who arrives at a hospital's emergency department. 42 U.S.C. § 1395dd(a) (2006). If the screening confirms an emergency medical condition, the hospital must stabilize the condition or transfer the patient to a more appropriate hospital. § 1395dd(b)(1). Although EMTALA applies to any individual, regardless of indigency, and hospitals may not delay screening or stabilizing a patient to "inquire about the individual's method of payment or insurance status," § 1395dd(h), the statute does not stop hospitals from later charging for their services. *See, e.g.*, Amato v. UPMC, 371 F. Supp. 2d 752, 758 (W.D. Pa. 2005) ("EMTALA does not forbid a hospital from inquiring into a patient's ability to pay for treatment, so long as its inquiry does not delay screening or treatment."). EMTALA is further limited in that treatment is required only up to stabilization, and it does not cover nonemergency conditions. *See* 42 C.F.R. § 489.24(d)(2)(i)–(ii) (2009). Thus, free-care laws theoretically may exceed emergency-care laws insofar as the rights that they grant to patients. Treatment that a hospital supplies pursuant to an emergency-care law, however, may become a form of uncompensated care if the hospital attempts, but fails, to collect payment for emergency screening or stabilization.

40. *See, e.g.*, OKLA. STAT. tit. 56, § 59.1 (2004). To lessen the financial impact on hospitals that provide concentrated amounts of charity care, public uncompensated care pools draw together a uniform surcharge from hospitals and distribute the resulting funds relative to hospitals' provision of charity care. RANDALL R. BOVBJERG ET AL., URBAN INST., MARKET COMPETITION AND UNCOMPENSATED CARE POOLS 5 (2000).

care as a condition to licensure[41] or to certificate of need;[42] and "lend" public dollars for charitable care by allowing a hospital or county to attach a lien to a charity-care patient's property.[43] Because they do not feature any of these provisions, Maine's free-care laws are relatively indigent-friendly and potentially more onerous on hospitals.[44]

Another major impetus for free-care is the tax-exempt status of nonprofit hospitals.[45] Nonprofit status bestows hospitals organized as such with a right to access tax-exempt bond debt, in addition to a host of lucrative federal, state, and local tax exemptions.[46] These entitlements are provisional, of course; the presumption is that, in return for their tax exemption, nonprofit hospitals confer public-health benefits, which the government itself would have to provide in their absence.[47]

At the federal level, for example, the Internal Revenue Service uses what is recognized as the "community benefits" standard to appraise hospitals' income-tax exemption.[48] The 1969 ruling that gave rise to this standard deems a nonprofit hospital a public-charity institution, which is exempt from the federal income tax, provided that it furnishes significant benefits to its local community.[49] Free care is one benefit under this standard, but other services that are less directly related to patient care, such as health fairs, also may count as community benefits.[50]

In addition to state funds and tax savings, hospitals may access other resources to support charity care. Hospitals that bear charity-care loads that are disproportionate to other hospitals' may be eligible for federal Medicaid Disproportionate Share Hospital funds.[51] Nonprofit hospitals also may receive tax-deductible funds from private donors,

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41. *See, e.g.*, R.I. GEN. LAWS ANN. § 23-17-43 (West 2010).

42. *See, e.g.*, S.C. CODE ANN. REGS. 61-15-202(2)(c)(1) (2010).

43. *See, e.g.*, IDAHO CODE ANN. § 31-3504(4) (West 2010).

44. *See* COMPENDIUM, *supra* note 16 (categorizing Maine as a "consumer friendly" state for free-care patients).

45. Nonprofits make up the vast majority of hospitals in the United States. *See Fast Facts on US Hospitals*, AM. HOSP. ASS'N, http://www.aha.org/aha/resource-center/Statistics-and-Studies/Fast_Facts_Nov_11_2009.pdf (last updated June 24, 2010).

46. Jack Hanson, *Are We Getting Our Money's Worth? Charity Care, Community Benefits, and Tax Exemption at Nonprofit Hospitals*, 17 LOY. CONSUMER L. REV. 395, 397 (2005).

47. *Id.*

48. *See* Rev. Rul. 69-545, 1969-2 C.B. 117. In many states, exemption from the federal income tax qualifies nonprofit hospitals for exemption from the state income tax as well. Hanson, *supra* note 46, at 410.

49. Rev. Rul. 69-545, 1969-2 C.B. 117.

50. *Id.*

51. Disproportionate Share Hospital payments are the federal government's primary source of funding uncompensated care. CHRISTINE PROVOST PETERS, NAT'L HEALTH POLICY FORUM, MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS 1 (2009). In fiscal year 2009, an expected $11.3 billion of the projected $216 billion federal Medicaid budget was allocated for Disproportionate Share Hospital payments. *Id.*

who may direct that their donations go toward charity care.[52]

B. *"Ad Hoc Inquiries" and Per Se Rules: Modern Takings Jurisprudence*

The Takings Clause of the Fifth Amendment provides that "private property [shall not] be taken for public use, without just compensation."[53] The purpose of this constitutional guarantee is 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."[54] This reasoning implies, of course, that the clause is not an absolute bar to the government imposing burdens on some people. As Justice Oliver Wendell Holmes observed in the first regulatory-takings case, *Pennsylvania Coal Co. v. Mahon*,[55] "[g]overnment 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."

Mahon established that government regulations, as well as government actions of appropriation or destruction, are subject to Takings Clause review.[56] The Court in that case concluded that the state statute in dispute, which prohibited subsidence coalmining under residential areas, was a taking of the property of a company with a right in coal underlying the Mahon family's house.[57] The Court reasoned that protection against public nuisance did not justify the statute under the facts at hand because only a single family's residence was liable to suffer damage from the mining.[58] Moreover, personal safety did not justify the statute because notice of a company's intent to mine under a house, which the Pennsylvania Coal Co. had provided to the Mahons, was sufficient to avert personal injury.[59] By contrast, the Court depicted the "extent of the diminution" in value of the coal as "great," where the statute deprived the company of the entire pillar of coal stabilizing the house.[60] Thus, on balance, the Court concluded that the "statute does not disclose a public

52. The health-care sector received $22.46 billion in charitable giving in 2009. GIVINGUSA FOUND., GIVING USA 2010: THE ANNUAL REPORT ON PHILANTHROPY FOR THE YEAR 2009, at 12 (2010). This is a growth of 3.8 percent from 2008 to 2009, maintaining the health-care sector's rank as the fifth largest recipient of charitable giving among recipient organizations. *Id.* at 13, 18–19.

53. U.S. CONST. amend. V. The Takings Clause binds state and local governments by virtue of the Fourteenth Amendment. *See* Chi., B. & Q.R. Co. v. City of Chicago, 166 U.S. 226 (1897).

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

55. 260 U.S. 393, 413 (1922).

56. *Id.* at 414–15.

57. *Id.*

58. *Id.* at 413–14.

59. *Id.* at 414.

60. *Id.*

interest sufficient to warrant so extensive a destruction of the defendant's constitutionally protected rights."[61] The Court's ruling, however—"if regulation goes too far it will be recognized as a taking"[62]—offered little guidance for future courts.

More than fifty years later, the Court elaborated its regulatory-takings jurisprudence in *Penn Central*. The case concerned a New York City "landmark" designation on the famous Grand Central Terminal, whose owners opposed the limitations on the use of the property that came with the recognition.[63] The Court's analysis proceeded with this oft-cited summary of its takings case law:

> 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.[64]

Applying these factors, the Court rejected Penn Central's claim that a taking had occurred.[65] According to the Court, Penn Central's continued ability to use and profit from the structure as a train station, together with the potentiality to construct a smaller building on the station or to transfer airspace rights to other nearby properties, moderated the economic impact of the landmark designation.[66] In regard to investment-backed expectations, the Court reasoned that the foremost expectation concerning the terminal—that it would operate as a transportation hub—was undisturbed.[67] Finally, the Court determined that the landmark designation was substantially related to the promotion of the general welfare and was not a physical appropriation of the building by the city.[68]

Since *Penn Central*, the Court has carved out certain regulatory actions as per se takings. The *Franklin Memorial* court addressed the exceptions from two cases: *Loretto v. Teleprompter Manhattan CATV Corp.*[69] and *Lucas v. South Carolina Coastal Commission*.[70] In the former case, a state statute had authorized cable-television companies to install cables and infrastructure on residential rental properties without a

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61. *Id.*
62. *Id.* at 415.
63. Penn Cent. Transp. Co. v. City of New York, 438 U.S. 104, 115–18 (1978).
64. *Id.* at 124 (citation omitted).
65. *Id.* at 138.
66. *Id.* at 136–37.
67. *Id.* at 136.
68. *Id.* at 131–35.
69. 458 U.S. 419 (1982).
70. 505 U.S. 1003 (1992).

landlord's permission.[71] The Court determined that the permanent installation of equipment on Loretto's apartment building was akin to the government's itself appropriating a portion of the property.[72] The Court thus ruled that a "permanent physical occupation authorized by government is a taking without regard to the public interests that it may serve."[73] In *Lucas*, a state statute banned all construction along a certain stretch of beach. In reviewing the law, the Court concentrated on the economic-impact factor from *Penn Central* and concluded that "when the owner of real property has been called upon to sacrifice *all* economically beneficial uses in the name of the common good . . . he has suffered a taking."[74] Applying this standard, the Court decided that the statute resulted in the taking of property developer Lucas's property rights in his beachfront residential lots.[75]

Recently, the Court expressed its continued adherence to *Penn Central* and the exceptions to its ad hoc standard. In *Lingle v. Chevron U.S.A. Inc.*,[76] the Court offered the following explanation of how *Penn Central*, *Loretto*, and *Lucas* interconnect:

> Although our regulatory takings jurisprudence cannot be characterized as unified, these three inquiries (reflected in *Loretto*, *Lucas*, and *Penn Central*) share a common touchstone. Each aims to identify regulatory actions that are functionally equivalent to the classic taking in which government directly appropriates private property or ousts the owner from his domain. Accordingly, each of these tests focuses directly upon the severity of the burden that government imposes upon private property rights.[77]

III. *FRANKLIN MEMORIAL HOSPITAL V. HARVEY*: NO RECOURSE UNDER THE TAKINGS CLAUSE FROM MAINE'S FREE-CARE LAWS AND MEDICAID REIMBURSEMENT RATE

The challenged rules in *Franklin Memorial* are part of a set of statutory and regulatory laws that collectively form Maine's free-care laws.[78] At their core, these laws state that "[n]o hospital shall deny ser-

71. *Loretto*, 458 U.S. at 423.

72. *Id.* at 438.

73. *Id.* at 426.

74. *Lucas*, 505 U.S. at 1019. The Court did except from this per se rule situations where "background principles of the State's law of property and nuisance" justify a regulation. *Id.* at 1029.

75. *Id.* at 1031–32. The Court remanded for a finding whether South Carolina common law supported prohibiting the development of Lucas's land. *Id.* at 1031. The Court, however, opined that it was "unlikely" to justify this prohibition. *Id.*

76. 544 U.S. 528, 539 (2005).

77. *Id.*

78. *See* ME. REV. STAT. ANN. tit. 22, §§ 1715–16 (2004); 10-144-150 ME. CODE R.

vices to any Maine resident solely because of the inability of the individual to pay for those services."[79] The term "services" broadly encompasses all "medically necessary inpatient and outpatient services."[80] The Maine Department of Health and Human Services, which issues guidelines for hospitals to follow in their free-care policies, including guidelines about income eligibility to receive free care, oversees compliance with this mandate.[81] As the First Circuit noted, the laws together are distinctive in that they apply to all for-profit and nonprofit hospitals and are not linked to licensure or certificate of need;[82] the state does not directly pay a hospital for any free care that it provides; the state attorney general or any affected patient may file an enforcement suit against a noncompliant hospital; and a noncompliant hospital may have to pay a penalty fee.[83] Although at first blush these laws might seem burdensome on hospitals whose patient bases are mostly indigent and eligible for free care, an enforcement provision recognizes an "affirmative defense to any legal action brought under th[e statute]" if the health-care provider can show "that the economic viability of the facility or practice would be jeopardized by compliance . . . ."[84]

These laws in turn overlap indirectly with another health-care entitlement program: the state's Medicaid program, or MaineCare. Through this program Maine subsidizes the costs of treating certain low-income patients via payments to hospitals and other health-care providers.[85] The free-care guidelines limit the obligation to provide free care to enrollees in public programs, such as MaineCare, so that only "any amount remaining due after payment by the insurer or medical assistance program will be considered free care."[86]

A nonprofit acute-care hospital situated in one of Maine's poorest counties,[87] Franklin Memorial Hospital saw the costs of treating low-

§§ 1.01–.10 (LexisNexis 2007). Free care is defined as a "service provided without expectation of payment from, or on behalf of, the individual receiving the hospital services." § 1.01(C).

79. § 1.01(A).

80. § 1.03.

81. tit. 22, § 1716.

82. *Id.* § 1715(1).

83. *Id.* § 1715(2).

84. *Id.* § 1715(2)(D). The statute as written appears to limit a hospital to raising an economic-viability defense only during administrative or judicial review. *See id.*

85. Franklin Mem'l Hosp. v. Harvey, 575 F.3d 121, 124 (1st Cir. 2009). Although not obligatory by law, all Maine hospitals participate in MaineCare. *Id.* at 130. As part of its health-care overhaul, Maine expanded MaineCare eligibility so that now almost a quarter of the state's population is enrolled in the program. Harris, *supra* note 14.

86. 10-144-150 ME. CODE R. § 1.05(B)(2) (LexisNexis 2007).

87. Average household income in Franklin County is one of the lowest county averages in Maine. Franklin Mem'l Hosp. v. Harvey, No. 07-125-B-S, 2008 WL 4416412, at *2 (D. Me. Sept. 24, 2008). The average per family income there is about 160 percent of the Federal Poverty Guidelines. *Id.*

income patients increase steadily in recent years. The hospital spent $131,280 on mandatory free care in 2004; $661,000 in 2007; and $890,212 during the first eleven months of the 2008 fiscal year.[88] With respect to MaineCare reimbursement, Franklin likewise bore a financial burden. The hospital in 2007 received $2,645.95 on average from the state for each patient discharged after receiving inpatient services, even though the cost for such patient care was generally about $4796.[89] The MaineCare reimbursement rate for outpatient services was more favorable to Franklin, but it still covered only about ninety percent of the hospital's outpatient costs.[90]

All told, Franklin's obligations under MaineCare and Maine's free-care laws were burdensome enough to induce the hospital to seek relief against the state in federal court. The hospital claimed that it suffered uncompensated takings under Maine's free-care laws and also under MaineCare's reimbursement arrangement.[91] In response, Maine Department of Health and Human Services Commissioner Brenda M. Harvey filed a motion to dismiss Franklin's takings claim regarding MaineCare reimbursement, which the district court granted because of Franklin's voluntary participation therein.[92] The parties then filed cross-motions for summary judgment on the free-care takings claim.[93] Following the recommendation of a magistrate judge, the district court granted Harvey's motion for summary judgment.[94] Franklin appealed to the First Circuit.[95]

On review, the First Circuit focused mainly on Franklin's takings challenge to Maine's free-care laws. As an initial step, the court noted that Maine's free-care laws, which do "not directly appropriate FMH's property but rather regulate[ ] how FMH may use it, [are] properly analyzed under the law of regulatory takings, not the law of physical tak-

88. *Id.* For an itemized breakdown of how much money Franklin spent per patient and on the goods and services that it supplied per patient, see *Franklin Mem'l*, 2008 WL 441612, at *1. Note that in 2007 regulators raised the income qualification for free care from 100 percent of the Federal Poverty Guidelines to 150 percent of the guidelines. *Franklin Mem'l*, 575 F.3d at 123 n.1; § 1.02(C); *see also* Annual Update of the Health and Human Services Poverty Guidelines, 74 Fed. Reg. 4199-04 (Jan. 23, 2009). As a result of this income change, Franklin's free-care patients increased from 127 people in 2006 to 238 people in 2007. *Franklin Mem'l*, 2008 WL 441612, at *2.

89. *Franklin Mem'l*, 575 F.3d at 124.

90. *Id.*

91. *Id.* at 124–25. Franklin pursued its takings claims under both the U.S. and Maine Constitutions. *Franklin Mem'l*, 2008 WL 4416412, at *11. In its order against the hospital, the district court dismissed without prejudice the takings claims under the latter. Franklin Mem'l Hosp. v. Harvey, No. 07-125-B-S, 2008 WL 4936403, at *1 (D. Me. Nov. 14, 2008).

92. *Franklin Mem'l*, 575 F.3d at 125.

93. *Id.*

94. *Franklin Mem'l*, 2008 WL 4936403, at *1.

95. *Franklin Mem'l*, 575 F.3d at 125.

ings."[96] In deciding first whether a per se taking had occurred, the court quickly determined that *Lucas* was inapposite because the hospital did not allege that the state had deprived it of all economically beneficial uses of its property, but only "that it face[d] higher operating costs as a result of the free care laws."[97]

As to whether *Loretto* was applicable, the court examined Franklin's argument that it had been subjected to a government-sanctioned physical invasion resembling that in *Loretto* because it was required to "give its real property (hospital rooms) away for free . . . [and to] give away its personal property to the extent that it must purchase and freely provide expensive medicines and supplies to low income patients."[98] Thus, according to the court, "in FMH's view, Maine's free care laws are not a form of price control but instead direct the transfer of property from the hospitals to low income patients."[99] The court then cited to a case that did concern a price control, *Yee v. City of Escondido*,[100] in which the Supreme Court held that a rent-control ordinance to which mobile-home parks were subjected did not effect an appropriation under *Loretto* of park owners' property.[101] In that case, the Court concluded that the ordinance did not facially require the park owners to continue renting their land as a mobile-home park; thus, because the park owners were free to exclude others from their property if they ceased using it as a mobile-home park, the ordinance did not compel unwanted tenants' invasion of the park owners' land.[102] By analogy, the First Circuit reasoned, Franklin was required to admit patients only as long as it used its property as a hospital; "it may choose to stop using its property as a hospital, which is what makes it subject to Maine's free care laws."[103] *Loretto* consequently was of no benefit to the hospital.

Next, the court applied the *Penn Central* factors, starting with the economic-impact factor.[104] Franklin maintained that the actual economic impact of Maine's free-care laws was severe, noting that it had expended considerable sums of money on the average free-care inpatient and that its free-care burden had increased nearly fivefold since income-eligibility changes in 2007.[105] It also argued that the structure of the laws was such that the state could confiscate a "significant and potentially unlim-

96. *Id.*
97. *Id.* at 126.
98. *Id.* (internal quotations omitted).
99. *Id.*
100. 503 U.S. 519 (1992).
101. *Franklin Mem'l*, 575 F.3d at 126 (citing *Yee*, 503 U.S. at 527–28).
102. *Id.*
103. *Id.*
104. *Id.* at 127.
105. *Id.*

ited" amount of the hospital's goods and services.[106] The court did not suggest that Franklin's expenditures were insubstantial, but it did remark that these sums were small in proportion to Franklin's gross revenues and that in 2007, for example, the $661,000 that the hospital spent on mandatory free care totaled only 0.51 percent of its annual gross revenues.[107] Further, the court concluded that the statutory escape clause, which gives hospitals an affirmative defense in enforcement proceedings if their "economic viability" is in jeopardy, ameliorated the potentially unconstitutional effects of the free-care laws.[108]

In regard to the investment-backed expectations factor, the court first dealt with Harvey's argument that the hospital, as a nonprofit entity, had no such expectations, thus eliminating this as a factor.[109] The court "disagree[d] very much with Harvey's categorical approach," reasoning that even nonprofit institutions like Franklin may acquire property with expectations about its use.[110] Nonetheless, the court acknowledged, the pervasive regulation of the hospital industry tempered Franklin's, or any hospital's, investment-backed expectations.[111]

Lastly, the court observed that "[t]he third *Penn Central* factor—the character of the government action—strongly favors finding no taking here."[112] Maine's free-care laws merely adjusted the "benefits and burdens of economic life," leaving the "core rights of [Franklin's] property ownership intact."[113] More precisely, the laws allowed Franklin to fashion the details of its free-care policy as long it respected the overriding income eligibility rules.[114] "[O]n these facts," the court concluded, "we hold that Maine's free care laws do not effect a taking."[115]

The court then analyzed Franklin's takings challenge to its reim-

106. *Id.* (internal quotations omitted).

107. *Id.* at 124.

108. *Id.* (citing ME. REV. STAT. ANN. tit. 22, § 1715(2)(D) (2004)). Notably, the court left open the resolution of future objections to Maine's free-care laws in circumstances where a litigant could show that free-care compliance does jeopardize a hospital's economic viability. *Id.* at 127 & n.6. Also notably, the court took issue with the magistrate judge's speculation that the revenue that Franklin received from other public programs should be a consideration in weighing the economic impact of Maine's free-care laws. *Id.* at 127. "This factor is not relevant to the question of whether Maine's free care laws constitute a taking," the court stated, "and plays no part in our analysis." *Id. Contra* Franklin Mem'l Hosp. v. Harvey, No. 07-125-B-S, 2008 WL 4416412, at *10 (D. Me. Sept. 24, 2008) ("It is not difficult to imagine, for example, that Franklin Memorial's revenue from other public programs . . . exceeds the financial burden imposed by Maine's Free Care Laws.").

109. *Franklin Mem'l*, 575 F.3d at 127.

110. *Id.* at 128.

111. *Id.*

112. *Id.*

113. *Id.* at 129.

114. *Id.*

115. *Id.*

bursement rate under MaineCare.[116] Anticipating that its voluntary participation in the program would defeat its claim, Franklin mounted a challenge to the combined impact of Maine's free-care laws and MaineCare.[117] The hospital argued that the regulatory guideline that compels a hospital to deliver care to MaineCare-insured patients, without any charges beyond the payment under MaineCare, in effect "require[s] that if a hospital opts out of MaineCare, it must pay [under the free-care laws] the entire cost of treating patients who are eligible for MaineCare."[118] Therefore, in Franklin's perspective, its MaineCare participation was involuntary because the choice "between receiving inadequate reimbursement by participating in MaineCare or receiving no reimbursement" was no choice at all.[119]

Harvey, however, put forth a different interpretation of her agency's regulation.[120] Under this reading, the regulatory provision stipulated that "if a hospital did not accept coverage from a particular insurer or government program, it could still obtain compensation by billing the patient directly for up to the amount that would be covered by the insurer or medical assistance program."[121] Thus, in accordance with this reading, which the court accepted, the state did not pressure Franklin with any "coercive financial incentive to participate in MaineCare."[122] Holding that Franklin's participation in the program was accordingly voluntary, the court rejected its taking challenge and left open whether, on Franklin's interpretation of its MaineCare and free-care mandates, MaineCare participation would be involuntary.[123] On a final note, the court stated that "FMH's objection to Maine's free care laws and MaineCare program is a dispute with the policy choices made by the state's political branches. As such, FMH's better course of action is to seek redress through the state's political process."[124]

IV. THE ROLE OF NONPROFIT OR CHARITABLE ORGANIZATIONAL STATUS UNDER *PENN CENTRAL*

Much of the First Circuit's application of *Penn Central* to Franklin Memorial Hospital's free-care takings claim is uncontroversial. In sug-

116. *Id.*
117. *Id.*
118. *Id.*; *see* 10-144-150 ME. CODE R. § 1.05(B)(2) (LexisNexis 2007).
119. *Franklin Mem'l*, 575 F.3d at 129.
120. *Id.*
121. *Id.*
122. *Id.*
123. *Id.* The word "coercive" in this instance suggests that, had the court agreed with Franklin's interpretation of the regulation, it also would have agreed with its claim that its participation in MaineCare was involuntary.
124. *Id.*

gesting that Maine's free-care laws, which consumed only .51 percent of the hospital's gross revenues in 2007, did not produce a sufficiently severe economic impact on Franklin, the *Franklin Memorial* court was well within the bounds of *Penn Central*. As the magistrate judge summarized, "[i]nsofar as the inquiry is designed to identify regulations that impose burdens functionally equivalent to a 'classic' taking (i.e., a taking on par with total condemnation), the economic impact at issue . . . is simply not significant enough to independently compel a finding that the Free Care Laws work a taking."[125] In discussing the character of the government-action factor from *Penn Central*, moreover, the First Circuit could declare confidently that this factor "strongly favors finding no taking" because Maine's free-care laws did not amount to a physical invasion by government but rather, as a quintessential health-care regulation, to a "public program adjusting the benefits and burdens of economic life to promote the common good."[126]

The second *Penn Central* factor, however—the investment-backed expectations of a takings claimant—raised a curious sub-issue that the First Circuit had to respond to before moving forward with its analysis: whether Franklin's status as a nonprofit hospital affected, or altogether cancelled, any such expectations. Looking to Maine nonprofit law, which gives nonprofit corporations rights to acquire, own, use, improve, and convey property,[127] the court easily rejected Harvey's categorical proposal to negate any investment-backed expectations that Franklin may have by virtue of its nonprofit status.[128] The court was sound in doing so because this proposition, by narrowly equating investment-backed expectations with profits, would broadly exclude takings claims by a party simply because of how it is incorporated. Such a result would not be in the spirit of *Penn Central*'s ad hoc, fact-intensive approach.

The more difficult issue was Harvey's alternative argument regarding the effect of Franklin's nonprofit, charitable status on its challenge to Maine's free-care laws. In addition to her categorical argument, Harvey implored the court to "adopt a new test for charitable organizations, which finds a taking only where the regulation interferes with the organ-

125. Franklin Mem'l Hosp. v. Harvey, No. 07-125-B-S, 2008 WL 4416412, at *5 (D. Me. Sept. 24, 2008) (citing Lingle v. Chevron U.S.A. Inc., 544 U.S. 528, 539 (2005)).

126. *Franklin Mem'l*, 575 F.3d at 128–29 (citing Penn Cent. Transp. Co. v. City of New York, 438 U.S. 104, 124 (1978)); *cf.* William S. Brewbaker III, Commentary, *Health Care Price Controls and the Takings Clause*, 21 HASTINGS CONST. L.Q. 669, 696 (1994) (concluding that national health-reform legislation is "clearly" a public program adjusting the benefits and burdens of economic life to promote the common good and, as such, would not require government compensation to adversely affected parties).

127. ME. REV. STAT. ANN. tit. 13-B, § 202(1)(I) (2004).

128. *See Franklin Mem'l*, 575 F.3d at 127–28.

ization's charitable purpose."[129] Without elaborating on its reasoning, the court simply declined, by way of a footnote, the invitation to adopt this standard.[130]

The First Circuit's disposal of Harvey's alternative argument is important because it may have created a federal circuit split on the issue of the *Penn Central* test as applied to a nonprofit or charitable institution. In *St. Bartholomew's Church v. City of New York*,[131] the Second Circuit dealt with this issue in a dispute between the historic St. Bartholomew's Church and the same regulatory body against which the Penn Central Terminal litigated in *Penn Central*: the New York City Landmarks Preservation Commission. Conjuring similar arguments, the church alleged that the commission's designation of "landmark" over the church's main house of worship and an adjacent church building prevented the church from razing the latter building to erect a large-scale office tower and thus amounted to a taking.[132] The situation was different from *Penn Central*, however, in that the takings claimant was incorporated under New York law as a nonprofit religious corporation; and the church used the property in question not for commercial purposes, as did the owners of the Penn Central Terminal, but for various charitable purposes, such as feeding, clothing, and sheltering the poor.[133]

In considering the church's takings claim, the district court adopted a standard that practically mirrors the standard that the First Circuit rejected in *Franklin Memorial*: An unconstitutional taking occurs "where the landmark designation [of a charity's property] would prevent or seriously interfere with the carrying out of the charitable purpose of the institution."[134] The court explained that the *Penn Central* factors "must be evaluated in light of the overriding rule that the Fifth Amendment contemplates continued use of a property as it was used in the past, and thus permits no substantial interference with the property owner's primary investment expectations or reasonable beneficial use."[135] The charitable-takings standard, moreover, embodies a view that "[w]hile the concept of legitimate investment expectation is not directly transferable to a charitable or religious institution, the concepts of reasonable benefi-

129. *Id.* at 128 n.7.

130. *Id.*

131. 914 F.2d 348 (2d Cir. 1990).

132. *Id.* at 356.

133. *Id.* at 351.

134. St. Bartholomew's Church v. City of New York, 728 F. Supp. 958, 966 (S.D.N.Y. 1989), *aff'd*, 914 F.2d 348 (2d Cir. 1990). The district court adopted this standard from New York state-court decisions. *See* Soc'y for Ethical Culture v. Spatt, 415 N.E.2d 922, 925 (N.Y. 1980); Lutheran Church in Am. v. City of New York, 316 N.E.2d 305, 311 (N.Y. 1974); *accord* Canisius Coll. v. City of Buffalo, 629 N.Y.S.2d 886, 888 (App. Div. 1995).

135. *St. Bartholomew's*, 728 F. Supp. at 966.

cial use and the owner's primary expectations are equally applicable to both."[136] On appeal, the Second Circuit approved this standard and framed the takings inquiry as "whether the land-use regulation impairs the continued operation of the property in its originally expected use."[137] As long as St. Bartholomew's Church could continue its existing charitable and religious activities in the structure that complemented the main house of worship, the court held, the landmark law did not effect an unconstitutional taking.[138] The court acknowledged that the deprivation of commercial value that the church would gain in rebuilding its landmarked structure was "palpable," but resolved that this was acceptable under *Penn Central.*[139]

The *St. Bartholomew's* courts—and Commissioner Harvey in her argument before the First Circuit—offer a sensible modification of *Penn Central* when a takings claimant is a nonprofit or charitable organization. Rather than deviate radically from *Penn Central,* the charitable-takings standard recognizes that a takings claimant's expectations regarding its property will differ depending on whether the claimant has used—and under its organizational form, will use—the property for charitable or commercial purposes. Although the First Circuit appeared expressly to rebuff this standard, its language elsewhere seems to acknowledge the relevance of Franklin's nonprofit status. "To the extent that Maine's free care laws may force FMH to use its property in ways that it would not otherwise," the court held, "they may interfere with FMH's investment-backed expectations."[140] This language resembles the inverse of the Second Circuit's holding in *St. Bartholomew's* that "[s]o long as the Church can continue to use its property in the way that it has been using it—to house its charitable and religious activity—there is no unconstitutional taking."[141]

In any event, the First Circuit did not explicitly determine whether Maine's free-care laws in fact disrupted Franklin's investment-backed expectations so as to "force FMH to use its property in ways that it would not otherwise." The magistrate judge, on the other hand, did deal with this claim: Because Franklin had been operating for years under Maine's free-care laws and because it had a "non-profit health care mission," it understood prospectively that a "portion of the medical supplies it purchases and a portion of the time that its staff expends on patients

136. *Id.*

137. *St. Bartholomew's*, 914 F.2d at 356.

138. *Id.* at 357.

139. *Id.*

140. Franklin Mem'l Hosp. v. Harvey, 575 F.3d 121, 128 (1st Cir. 2009).

141. *St. Bartholomew's*, 914 F.2d at 357.

simply will not produce a return on investment."[142] In other words, Maine's free-care laws did not force Franklin to use its property in ways that it would not have used them otherwise because (1) the regulatory regime had sufficiently shaped over time how the hospital used its property; and (2) even if the regime were not in place, as a "public-benefit charity, with community health as its mission," the hospital would continue to supply free care.[143]

In total, both the charitable-takings standard and the First Circuit's "forced use" standard lead to the same conclusion under the facts of *Franklin Memorial*—that the investment-backed expectations factor from *Penn Central* does not support a finding that Maine's free-care laws effectuated a taking of Franklin's property. Ultimately, either standard could prove arduous to meet for nonprofit hospitals that in the future might challenge mandatory free-care requirements on a takings theory. As the *Franklin Memorial* magistrate judge pointed out, these hospitals presumably would make available some level of free care despite such requirements (for example, to earn their federal income tax exemption); thus, a court might doubt whether mandatory free-care obligations fundamentally change how a hospital "uses" its property. Even so, some limitations would still exist. A nonprofit hospital that must relinquish, for example, all, or virtually all, of its resources for mandatory free care probably would not have to relinquish the same amount under other internalized or externally imposed obligations, such as the "community benefit" standard that the IRS uses to measure nonprofit hospitals' tax exemption. In such a scenario, the hospital would have to, in the words of the First Circuit, "use its property in ways that it would not otherwise" and would accordingly experience an interference with its investment-backed expectations.

V. BEYOND *PENN CENTRAL*: AN ALTERNATIVE ANALYSIS OF *FRANKLIN MEMORIAL*

As the magistrate judge in *Franklin Memorial* commented, *Franklin Memorial* "presents a novel question that is not easily resolved by

142. Franklin Mem'l Hosp. v. Harvey, No. 07-125-B-S, 2008 WL 4416412, at *4 (D. Me. Sept. 24, 2008).

143. *Id.* at *8. The magistrate judge added that, even if Maine's free-care laws had not influenced Franklin's expectations about specific supplies and labor, "Franklin Memorial expresses only a desire to collect some fraction of what it would ordinarily charge for supplies and services, without expressing or quantifying any expectation of actually *profiting* from these items in the absence of the Free Care Laws." *Id.* at *5. *But cf. St. Bartholomew's*, 914 F.2d at 357 (rejecting as irrelevant St. Bartholomew's attempt to distinguish *Penn Central* on the ground that the church's desired use of its property would yield only an estimated six percent return).

resort to existing precedent."[144] Hence, the novelty of this case allows for a deeper analysis of the issues that the First Circuit did not focus on, but which might arise in future takings actions against free-care laws and other public health-care entitlements. In particular, the First Circuit's insinuation that Franklin Memorial Hospital could have construed Maine's free-care laws as a form of price control[145] offers the opportunity to build on earlier scholarship that investigated health-care price controls under the Takings Clause. To this end, the court's opinion invites discussion whether the Constitution would require free-care laws, interpreted as a price control, to guarantee just compensation.

The analysis in this section comprises several subparts. Subpart A explores how courts have resolved takings claims against price controls. With *Franklin Memorial* as the reference point, Subpart B submits a framework to conceptualize Maine's free-care laws as a price control that warrants Takings Clause scrutiny. Reaching the same final conclusion as the First Circuit—that Franklin Memorial Hospital's free-care takings claim would fail—Subpart C presents a different standard from that of *Penn Central* to review Maine's free-care laws, construed as a price control, under the Takings Clause.

A. *Price Controls, the "Fair Return" Standard, and Takings Law*

Takings cases involving price controls on a program or activity trigger different constitutional standards than those that the Supreme Court uses in its regulatory-takings cases, such as *Penn Central*, *Loretto*, and *Lucas*. In the particularized context of public utility rate-setting, courts apply what is known as the "fair return" standard. Under this standard, "[r]ates which enable [a] company to operate successfully, to maintain its financial integrity, to attract capital, and to compensate its investors for the risks assumed certainly cannot be condemned as invalid . . . ."[146] For constitutional purposes the impact of the rate is ultimately important, not its methodology; "[i]f the total effect of the rate order cannot be said to be unjust and unreasonable, judicial inquiry . . . is at an end."[147]

The standard of review, however, for price controls of firms other than public utilities remains an unresolved question. Because the Supreme Court has not explicitly provided an answer, scholarly discussion has transpired over whether the *Penn Central* test or the fair-return

144. *Franklin Mem'l*, 2008 WL 4416412, at *11.

145. Because the court never examined the potential argument that Maine's free-care laws are a form of price control, a future plaintiff presumably could make such an argument. *See Franklin Mem'l*, 575 F.3d at 126.

146. Fed. Power Comm'n v. Hope Natural Gas Co., 320 U.S. 591, 605 (1944).

147. *Id.* at 602.

standard is the appropriate rule to gauge takings claims regarding non-utility price controls. As in *Yee*, which the *Franklin Memorial* court cited approvingly, many courts have been able to avoid this discussion by looking to one dispositive fact: whether a party is legally free to withdraw from the price-controlled market. With respect to price controls covering health-care providers under public-entitlement programs, this bar has defeated numerous takings claims against rate regulation under Medicare, among other administrative systems.[148]

Illustrative of these cases is *Minnesota Association of Health Care Facilities, Inc. v. Minnesota Department of Public Welfare*.[149] At issue was a state statute that limited the rates that nursing homes that received federal Medicaid money could charge non-Medicaid residents for services.[150] The appellants, the Minnesota Association of Health Care Facilities, Inc. and other health-care providers, claimed that the rate limitation on non-Medicaid residents, in combination with an already insufficient reimbursement rate for Medicaid residents, was an uncompensated taking of their property.[151] The appellants urged the court to examine the scheme of reimbursement under the fair-return standard.[152] The court responded that "cases concerning public utilities are inapposite, however, because . . . Minnesota nursing homes, unlike public utilities, have freedom to decide whether to remain in business and thus subject themselves voluntarily to the limits imposed by Minnesota on the return they obtain from investment of their assets in nursing home operation."[153] The court further discarded the appellants' interpretation of voluntariness, whereby market realities made their participation in Medicaid practically involuntary.[154] Because it disposed the takings claim on these grounds, the court avoided the need to determine the applicability of the fair-return standard outside public-utility rate cases.[155]

Somewhat in contrast to the court in *Minnesota Association of Health Care Facilities, Inc.*, the court in *Calloway Community Hospital v. Sullivan*[156] suggested that it could have continued to a constitutional

148. *See, e.g.*, Garelick v. Sullivan, 987 F.2d 913, 915–18 (2d Cir. 1993) (rejecting anesthesiologists' takings challenge to a statutory scheme that limited physician charges under Medicare Part B); Whitney v. Heckler, 780 F.2d 963, 972 (11th Cir. 1986) (rejecting physicians' takings challenge to a statutory scheme that froze physician charges under Medicare Part B).

149. 742 F.2d 442 (8th Cir. 1984).

150. *Id.* at 444–45.

151. *Id.* at 445.

152. *Id.* at 446.

153. *Id.* (citation omitted).

154. *Id.*

155. *See id.*

156. 784 F. Supp 693 (W.D. Mo. 1992).

takings standard because the Medicare participation of the plaintiff-hospitals was involuntary to the extent that they had to participate to obtain federal dollars for capital expenditures under the Hill-Burton Act.[157] The plaintiffs contended that they lost money under Medicare's Prospective Payment System,[158] which infringed the Takings Clause.[159] Discussing applicable law, the court cited the *Penn Central* factors,[160] while noting that "[i]n another context, government review of electrical power rates, the Supreme Court has held that rate setting is not an exact science, but that there is a range of just and reasonable rates."[161] The court found, however, that the plaintiffs failed to provide sufficient evidence "to demonstrate a nexus between the PPS reimbursement rates and their declining PPS margins," suggesting that, if the hospitals had furnished more concrete proof of their financial losses, they might have been able to show that they had suffered an unconstitutional taking.[162]

B. *Free Care and Price Controls*

Before the *Franklin Memorial* court even could have gotten to the point of deciding whether to extend the fair-return standard from public-utility rate cases, it presumably would have explained how Maine's free-care laws are a form of price control. Maine's free-care laws, though, are not explicitly a price control in the same way as the laws at issue in *Minnesota Association of Health Care Facilities, Inc.* or the rate-setting under a program like Medicaid. The first question is thus how to determine whether a regulation effectively equals a price control. Professor Merrill, in discussing physician price controls, proposes this two-part test:

> The . . . inquiry is whether a proposal calls for government action that causes prices to fall or to rise less rapidly. This inquiry, in turn, can be broken down into two subsidiary questions: (1) whether there is governmental action, and (2) whether that action causes a moderation

157. 42 U.S.C. § 291(a)–(*o*-1) (2006). The Hill-Burton Act was a major construction program through which hospitals received federal grants in exchange for rendering free or reduced care. *See* SEARCH FOR FREE HOSPITAL CARE, *supra* note 15, at 43. Although participation in the Hill-Burton program itself was voluntary, the *Calloway* court did not treat this as dispositive in addressing the hospitals' takings claim, focusing instead exclusively on their mandated Medicare participation.

158. A prospective-payment system formulates a predetermined fee for a service provider, generally disregarding the actual cost of the provider's service. *Calloway*, 784 F. Supp. at 696.

159. *Id.* at 694–95.

160. *Id.* at 698 (citing Connolly v. Pension Benefit Guar. Corp., 475 U.S. 211, 224 (1986)).

161. *Id.* (citing Fed. Power Comm'n v. Conway Corp., 426 U.S. 271, 278 (1976)).

162. *Id.* at 698–99 ("For instance, if plaintiffs had shown that a typical appendectomy or a typical acute-care room costs 'X' dollars but that the PPS reimbursed them at a lesser amount, then the Court might conclude that plaintiffs suffered a significant monetary loss, an unconstitutional taking.").

in the rise of prices.[163]

Maine's free-care laws clearly constitute governmental action because they require the provision of free care under threat of state sanction. As to the second question, these laws caused a moderation in the rise of prices in *Franklin Memorial* in that they altogether barred Franklin Memorial Hospital from charging patients who qualified under the free-care laws—or, put another way, they imposed a price of zero dollars for the care that the hospital rendered for eligible patients. This "cap" was directly contrary to the wishes of Franklin, which expressed the "desire to negotiate contracts for [free] care that would, on average, serve to recoup some portion of its costs."[164]

Assuming that Maine's free-care laws could be understood as a price control, the "second general question [is] whether these price controls trigger scrutiny under the Takings Clause."[165] Professor Merrill synthesizes from Supreme Court case law "two distinct understandings for answering this . . . question, although they are not recognized as alternatives or identified by name": the legal-obligation theory and the specific-capital theory.[166] Pursuant to the former theory, a takings issue arises from a price control only where the government obliges a private entity to offer its products or services to the public at a government-scheduled price, and the entity cannot legally exit the controlled market.[167] This theory supports courts' sometimes evasive responses to arguments that the government practically forces a party to offer its price-subjugated products or services to the public, as in *Minnesota Association of Health Care Facilities, Inc.* where the court asserted that, "[d]espite the strong financial inducement to participate in Medicaid, a nursing home's decision to do so is nonetheless voluntary."[168] When the

163. Thomas W. Merrill, Commentary, *Constitutional Limits on Physician Price Controls*, 21 HASTINGS CONST. L.Q. 635, 663–64 (1994); *see id.* at 636 (remarking that, although "[t]he specific focus is on physician price controls . . . much of the analysis applies to other health care providers as well").

164. Franklin Mem'l Hosp. v. Harvey, No. 07-125-B-S, 2008 WL 4416412, at *8 (D. Me. Sept. 24, 2008). In particular, Franklin wanted to recoup money for "free care to individuals who have substantial wealth, but little income." *Id.* at *2. Maine's free-care laws created something of a loophole whereby "hospitals like Franklin Memorial [must] provide free care to individuals who have sufficient assets to pay for all or part of their care, because capital gains, cash deposits or savings, and other property assets are not factored into the Department's income qualification guidelines." *Id.*; 10-144-150 ME. CODE R. § 1.02(A)(3)(b) (LexisNexis 2007); *see also infra* Part V.C (describing the degree to which Franklin Memorial Hospital claimed that it would provide free care to low-income patients absent Maine's free-care laws).

165. Merrill, *supra* note 163, at 665.

166. *Id.* at 639.

167. *Id.* at 639–40.

168. Minn. Ass'n of Health Care Facilities, Inc. v. Minn. Dep't of Pub. Welfare, 742 F.2d 442, 446 (8th Cir. 1984).

First Circuit in *Franklin Memorial* discussed price controls as they related to *Yee* and *Loretto*, it stated similarly that "FMH is not required to serve low income patients; it may choose to stop using its property as a hospital, which is what makes it subject to Maine's free care laws."[169] From Franklin Memorial Hospital's perspective, of course, this option surely would be unimaginable, as would be withdrawing from MaineCare.

Although "as the law presently stands, economic hardship is not equivalent to legal compulsion for purposes of takings analysis,"[170] the law has experienced some fissures. In *Yee*, the mobile-home park owners argued that changing the use of their property was highly implausible.[171] Rather than categorically rejecting this position, the Supreme Court said merely that, because the property owners had not run the statutory gauntlet for changing the use of a mobile-home park, it would confine its review to the face of the statute.[172] But the Court hypothesized that "[a] different case would be presented were the statute, on its face or as applied, to compel a landowner over objection to rent his property or to refrain in perpetuity from terminating a tenancy."[173] Likewise, in a case in which gasoline wholesalers and refiners attacked price controls on gasoline in Puerto Rico, the First Circuit itself looked skeptically upon the argument that the gasoline wholesalers could avoid losses under the controls by abstaining from selling gasoline: "This supposed freedom to temporarily leave the market," the court said, "may be largely illusory . . . ."[174]

Professor Merrill's second theory, the specific-capital theory, may be more useful to a hospital challenging Maine's free-care laws as a price control and getting past the freedom-to-withdraw bar. This theory posits that a takings issue emerges when a private entity has invested capital in a market subject to a price control, and that capital has little or no value in any alternative use; in other words, the theoretical ability to

169. Franklin Mem'l Hosp. v. Harvey, 575 F.3d 121, 126 (1st Cir. 2009).

170. Garelick v. Sullivan, 987 F.2d 913, 917 (2d Cir. 1993).

171. Yee v. City of Escondido, 503 U.S. 519, 528 (1992).

172. *Id.*

173. *Id.*

174. Tenoco Oil Co., Inc. v. Dep't of Consumer Affairs, 876 F.2d 1013, 1027 n.21 (1st Cir. 1989). In another case concerning price controls on rice imports in Puerto Rico, the First Circuit expressed similar reservations:

> It is ordinarily true that a member of an industry which is under price control can withdraw from the field and thus avoid control. But it is wholly unrealistic to apply this principle to the case before us. For the rice importers supply Puerto Rico with the most important staple in the diet of the people. . . . Accordingly the application of the principle that the members of the industry could escape loss by withdrawing from the business of importing rice is not an honest answer to the question at issue.

Mora v. Meijas, 223 F.2d 814, 817 (1st Cir. 1955).

leave the price-controlled market is not dispositive.[175] Professor Merrill marshals a convincing argument that "[t]here can be little doubt that price controls on physicians should be subject to the Takings Clause under the specific capital theory" because of the major investments that they make in their medical education and other outlays, which would have negligible value outside of medicine.[176] Despite the *Franklin Memorial* court's suggestion to the contrary, there can be *no* doubt, then, that mandatory free-care laws operating on hospitals like Franklin Memorial Hospital, which by virtue of their fixed infrastructure cannot simply relocate to another geographic or product market to flee their free-care obligations, satisfy this standard.[177]

Thus far, this line of reasoning establishes only that Franklin Memorial Hospital's alleged freedom to discontinue its use as a hospital would not have resolved its takings claim against Maine's free-care laws if it had argued in *Franklin Memorial* that they were a price control. A legal standard is still necessary to judge the constitutionality of these laws under the Takings Clause.[178] Two main options exist: the multifactor test from *Penn Central* or the fair-return standard from public-utility rate cases.[179] Application of the *Penn Central* test to a hypothetical *Franklin Memorial* in which the court assessed Maine's free-care laws as a price control would produce an analysis that would largely mirror the analysis that the First Circuit actually rendered and the additional considerations that Part IV put forth. The following analysis, therefore, is limited to examining Maine's free-care laws, construed as price control, under the fair-return standard from public-utility rate cases.

C. *Free Care, Price Controls, and the "Fair Return" Standard*

A prerequisite to the inquiry of whether Maine's free-care laws would hold up against the fair-return standard is whether this standard is applicable outside the traditionally understood public-utility rate context. The scholars diverge at this juncture; whereas Professor Brewbaker proffers that "it is the nature of the utility enterprise and of utility regulation, and not the presence of price controls, that is constitutionally significant,"[180] Professor Merrill stresses that "the fair return standard is designed for the specific purpose of assessing the constitutionality of

175. Merrill, *supra* note 163, at 640.
176. *Id.* at 650.
177. *See id.* at 640.
178. *Id.* at 653.
179. *Id.*
180. Brewbaker, *supra* note 126, at 704.

price controls."[181] A conception of what is a utility and why it is subject to a constitutional takings standard distinct from that in other takings cases necessarily infuses this debate. Barr, Weissmann, and Frantz offer a useful definition of the classic public utility 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."[182] According to these authors, compulsion to provide the essential goods or services "lies at the heart of the classic utility regime," and this compulsion may exist in de jure or de facto form.[183] Like Professor Brewbaker, Barr, Weissmann, and Frantz further underscore the nature of utilities as inseparable from the fair-return standard, reasoning that the Takings Clause is concerned fundamentally about government appropriation and that, as a system of government-compelled production, a utility regime inherently appropriates, and thus for constitutional purposes, takes, a utility's capital.[184]

The expandability of the fair-return standard need be addressed only narrowly in this casenote. Although "[t]here is an increasing tendency to use the word 'utility' loosely in referring to many different kinds of regulation covering a wide range of businesses,"[185] those primarily accountable under Maine's free-care laws—hospitals—are in effect utilities in ways that most businesses are not. Therefore, the proper standard in challenges to these laws, interpreted as price controls, is the fair-return standard rather than the *Penn Central* test. 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.[186] In underlining the government compulsion that characterizes utilities, Barr, Weissmann, and Frantz argue that "[a] legal duty to serve and a restriction on the right to exit are hallmarks of utility systems";[187] according to this argument, then, hospitals bear further indicia of a typical utility. In the face of the Emergency Medical Treatment and Active

181. Merrill, *supra* note 163, at 654.

182. William P. Barr, Henry Weissmann & John P. Frantz, *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).

183. *Id.* at 440–42; *see also* Walter Pond, *The Law Governing the Fixing of Public Utility Rates: A Response to Recent Judicial and Academic Misconceptions*, 41 ADMIN. L. REV. 1, 5 (1989).

184. Barr, Weissmann & Frantz, *supra* note 182, at 436–48.

185. *Id.* at 438.

186. Tammy Lundstrom, Note, *Under-Reimbursement of Medicaid and Medicare Hospitalizations as an Unconstitutional Taking of Hospital Services*, 50 WAYNE L. REV. 1243, 1254 (2005).

187. Barr, Weissmann & Frantz, *supra* note 182, at 491.

Labor Act, state laws that impose a legal duty on hospitals to provide emergency care, and free-care laws, hospitals indeed face numerable legal duties to serve. Moreover, hospitals are usually not at liberty to exit a market on their own terms. Lengthy and exhaustive administrative procedures substantially may limit this right.[188]

Thus, the question of whether Maine's free-care laws actually would pass muster under the fair-return standard finally emerges. In other words, do these laws prohibit a fair return on a hospital's reasonable costs and prudential investment? In the seminal case in articulating the fair-return standard, *Federal Power Commission v. Hope Natural Gas Co.*, the Supreme Court, in upholding a utility rate regulation under the Natural Gas Act of 1938, stated that "[r]ates which enable [a] company to operate successfully, to maintain its financial integrity, to attract capital, and to compensate its investors for the risks assumed certainly cannot be condemned as invalid . . . ."[189] The Court elaborated further that "[i]t is not theory but the impact of the rate order which counts. If the total effect of the rate order cannot be said to be unjust and unreasonable, judicial inquiry . . . is at an end."[190]

Determining what exactly the Court meant with its reference to the "total effect" of a rate has proved contentious. Professor Drobak, for example, maintains that the "total effect" test constitutionally allows significant financial harm to utility investors if the harm is in the public interest.[191] He offers as examples of such justifiable harm "utility rates that will generate below normal returns to the owners of the utility's common stock, or . . . rates that fail temporarily to provide any common equity earnings . . . ."[192] Barr, Weissmann, and Frantz, by contrast, start from the premise that the government must compensate a utility for appropriated capital and argue that the government's right to require fluctuation of rates is conditioned on its responsibility to permit the utility to generate offsetting revenue.[193] They add that such offsetting revenue streams may not include revenues that a utility earned in a market open to competition because those revenues are compensation for the utility's risk in participating in that market.[194] "In simpler terms, the government could not compel General Motors to sell Chevrolets to the

188. *See, e.g.*, HEALTH PLANNING DEP'T, N.J. HOSP. ASS'N, HOSPITAL CLOSURE GUIDELINES: BEST PRACTICES FROM THE FIELD (2008) (detailing the hospital-closure process in New Jersey).

189. 320 U.S. 591, 605 (1944).

190. *Id.* at 602.

191. John N. Drobak, *From Turnpike to Nuclear Power: The Constitutional Limits on Utility Rate Regulation*, 65 B.U. L. REV. 65, 67 (1985).

192. *Id.*

193. Barr, Weissmann & Frantz, *supra* note 182, at 461.

194. *Id.* at 462.

poor below cost because, due to earnings on Cadillacs and Buicks, the company as a whole remained profitable."[195]

The foregoing theories could have important implications for the fair-return standard in the free-care context. Recall that in *Franklin Memorial*, Franklin Memorial Hospital spent $661,000 in mandatory free care during 2007, but this amount was only 0.51 percent of the hospital's gross revenues for that period.[196] "Although it would be silly to suggest"[197] that this was an insignificant amount of money, "these expenditures [thus] represent[ed] only a small fraction of FMH's overall budget."[198] The facts were not, as the First Circuit noted, that the hospital alleged that the "level of free care that it currently provides threatens its continued economic viability."[199]

Under Professor Drobak's public-interest theory, Maine's free-care laws, working as a price control, probably could push a hospital like Franklin to the brink of economic non-viability. This theory, as the professor describes, is "extremely broad . . . emcompass[ing] everything within a government's authority that is related in any way to the regulated firm's business, including the effects of the regulated prices on customers and society."[200] Arguably, then, burdensome free-care loads pursuant to Maine's laws are permissible on the ground that the public has an interest in seeing that society's most indigent citizens—who may otherwise lack recourse to health care and who, if left untreated, could pose public-health threats—have access to free, basic care at hospitals. Thus, with regard to *Franklin Memorial* specifically, Professor Drobak's theory would support its outcome under the preceding framework.

But this theory is vulnerable to criticism. As Professor Drobak concedes, a public-interest theory that lopsidedly favors consumer interests over investor interests could lead to long-term harm to the public if sufficiently low rates precluded utilities from obtaining capital, induced delay of capital-intensive construction projects, and contributed to lower-quality utility services.[201] And, more practically, Professor Drobak's theory may be too novel for judges and regulators. He acknowledges that "hundreds, probably thousands, of judicial and administrative decisions, both state and federal," have understood *Hope*

195. *Id.* at 461–62.

196. Franklin Mem'l Hosp. v. Harvey, 575 F.3d 121, 124 (1st Cir. 2009).

197. Franklin Mem'l Hosp. v. Harvey, No. 07-125-B-S, 2008 WL 4416412, at *5 (D. Me. Sept. 24, 2008).

198. *Franklin Mem'l*, 575 F.3d at 124.

199. *Id.*

200. Drobak, *supra* note 191, at 96.

201. *Id.* at 124–25.

to require rates to satisfy only investor interests.[202]

In this light, Barr, Weissmann, and Frantz's claim—that courts and regulators should not wait until a utility's financial integrity becomes compromised to recognize as cognizable a takings claim[203]—is more convincing. The repercussion of this understanding for *Franklin Memorial* is that the First Circuit's conclusion that Maine's free-care laws did not jeopardize the "economic viability" of Franklin Memorial Hospital is insufficient. As one *Franklin Memorial* commentator observes,

> [i]n the utility context . . . the confiscatory rate test is not so low—not "jeopardizing economic viability," but rather elimination of a "reasonable return" on your investment (or opportunity to earn a reasonable return). . . . [A]t least in theory, takings law in the utility context requires an opportunity to earn a reasonable return, not just to survive.[204]

And therein is the reason that a hospital challenging Maine's free-care laws as a price control might wish to pursue a fair-return utility theory: A court may more easily find a taking under this theory than under *Penn Central*, which has authorized extensive diminutions of property values that verge close to complete diminution.[205]

Nevertheless, the facts of *Franklin Memorial* suggest that the government did not deprive Franklin of a fair return. Looking not to the hospital's overall budget, which comprises both its free-care and non-free care business—or, to borrow Barr, Weissmann, and Frantz's analogy, the sum of Chevrolets, Cadillacs, and Buicks—but rather only to the hospital's free-care business, is revealing. The magistrate judge in *Franklin Memorial* differentiated between these two spheres, recognizing that the "portion of the medical supplies [that Franklin] purchases and [the] portion of the time that its staff expends on [free-care] patients"[206] in turn was divisible into mandatory free care under Maine law and free care that the hospital doled out voluntarily.[207] Of these two types of free care, Franklin provided the latter "above and beyond the requirements of the Free Care Laws."[208] For the fiscal year 2007, for example, less than half of the $1,574,000 that the hospital spent on free

202. *Id.* at 65–66.

203. Barr, Weissmann & Frantz, *supra* note 182, at 461.

204. Catherine R. Connors, *Hospitals, Takings and Reasonable Returns*, MAINE APPEALS BLOG (Aug. 31, 2009, 7:07 PM), http://www.maineappeals.com/2009/08/hospitals-and-takings.html.

205. *See, e.g.*, Andrus v. Allard, 444 U.S. 51, 64–67 (1979) (upholding under *Penn Central* a prohibition on the sale of valuable, lawfully acquired eagle feathers).

206. Franklin Mem'l Hosp. v. Harvey, No. 07-125-B-S, 2008 WL 4416412, at *4 (D. Me. Sept. 24, 2008).

207. *Id.* at *2.

208. *Id.* at *4.

care was mandatory;[209] the hospital spent the rest in furtherance of its "non-profit health care mission."[210]

Freed from its mandatory free-care obligation, Franklin in fact would have continued to provide voluntary care commensurate with or close to its mandatory share.[211] Only then the hospital would have used a sliding billing schedule based on the Federal Poverty Guidelines to consider a patient's ability to pay for services.[212] Additionally, it would have used its "contract for care" program to allow low-income patients to waive the balance of their expected payments by volunteering their services to the hospital.[213] Franklin, however, would not have provided free care to "individuals who have substantial wealth, but little income"[214] as a result of how the Maine Department of Health and Human Services defines "income."[215] Franklin did not specify in such a situation what kind of return on its investment that it would have realized from its provision of supplies and services to this patient population.[216] The magistrate judge deduced, however, that the value of payments by low-income patients, plus the value of the services that they might give back under the "contract for care" program, would still fall short of $661,000.[217]

In short, this "rate" was not unfair, where Franklin could "operate successfully, . . . maintain its financial integrity, . . . attract capital, and . . . compensate its investors"[218] as a result of the hospital's "return," presumably in the form of tax savings and other benefits, on its share of "voluntary" free care.[219] An exact line between "fair" and "unfair" under these facts may be unascertainable; but presumably, the circumstances would have to have been such that Franklin's mandatory free-care substantially exceeded its voluntary free care and upended some aspect of its investment-backed operations.

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209. *Id.* at *2.
210. *Id.* at *4.
211. *Id.* at *1.
212. *Id.*
213. *Id.*
214. *Id.* at *2.
215. 10-144-150 ME. CODE R. § 1.02(A)(3) (LexisNexis 2007).
216. *Franklin Mem'l.*, 2008 WL 4416412, at *5.
217. *Id.* at *5 n.2.
218. Fed. Power Comm'n v. Hope Natural Gas Co., 320 U.S. 591, 605 (1944).
219. The magistrate judge said as much:

> It is not difficult to imagine . . . that Franklin Memorial's revenue from other public programs, or better yet, the profit from such programs, exceeds the financial burden imposed by Maine's Free Care Laws. Do these various state programs, in the aggregate, cover, or more than cover, the cost of the related supplies and services? If so, then is not the public essentially bearing the costs?

Franklin Mem'l, 2008 WL 4416412, at *10.

In today's health-care marketplace, where demand for free care has soared to record levels,[220] the previously described circumstances are not implausible. The strained economic situation with which Minneapolis-based Park Nicollet Health Services has struggled is representative of the difficult times that hospitals across the United States are facing. The nonprofit health system has scaled back services and laid off hundreds of workers as its level of uncompensated care rose from $29 million in 2007 to $43 million in 2008.[221] Nationwide, the American Hospital Association reported that 5010 of its registered community hospitals spent $36 billion on such care in 2008.[222] Although legal regimes may differ across jurisdictions, and complex issues of causation may thwart attempts to discern the effects of free care on a hospital's financial health, these economic realities suggest that hospitals may need the relief available by using a utility fair-return theory under the Takings Clause to challenge their free-care obligations.

VI. FREE CARE IN A CHANGING HEALTH-CARE LANDSCAPE

In light of the passage of the Patient Protection and Affordable Care Act, one might think that the charity-care burdens on health-care providers like Park Nicollet Health Services will eventually be relics of a bygone era of health care. Broadly speaking, the law purports to bring into the ranks of the insured an estimated 32 million people by 2019 by expanding Medicaid eligibility, subsidizing the purchase of private insurance through regulated health-insurance exchanges, and requiring most U.S. citizens and legal residents to have health insurance.[223] For hospitals, a system in which millions more patients are insured means that the demand for and costs of free care should decrease appreciably, allowing for reallocation of money that goes toward these expenses. The Urban Institute estimated that under the Senate's original health-reform bill,[224] which served as the backbone of the final legislation, the uninsured would decrease from 49.1 million people in 2009 to 23 million people in 2019, and total uncompensated-care costs would fall from

220. *See* ECONOMIC CRISIS, *supra* note 19, at 3.

221. Reed Abelson, *Bills Stalled, Hospitals Fear Rising Unpaid Care*, N.Y. TIMES, Feb. 8, 2010, http://www.nytimes.com/2010/02/09/health/policy/09hospital.html?scp=1&sq=bills%20stalled%20hospitals%20fear%20rising%20unpaid%20care&st=cse; Casey Selix, *Park Nicollet Forced to Bring in Outsider to Review Finances, Outline 'Action Steps,'* MINNPOST.COM (Apr. 30, 2009, 11:06 AM), http://www.minnpost.com/stories/2009/04/30/8468/park_nicollet_forced_to_bring_in_outsider_to_review_finances_outline_action_steps.

222. UNCOMPENSATED HOSPITAL CARE, *supra* note 25, at 4.

223. *See* KAISER FAMILY FOUND., SUMMARY OF NEW HEALTH REFORM LAW 1 (2010).

224. *See* Patient Protection and Affordable Care Act, H.R. 3590, 111th Cong. (as passed by Senate, Dec. 24, 2009).

$62.1 billion to $46.6 billion between 2009 and 2019.[225]

Without health-care reform, by contrast, the situation could have been much direr. Based on assumptions about economic recovery, health-care costs, and insurance premiums, the Urban Institute estimated that in a worst-case scenario the uninsured would increase from 49.1 million people in 2009 to 65.7 million people in 2019, and uncompensated-care costs would increase from $62.1 billion to $141.4 billion during the same period.[226] By these measures, then, hospitals stand to benefit significantly from the passage of the PPACA.[227]

Contrary to perceptions that free care may become irrelevant with the implementation of the PPACA, however, free care is, and will be for some time, an important topic in the post-reform landscape. As the Urban Institute's figures assume, the very need for free care will exist for years to come. In the short term, key components of the PPACA, including the disbursement of subsidies to purchase health insurance and the prohibition on insurers denying health insurance to people with pre-existing health conditions, will not take effect until 2014.[228] Until then, as long as adverse economic conditions cause more people to lose their jobs, and thus their health insurance, demand for free care is bound to increase.[229] Even those who weather the downtrodden economy and maintain their employment and health insurance may need free care as their employers pass on increasing health-care costs through higher deductibles and copayments.[230]

By 2019, the Congressional Budget Office estimated that, even with health-reform legislation in place, 23 million people will remain uninsured,[231] suggesting that the need for free care will exist in the long term as well. For one, the PPACA categorically excludes the estimated

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225. JOHN HOLAHAN & BOWEN GARRETT, URBAN INST., THE COST OF UNCOMPENSATED CARE WITH AND WITHOUT HEALTH REFORM 2–3 (2010). Note that these uncompensated-care costs account for "underpayment" of Medicaid funds, *id.* at 1–2, whereas the $36 billion in uncompensated-care costs that the American Hospital Association reported for 2008 exclude the underpayment of these funds, UNCOMPENSATED HOSPITAL CARE, *supra* note 25, at 1. *See* AM. HOSP. ASS'N, UNDERPAYMENT BY MEDICARE AND MEDICAID FACT SHEET 2 (2009) ("Underpayment is the difference between the costs incurred and the reimbursement received for delivering care to patients.").

226. HOLAHAN & GARRETT *supra* note 225, at 2–3.

227. *See* Reed Abelson, *In Health Care Overhaul, Boons for Hospitals and Drug Makers*, N.Y. TIMES, Mar. 21, 2010, http://www.nytimes.com/2010/03/22/business/22bizhealth.html?scp=1&sq=in%20health%20care%20overhaul%20boons%20for%20hospitals&st=cse (describing hospitals as "clear beneficiaries" of health-reform legislation and having "little to fear" with its passage).

228. CAROL PRYOR ET AL., CMTY. CATALYST, BEST KEPT SECRETS: ARE NON-PROFIT HOSPITALS INFORMING PATIENTS ABOUT CHARITY CARE PROGRAMS?, at 5 (2010).

229. *Id.*

230. *Id.*

231. Maggie Mertens, *Some Will Remain Uninsured After Reform*, KAISER HEALTH NEWS

11.9 million undocumented immigrants in the United States—a core group of mostly uninsured, low-income people who rely on free care—from Medicaid eligibility and participation in the health-insurance exchanges.[232] Even for some U.S. citizens, the "devil may be in the details"[233] of the statute. Some low- and middle-income people, such as those who have employer-based health insurance, will be ineligible for federal subsidies and may find their copayments, deductibles, and premiums difficult to pay, notwithstanding more stringent regulations on insurance companies.[234] Moreover, despite not being able to afford private health insurance, some of these people also may not qualify for Medicaid.[235] Some who do qualify might not enroll anyway because they are unaware of its availability or find it unnecessary.[236] Left in the shadows of health reform, these groups may continue to depend on the safety-net institutions that traditionally have served them at free or reduced rates.

The future of these institutions in the post-reform landscape, however, is uncertain. Once uninsured patients get health insurance through Medicaid, for example, they may afford to go to hospitals outside the safety net.[237] Meanwhile, the still uninsured may concentrate at community-health centers and public hospitals in search of free care.[238] "Put . . . bluntly, even if we halve the number of insured, the safety net could be endangered if it simultaneously experiences the exodus of its remaining insured patients."[239] Another complication is that, despite the potential for high demand for free care, community health centers and public hospitals may have less money to provide such care. To cover the costs of insurance subsidies, the PPACA aims to cut a principal funding source for safety-net hospitals: Medicaid Disproportionate Share Hospital

(Mar. 24, 2010), http://www.kaiserhealthnews.org/Stories/2010/March/24/Some-Will-Remain-Uninsured.aspx.

232. *See* SAMANTHA ARTIGA & JENNIFER TOLBERT, KAISER FAMILY FOUND., IMMIGRANTS' HEALTH COVERAGE AND HEALTH REFORM: KEY QUESTIONS AND ANSWERS 1 (2009); *cf.* Siegel, Regenstein & Shin, *supra* note 33, at 428 ("Health reform that excludes undocumented immigrants . . . may be of less benefit to many communities and their safety net providers, where such immigrants make up a large part of the population."). The CBO calculated that, of the 23 million uninsured people in 2019, about 7 million of them, or one-third, will be undocumented immigrants. Mertens, *supra* note 231.

233. Siegel, Regenstein & Shin, *supra* note 33, at 428.

234. *See* PRYOR ET AL., *supra* note 228, at 5–6; Siegel, Regenstein & Shin, *supra* note 33, at 428.

235. Mertens, *supra* note 231.

236. *Id.*

237. *See* Siegel, Regenstein & Shin, *supra* note 33, at 429.

238. *See id.*

239. *Id.*

funds.[240]

A further question left open in the post-reform landscape concerns the federal and state tax-exempt status of nonprofit hospitals. As noted above, the "community benefit" standard that the IRS uses to assess nonprofit hospitals' federal tax exemption looks to free care as one sufficient, but not necessary, provision.[241] Nevertheless, various governmental policy signals—such as IRS Form 13790,[242] a questionnaire that the IRS sent to about 600 nonprofit hospitals in May of 2006, in which the agency asked a number of questions about charity care in evaluating whether the hospitals were imparting benefits to their communities—imply that free care has been a salient factor justifying nonprofit hospitals' tax exemption.[243] Thus, nonprofit hospitals that experience substantial decreases in their free-care burdens as a result of most of their patient base being insured may face greater public scrutiny as to whether other "community benefits," such as medical research and health fairs, genuinely warrant their tax exemption.[244] This point bears especial importance because of the increased willingness of federal, state, and local governments, which in some cases are desperate in the downturned economy to collect new tax revenues, to probe—and even to strip—nonprofit hospitals' tax-exempt status for failure to provide sufficient free care.[245]

The foregoing uncertainties about the PPACA and current eco-

240. CMTY. CATALYST, PROTECT AND TARGET FEDERAL FUNDING FOR SAFETY NET HOSPITALS 1 (2010).

241. Rev. Rul. 69-545, 1969-2 C.B. 117.

242. I.R.S. Form 13790 (May 2006).

243. Jessica Berg, *Putting the Community Back into the "Community Benefit" Standard*, 44 GA. L. REV. 375, 386 (2010).

244. To avert such scrutiny, the hospital industry was strategic in emphasizing during the deliberation over health-reform legislation that charity care is not the sole pillar of nonprofit hospitals' federal tax exemption. In response to a proposal by the Senate Finance Committee to impose an excise tax on nonprofit hospitals if they did not furnish a minimum amount of charity care, Barbara Martinez, *Senators Consider Curtailing Hospitals' Tax Breaks*, WALL ST. J., July 10, 2009, http://online.wsj.com/article/NA_WSJ_PUB:SB124718085849920111.html, the American Hospital Association warned that a "formulaic, one-size-fits-all charity care standard will hamstring hospitals' efforts to respond to community needs," *AHA: Schedule H Filings Will Provide Clearer Picture of Community Benefit*, AHANEWS (Am. Hosp. Ass'n, Wash., D.C.), June 8, 2009, *available at* http://www.ahanews.com/ahanews_app/jsp/display.jsp?dcrpath=AHANEWS/AHANewsArticle/data/AHA_News_090608_scheduleH&domain=AHANEWS. When the Senate Finance Committee unveiled the bill, it did not feature the excise-tax measure. Barbara Martinez, *Nonprofit Hospitals Dodge Excise-Tax Bullet in Baucus Bill*, WALL ST. J. HEALTH BLOG (Sept. 16, 2009, 1:26 PM), http://blogs.wsj.com/health/2009/09/16/nonprofit-hospitals-dodge-excise-tax-bullet-in-baucus-bill/tab/article/. Instead, it laid out four less forceful requirements, such as a prohibition of "extraordinary collection actions." *Id.*; *see* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 9007(a), 124 Stat. 119, 855–57 (2010) (to be codified at 26 U.S.C.A. § 501) (incorporating these provisions).

245. *See* Berg, *supra* note 243, at 383 nn.36–41 (detailing governmental action).

nomic realities suggest that policymakers should be flexible in formulating free-care policies to respond to the different needs of their constituents. Meanwhile, the federal government should act swiftly in dispensing guidance about what the provisions of the PPACA regarding free care require. Pursuant to the statute, the secretary of the Department of Treasury, for instance, could issue regulations about "what constitutes reasonable efforts to determine the eligibility of a patient under a financial assistance policy . . . ."[246] The government further could articulate clear standards for what a financial assistance policy should entail and the means by which patients may find out about the availability of assistance.[247]

In sum, working within the strictures of the PPACA to determine what a free-care policy should look like in the post-reform landscape may be a modest starting point, but one that may be preferable to a new legislative undertaking. As Professors Siegel, Regenstein, and Shin caution, "after reform, many local and national health care debates may take on a different tenor, greatly affecting the ability of various actors in the health care system to argue their respective cases."[248] The debate that surrounded the PPACA—a debate that is ongoing—was undoubtedly impassioned and exhausting for both proponents and opponents of the legislation.[249] The current political climate thus may hinder actors in the health-care system from effectively presenting arguments about those whom health-care reform left behind.

VII. CONCLUSION

Rooted in hospitals' societal role as caregivers, free care is today less of a solution to the inequalities of health-care access, quality, and costs rather than it is a symptom of a larger system characterized by these disparities. Given the recently growing rates at which hospitals have been providing free care, Franklin Memorial Hospital may prove to be more than a novelty in citing to the Takings Clause to challenge its free-care obligations in court. At least with respect to Maine's free-care laws, however, this casenote lays out the challenges and complexities of doing so, whether a litigant pursues a regulatory-takings theory or a fair-return utility theory. As the First Circuit concluded, the political process,

246. § 9007(a) (to be codified at 26 U.S.C.A. § 501(r)(7)).

247. *See* PRYOR ET AL., *supra* note 228, at 15.

248. Siegel, Regenstein & Shin, *supra* note 33, at 431.

249. One need only to consider the epithets and gestures, which included spitting and the displaying of an effigy hanging from a noose, that legislators faced in the build-up to the passage of the PPACA. *See* Phillip Rucker & Dan Eggen, *Protests at Democrats' Health-Care Events Spark Political Tug of War*, WASH. POST, Aug. 6, 2009, http://www.washingtonpost.com/wp-dyn/content/article/2009/08/05/AR2009080502780.html?sid=ST2009080504000.

on the other hand, may be more responsive to hospitals' concerns about their free-care burdens. Indeed, the political process has been responsive to these concerns, and Congress's Patient Protection and Affordable Care Act promises to radically lessen the need for free care. But, as long as cracks exist into which society's vulnerable populations may descend—and even the PPACA will not fill every crack—free care will remain a unique fixture of the U.S. health-care system.