Supreme Court of New Jersey

ENGLEWOOD HOSPITAL & MEDICAL CENTER; HUDSON HOSPITAL OPCO, LLC d/b/a CHRIST HOSPITAL; IJKG OPCO, LLC d/b/a BAYONNE MEDICAL CENTER; HUMC OPCO, LLC d/b/a HOBOKEN UNIVERSITY MEDICAL CENTER; CAPITAL HEALTH REGIONAL MEDICAL CENTER; CAPITAL HEALTH MEDICAL CENTER-HOPEWELL; ST. FRANCIS MEDICAL CENTER; and PRIME HEALTCARE SERVICES-ST. MARY'S PASSAIC, LLC d/b/a ST. MARY'S GENERAL HOSPITAL,

Plaintiffs-Petitioners,

v.

THE STATE OF NEW JERSEY; THE STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES; SARAH ADELMAN, IN HER CAPACITY AS COMMISSIONER OF THE DEPARTMENT OF HUMAN SERVICES, STATE OF NEW JERSEY DEPARTMENT OF HUMAN SERVICES, DIVISION OF MEDICAL ASSITANCE AND HEALTH SERVICES;

(cont.)

DOCKET NO.: 089696

Civil Action

ON PETITION FOR CERTIFICATION FROM SUPERIOR COURT OF NEW JERSEY, APPELLATE DIVISION:
Docket No. A-2767-21

SAT BELOW:
Hon. Lisa Rose, J.A.D.
Hon. Morris G. Smith., J.A.D.
Hon. Lisa Perez Friscia, J.A.D.

MEGHAN DAVEY, IN HER CAPACITY AS DIRECTOR OF THE DVISION OF MEDICAL ASSISTNCE AND HEALTH SERVICES, STATE OF NEW JERSEY, DEPARTMENT OF HEALTH; and DR. KAITLAN BASTON, IN HER CAPACITY AS COMMISSIONER OF THE DEPARTMENT OF HEALTH,

Defendants-Respondents.

JOINT BRIEF OF *AMICI CURIAE*
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PRELIMINARY STATEMENT

New Jersey's charity care program (sometimes referred to herein as Charity Care) provides bedrock access to health care for the state's lowest-income residents. Our charity care laws – in place largely in their current form since 1992, reflecting historical aspirations of the medical profession, and emulated in other states that have followed New Jersey's lead – ensure that residents without the ability to pay will not be turned away when they seek treatment at their local hospital.

Charity care in New Jersey is available regardless of the vicissitudes of federally-determined access to Medicaid coverage, and regardless of whether a patient presents at the emergency room or another department of the hospital. And unlike the federal EMTALA statute, which requires all hospitals to screen and stabilize patients in their emergency rooms, but provides no reimbursement, New Jersey's charity care program ensures that hospitals receive substantial compensation by way of an annual charity care subsidy from the state.

Nonetheless, petitioners in this case, 8 of New Jersey's 72 acute care hospitals, allege that the state's charity care subsidy methodology is unconstitutional because it provides them with an amount less than the full "costs" they incur in treating charity care patients. Significantly, nowhere in their complaint do the hospitals elaborate on the basis for these costs (i.e., whether

"costs" denote out-of-pocket expenditures, Medicaid reimbursement rates, full sticker price, or perhaps another measure). And, tellingly, the hospitals do not allege that the state has the fiscal resources to fund the charity care program at the full amount of the undefined rates they seek.

On behalf of our low-income clients, LSNJ and DRNJ are deeply concerned that if the plaintiffs prevail, the state will not reimburse them in the future at the higher rates they seek, but would instead be forced as a budgetary matter to discontinue the charity care program, leaving uninsured and under-insured patients across the state without access to health care. At the same time, there is reason for concern that the state could face very substantial reimbursement claims from hospitals, many of which have been operating quite successfully for the past 20+ years while fulfilling their charity care obligations.

The law, however, is clear – there is no taking because Charity Care is a reasonable public program promoting the common good, and nothing about it "goes too far." Petitioners focus their takings arguments on two recent U.S. Supreme Court per se takings decisions involving farmers, neither of which is dispositive, or even more than tangentially relevant. In Cedar Point, the sole property right at issue was the right to exclude union organizers from entering a farm at specified times to meet with workers. The only similarity to Charity Care is the presence of laws allowing temporary but not permanent access to a business

owner's premises. Unlike the law that applies to California farms, however, New Jersey law does not give hospital owners a legally-enforceable right to exclude patients based on their ability to pay in the first place – and with no right to exclude, there is no Cedar Point taking.

In the second case, Horne, the Court held that per se takings analysis applies to personal property (shares of raisin crops appropriated for a government agency's marketing efforts). Again, the superficial similarity (raisins and health care supplies, space, and services are alike only in that they are not fixed real property) evaporates on closer examination. Unlike the raisin farms in Horne, hospitals in New Jersey are not required to surrender property; they are only required to use their space and medical supplies in the ordinary course of their business. And unlike raisin farms, they are quasi-public fiduciaries providing necessary services to their communities. This brings them within the scope of longstanding precedent holding that business fulfilling key needs – from Chicago grain elevators in the 19th century to New Jersey attorneys in the 21st – can be required to accept somewhat less than full market returns for some of their products, or even provide some services gratis, without triggering a constitutional claim for compensation.[1]

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[1] Absent a per se takings claim, the hospitals may continue to maintain a "regulatory takings" argument. Cf. Rsb 2. For the reasons eloquently expressed in the decision below and the Attorney General's briefs, it is clear that the hospitals cannot establish that the charity care program is a regulation that goes "too far" under the U.S. Supreme Court's three-part Penn Central test. LSNJ and DRNJ also

BACKGROUND

New Jersey's Charity Care Program. The charity care program is a core component of New Jersey's promise to its residents that basic health care services will always be available. By statute, all New Jersey acute care hospitals must provide treatment to all patients regardless of a patient's "ability to pay or source of payment." N.J.S.A. 26:2H-18.64; see also N.J.S.A. 26:2H-18.51 ("Access to quality health care shall not be denied to residents of this State because of their inability to pay for the care.").

New Jersey charity care functions as a payor of last resort in virtually all circumstances for eligible uninsured and underinsured patients. N.J.A.C. 10:52-11.5(k). This means that if patient has other insurance coverage (such as Medicare, Medicaid, or private health insurance), a hospital first receives whatever amounts the patient's third-party insurance covers. See N.J.A.C. 10:52-11.5(c)-(e). Then, uninsured and underinsured patients are eligible for full charity care if their income is 200% or less than the federal poverty guidelines, N.J.A.C. 10:52-11.8(b)(1), and reduced charges (in the form of a sliding-scale discount ranging from 20% to 80%) if the patient's income falls between 200% and 300% of the federal poverty guidelines. N.J.A.C. 10:52-11.8(b)(2), (c). Applicants must also

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join the arguments in Points I and IV of the Attorney General's supplemental merits brief.

provide proof that they do not have individual assets that exceed $7,500, or family assets that exceed $15,000, as of the date of service. N.J.A.C. 10:52-11.10(a). To the extent a patient is determined to be eligible for charity care, they "shall not receive a bill for services or be subject to collection procedures." N.J.A.C. 10:52-11.14.

While the availability of charity care is crucial, obtaining charity care in New Jersey is not a simple process. Applicants must provide the hospital with identification, income, and asset information that the hospital then uses to determine charity care eligibility. N.J.A.C. 10:52-11.5 to 11.13. Although hospitals may make efforts to obtain this information prior to providing services, hospitals most commonly begin the application process after an individual has arrived at the hospital, or even after treatment has concluded. See N.J.A.C. 10:52-11.5(a) ("The hospital shall provide all patients with an individual written notice of the availability of charity care . . . at the time of service, but no later than the issuance of the first billing statement to the patient."). Patients often do not know they are potentially eligible for charity care, or how to apply for assistance, until the hospital provides them with information about the program. Given the extensive documentation requirements, much of which patients are unlikely to bring with them when seeking care from the hospital, charity care applicants have up to a year after date of service or discharge to complete a charity care

application. N.J.A.C. 10:52-11.13(b). Patients might also not receive written notice of the availability of charity care until receiving their first bill from the hospital. See N.J.A.C. 10:52-11.5(a).

Demographics of Charity Care in New Jersey. New Jersey's charity care program provides a backstop to ensure access to health care for precisely those households facing true poverty: those with incomes under 300% of the federal poverty guidelines.[2] About a third of all households in the state, or about 2.9 million people as of 2019, live at or below this threshold.[3] As of 2022, an estimated 8% of New Jersey's population – about 600,000 people under the age of 65 – were without health insurance coverage.[4] Data suggest that an even larger number of New Jerseyans are underinsured.[5] Although current figures on the

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[2] LSNJ Poverty Research Institute, True Poverty: What it Takes to Avoid Poverty and Deprivation in the Garden State 11 (2021) https://proxy.lsnj.org/rcenter/GetPublicDocument/00b5ccde-9b51-48de-abe3-55dd767a685a

[3] LSNJ Poverty Research Institute, New Jersey True Poverty Tracker 10 (2022) https://proxy.lsnj.org/rcenter/GetPublicDocument/380358ae-ad82-43a2-8e35-cd243030dbbc.

[4] New Jersey Department of Health, New Jersey Health Assessment Data, Uninsured Persons Under Age 65 by County, New Jersey, 2022, https://www-doh.nj.gov/doh-shad/indicator/view/HealthInsCov.County.html. Sources cited herein for information directly on a web page were last visited on Mar. 3, 2025.

[5] The Commonwealth Fund, Health Insurance Coverage Eight Years After the ACA (2019) ("Compared to 2010, . . . fewer people [in 2019] are uninsured, but more people are underinsured. Of the 194 million U.S. adults ages 19 to 64 in 2018, an estimated 87 million, or 45 percent, were inadequately insured."),

number of patients who receive charity care in New Jersey hospitals are not readily available, in its early years, the New Jersey charity care program covered between 500.000 and 1,000,000 health care service interactions (outpatient visits or inpatient admissions) annually.[6]

Charity care is also critical for economically vulnerable communities facing disproportionate impacts from limitations on access to health care. National and state data show that the uninsured population is disproportionately made up of people of color.[7] Medical debt disproportionately affects disabled adults, who are

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https://www.commonwealthfund.org/publications/issue-briefs/2019/feb/health-insurance-coverage-eight-years-after-aca; Altarum Healthcare Value Hub, Many New Jersey Residents Struggle with Medical Debt, Highlighting Healthcare Affordability Issues Even for Those with Insurance (2022) (In a survey of nearly 1,000 New Jerseyans with medical debt, "[o]ne-third (33%) report accruing medical debt because their deductible was too high and they were unable to meet it, while 14% report that their coinsurance was too high."), https://www.healthcarevaluehub.org/application/files/5716/6602/4984/Hub-Altarum_Data_Brief_No._126_-_New_Jersey_Medical_Debt.pdf.

[6] Derek Delia, Evaluation of the Hospital Charity Care Program in New Jersey, Rutgers Center for State Health Policy (2007) 13, https://cshp.rutgers.edu/publications/evaluation-of-the-hospital-charity-care-program-in-new-jersey.

[7] In 2023, 38.7% of the U.S. population were people of color, while people of color accounted for 60.4% of the uninsured population. Peter G. Peterson Foundation, The Share of Americans Without Health Insurance in 2023 Remained Low (data last updated Nov. 21, 2024), https://www.pgpf.org/article/the-share-of-americans-without-health-insurance-in-2023-remained-low. In New Jersey, 3.8% of white individuals were uninsured, compared to 7.7% of black individuals and 19.6% of Hispanic individuals. Kaiser Family Foundation, Uninsured Rates for People Ages

more than twice as likely to report owing medical debt.[8] And older adults not covered by Medicare, including newly disabled individuals under 65 (who must wait two years for Medicare coverage), and lawfully present immigrants who are excluded from receiving government benefits by a five-year bar, also benefit from charity care due to income and age-related disability.[9] Meanwhile, health care costs have increased substantially for decades, and the cost of medical care has outpaced both income growth and inflation, driven substantially by increasing hospital prices.[10]

The importance of the charity care program is further demonstrated by a brief look at the types of care it most commonly covers. According to a 2007 analysis of hospital billing records, by far the largest number of claims for charity

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0-64 by Ethnicity, https://www.kff.org/uninsured/state-indicator/people-0-64-uninsured-rate-by-raceethnicity.

[8] Shameek Rakshit, et. al., The Burden of Medical Debt in the United States, (Peterson-Kaiser Family Foundation Health System Tracker 2024), https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states (reporting that 13% of adults with disabilities had medical debt in 2021, as compared to 6% of adults without disabilities).

[9] DeLia, Evaluation of the Hospital Charity Care Program, supra, at 30.

[10] Brittany Holom-Trundy, People Pay, Hospital Profit: Rising Prices Drive High Health Care Costs, New Jersey Policy Perspectives (2022), https://www.njpp.org/publications/report/people-pay-hospitals-profit-rising-prices-drive-high-health-care-costs.

care were filed for pregnancy-related care.[11] Other frequently filed claims included hypertension, diabetes, and HIV.[12] A 2006 study found that younger charity care recipients were more likely to receive charity care for mental health diagnoses, substance use disorder, and pregnancy, while older charity care recipients are more likely to receive charity care for circulatory disorders, nervous system and sense organ conditions, and kidney and urinary problems.[13]

And the ability to access charity care has significant benefits both for individual patients and for the community at large. A recent study, for instance, found that more than one-third of New Jersey respondents (36%) reported that concerns about medical debt has prevented them or someone they live with from seeking care when they need it.[14] Nationwide, about one in seven adults reported delaying hospital services in the past year due to cost.[15] A 2020 study of cancer

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[11] DeLia, Evaluation of the Hospital Charity Care Program, supra, at 17.

[12] Id.

[13] Derek DeLia, Caring for the New Uninsured: Hospital Charity Care for Older People without Coverage, 54 J. Am. Geriatric Soc'y 1933, 1935 (2006).

[14] Many New Jersey Residents Struggle with Medical Debt, Highlighting Healthcare Affordability Issues, supra.

[15] Ashley Kirzinger, et al., KFF Health Tracking Poll – March 2022: Economic Concerns and Health Policy, The ACA, and Views of Long-term Care Facilities (2022), https://www.kff.org/health-costs/poll-finding/kff-health-tracking-poll-march-2022.

survivors in Southern New Jersey found that over one in four (27.2%) of those surveyed forewent medical care in the prior 12 months.[16] This phenomenon is particularly pronounced among low-income New Jerseyans; according to a 2022 survey, lower income individuals were much more likely to forego care than higher income New Jersey residents.[17] Indeed, uninsured individuals are less likely to seek medical care for chronic conditions, resulting in more costly and expensive health care complications.[18] Diagnosis as a result of charity care can give uninsured patients the information they need to manage chronic health conditions such as hypertension, diabetes, and HIV, improving their healthcare outcomes and the overall health of the community.[19]

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[16] Irina B. Grafova, et. al., Financial Hardship Amongst Cancer Survivors in Southern New Jersey, 29 Supportive Care in Cancer 6613 (2021).

[17] New Jersey Residents Struggle to Afford High Healthcare Costs; Worry about Affording Healthcare in the Future; Support Government Action across Party Lines, Data Brief No. 140, Healthcare Value Hub 1, 5 (2023), https://www.healthcarevaluehub.org/application/files/5516/7450/4192/DB_140_-_NJ_Affordability_Brief.pdf.

[18] Jennifer Tolbert, et. al., Key Facts about the Uninsured Population, Kaiser Family Foundation (2024), https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/.

[19] Medha D. Makhlouf, Charity Care for All: State Efforts to Ensure Equitable Access to Financial Assistance for Noncitizen Patients, 23 Houston J. Health L. & Policy 55, 90-91 (2024).

New Jersey's Hospital System. New Jersey's 72 acute care hospitals anchor the State's healthcare system, and collectively care for more than 15 million patients, including approximately 3.8 million emergency department visits, each year.[20] The state's public policy is that accessible hospital services "are of vital concern to the public health." N.J.S.A. § 26:2H-1.

A substantial majority of the state's hospitals are organized as non-profit entities – and they provide about 95% of inpatient care in the state.[21] These non-profit hospitals enjoy substantial tax advantages. Until 2015, this typically included a broad exemption from local property taxes,[22] and today includes a substantially reduced obligation to make payments in lieu of property taxes under N.J.S.A. § 54:4-3.145. Non-profit hospitals also receive substantial federal tax exemptions.[23] A few of New Jersey's hospitals choose to operate as for-profit

[20] N.J. Hospital Fast Facts, New Jersey Hospital Association, https://njha.com/pressroom/nj-hospital-fast-facts.

[21] Health Talk Q&A with NJHA President & CEO, N.J. Hosp. Ass'n, https://www.njha.com/media/777527/health-talk-11625.pdf (2025).

[22] AHS Hosp. Corp. v. Town of Morristown, 28 N.J. Tax 456, 464-65 (Tax 2015).

[23] To be eligible for federal tax exemptions, the IRS by statute and regulation requires that a hospital have (and publicize) a financial assistance policy, and conduct a triennial community health needs assessment pursuant to which "a hospital... may not define its community to exclude medically underserved, low-income, or minority populations who live in the geographic areas from which the hospital facility draws its patients" and "must take into account all patients without regard to whether (or how much) they or their insurers pay for the care received or whether they are eligible for assistance under the hospital facility's financial

entities (which may take income tax deductions for costs related to charity care),[24] and there is one public hospital, University Hospital in Newark. Most, if not all, of New Jersey's hospitals solicit and accept financial donations and volunteer participation from the public, either directly or through associated foundations, to support their operations.[25]

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assistance policy." 26 C.F.R. § 1.501(r)-3(b)(3). See generally Zachary Levinson, et. al., Hospital Charity Care: How it Works and Why it Matters, Kaiser Family Foundation (2022), https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters ("Federal, state, and local governments provide funding in a variety of ways—including through tax benefits for nonprofit hospitals—to support hospital charity care.")

[24] Id. (noting that "for-profit hospitals may have a greater willingness to provide charity care . . . because they can take a tax deduction for these expenses").

[25] E.g., Giving at RWJBarnabas Health, RWJ Barnabas Health, https://www.rwjbh.org/giving ("Today you have the opportunity to impact thousands of lives by clicking on one of the hospitals listed below and making a donation."); Donate & Volunteer, Atlantic Health System, https://ahs.atlantichealth.org/patients-visitors/donate-volunteer.html ("Your contributions help us to provide the highest-quality, compassionate care."); Donate Today, Hackensack Meridian Health Foundation, https://www.hackensackmeridianhealth.org/en/donate/jersey-shore-university-medical-center-foundation ("Philanthropy helps Jersey Shore University Medical Center fulfill its mission to provide the best care, close to home. Jersey Shore University Medical Center Foundation is the tax-exempt arm of the medical center and gladly accepts gifts from individuals, families, grateful patients, businesses, corporations, foundations and other similar sources"); Explore Giving, Inspira Health, https://www.inspirahealthnetwork.org/inspira-health-foundation/explore-giving ("You can make a direct investment in health care for YOUR community. . . . Together, gifts of all sizes add up to make a big difference right here in the community you love."); Donate, Hudson Regional Hospital Foundation, https://hudsonregionalfoundation.com/donate ("The Hudson Regional Hospital Foundation is serious about investing in the community that surrounds us. . . .

Although charity care is of great importance in the aggregate, it typically only commandeers a small percentage of a hospital's operating budget. A recent nationwide study, for instance, found that half of all hospitals had charity care costs that were 1.4% or less of their operating expenses in 2020 – and that less than 10% of all hospitals had charity care costs that reached 7% or more of operating expenses.[26] Another nationwide study found that benefits stemming from non-profit hospitals' status cover on average over 50% of the costs related to charity care, and that "86% of [non-profit] hospitals spent less on incremental charity care than the value of their tax exemption."[27]

Every acute care hospital in New Jersey operates pursuant to a Certificate of Need granted by New Jersey's Department of Health (NJDOH). N.J.A.C. 8:33-4.1. Each applicant for a Certificate of Need must "contractually commit to provide services to medically underserved populations residing or working in its service area," and may not "discriminate against low income persons, minorities,

Please consider donating to our various community programs and hospital at-large.").

[26] Zachary Levinson, et. al., Hospital Charity Care: How it Works and Why it Matters, Kaiser Family Foundation, https://www.kff.org/health-costs/issue-brief/hospital-charity-care-how-it-works-and-why-it-matters (2022).

[27] Hossein Zare, et. al., Comparing the Value of Community Benefit and Tax-Exemption in Non-profit Hospitals, 57 Health Services Research 270, 279. 282 (2022), https://pmc.ncbi.nlm.nih.gov/articles/PMC8928013/pdf/HESR-57-270.pdf.

and disabled individuals." N.J.A.C. § 8:33-4.9(c). Applicants for a Certificate of Need must also demonstrate that they "promote access to low income persons . . . and other person who are unable to obtain care," N.J.A.C. § 8:33-4.10(a), demonstrate "how and to what extent the applicant will provide services to the medically indigent," N.J.A.C. § 8:33-4.10(a)(4), and provide representations as to "the amount of charity care, both free and below cost services, that will be provided by the applicant," N.J.A.C. § 8:33-4.10(a)(6). If approved for a Certificate of Need, a hospital receives an approval letter from NJDOH setting forth the regulatory requirements by which the hospital must abide, including an obligation to provide medical services to patients regardless of their ability to pay.[28]

Similar Programs in Other States. New Jersey is one of 12 states with broad charity care mandates that apply to for-profit, non-profit, and public hospitals alike, and that look to hospitals themselves to bear some of the cost of care for patients unable to pay. In addition to New Jersey, these states include California, Colorado, Connecticut, Illinois, Maryland, Maine, Nevada, New York, Rhode

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[28] See, e.g., Letter dated June 13, 2014, from Mary O'Dowd to Edward J. Condit re: Transfer of Ownership – St. Mary's Hospital 12, https://www.nj.gov/health/bc/documents/shpb/cn/cn_letters_saint_mary_hospital.pdf.

Island, Vermont, and Washington.[29] At least two other states, Delaware and Virginia, along with the District of Columbia, have similar mandates that apply when hospitals seek a new Certificate of Need.[30]

Historical Antecedents. Today's New Jersey charity care program continues a long tradition of free and reduced cost medical care for those in need of financial assistance in New Jersey. At the time of its founding in 1847, the American Medical Association promulgated a Code of Medical Ethics recognizing that physicians had a duty to provide free care when required by patients' financial circumstances: "Poverty . . . should always be recognized as presenting [a] valid claim[] for gratuitous services. . . . [T]o persons in indigent circumstances such services should always be cheerfully and freely accorded."[31] Early hospitals across the United States in the late 19th and early 20th centuries were charities that built

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[29] Andrea Bopp Stark, et al., An Ounce of Prevention: A Review of Financial Assistance Policies in the States 11-13, 19-23 (National Consumer Law Center 2023), https://www.nclc.org/wp-content/uploads/2023/08/202310_Report_An-Ounce-of-Prevention.pdf (collecting statutory citations, and noting hospital responsibility to bear some or all costs in the "How is it Funded" column of Appendix A).

[30] Id. at 15, 25-26.

[31] American Medical Association, Code of Ethics 105-06 (1847) (Ch. III, Art. 1. § 3), https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/ethics/1847code_0.pdf.

care for their communities into their missions,[32] and New Jersey hospitals were no exception; in its first annual report in 1906, Newark Beth Israel Hospital (now Newark Beth Israel Medical Center) reported that two-thirds of its patients in its first four years were charity patients.[33] Reflecting a public policy of providing health care services at hospitals regardless of an individual's ability to pay, New Jersey created its first charity care program in 1979.[34] In 1987, the New Jersey Legislature created the Uncompensated Care Trust Fund, "which, through the equitable collection and distribution of monies generated by increasing the rates charged to payers at all New Jersey hospitals, [sought] to spread the costs of indigent health care across the state."[35]

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[32] Daniel G. Bird & Eric J. Maier, Wayward Samaritans: "Nonprofit" Hospitals and Their Tax-Exempt Status, 85 U. Pitt. L. Rev. 81, 88 (2023); Tamara R. Coley, Extreme Pricing of Hospital Care for the Uninsured: New Jersey's Response and the Likely Results, 34 Seton Hall Legis. J. 275, 279 (2010), citing Morris J. Vogel, The Invention of the Modern Hospital 1 (1980)

[33] Alan M. Kraut & Deborah A. Kraut, Covenant of Care : Newark Beth Israel and the Jewish Hospital in America 27 (Rutgers University Press 2007).

[34] See 27 N.J.R. 656(a) (Feb. 21, 1995); L. 1978, c. 83 at 456 (providing funding to hospitals for "the provision of health care services to individuals unable to pay for them").

[35] Saint Barnabas Med. Ctr. v. Essex Cty., 111 N.J. 67, 76 (1988), citing L.1986, c. 204 (providing that "access to quality health care shall not be denied to residents of the State because of their inability to pay for the care").

Access to health care for low-income individuals regardless of ability to pay also has well-established foundations under federal law, rooted in the Hill-Burton Act of 1946[36] and the Emergency Medical Treatment and Labor Act (EMTALA). Like Charity Care, these federal statutes demonstrate a longstanding recognition of the public interest in ensuring access to health care for low-income populations.

The Hill-Burton Act provided federal funding for the construction of hospitals and other healthcare facilities on the condition that facilities provide a "reasonable volume" of free or reduced-cost care to individuals unable to pay.[37] Many hospitals in New Jersey that still exist today, including Jersey City Medical Center, were constructed or expanded using funds awarded by the Hill-Burton Act.[38]

The Hill-Burton Act's requirement that new and expanding hospitals provide a reasonable volume of free or reduced cost care established a clear precedent that healthcare providers receiving public benefits have an obligation to serve the broader public good. The Act's implementing regulations further solidified this

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[36] Known formally as the "Hospital Survey and Construction Act," 42 U.S.C. § 291c.

[37] 42 U.S.C. § 291c(e).

[38] Health Resources & Services Administration, Hill-Burton Facilities Obligated to Provide Free or Reduced-Cost Health Care, https://data.hrsa.gov/data/reports/datagrid?gridName=HillBurtonFacilities.

obligation, requiring hospitals to maintain written policies for providing charity care and to publicize the availability of such services.[39]

Like Hill-Burton and New Jersey's longstanding obligation to provide care regardless of ability to pay, EMTALA, enacted in 1986, reinforces the principle that healthcare providers have a duty to provide care regardless of a patient's ability to pay. EMTALA mandates that hospitals participating in the federal Medicare program provide emergency medical treatment to all individuals who present through their emergency department, regardless of ability to pay, and prohibits the practice of "patient dumping" based on financial status.[40]

These many antecedents demonstrate that New Jersey's charity care program is rooted in longstanding historical framework promoting a more equitable health care system.

PROCEDURAL HISTORY AND STATEMENT OF FACTS

LSNJ adopts the Procedural History and Counterstatement of Facts set forth in the Supplemental Brief of Respondents dated February 14, 2025 (Rsb 3-10).[41]

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[39] 42 C.F.R. § 124.504 (2023).

[40] 42 U.S.C. § 1395dd.

[41] "Rsb" refers to Respondents' Supplemental Brief dated Feb. 14, 2025. "Pb" refers to Plaintiff-Appellants' Appellate Division Brief dated Aug. 25, 2022.

ARGUMENT

I. CEDAR POINT NURSERY V. HASSID IS INAPPLICABLE BECAUSE THE PROPERTY RIGHTS OF NEW JERSEY HOSPITALS DO NOT INCLUDE THE RIGHT TO EXCLUDE PATIENTS

In Cedar Point Nursery v. Hassid, 594 U.S. 139 (2021), the Supreme Court held that a California regulation granting union organizers access to farm employers' property was a per se physical taking. The Appellate Division below correctly recognized that Cedar Point is inapplicable to New Jersey's charity care program because "the public's presence in a hospital is a natural element of its business," and because treating charity care patients uses hospital premises "as [the hospital] intended – to treat patients." Englewood Hosp. & Med. Ctr. v. State, 478 N.J. Super. 626, 645 (App. Div. 2024). Accordingly, the Appellate Division held, this case is analogous to PruneYard Shopping Center v. Robins, 447 U.S. 74, 77, 82-84 (1980) (holding that a requirement that a shopping mall allow members of the public to distribute pamphlets and seek signatures on petitions in the mall's central courtyard was not a taking).

The hospitals respond that PruneYard is distinguishable because (1) hospital patients seeking treatment are not exercising First Amendment rights, and (2) hospitals typically do not grant unfettered access to the general public. Cert. Pet.

"Cert. Pet." refers to Plaintiffs-Petitioners' Petition for Certification dated Jul. 25, 2024.

9-10. These arguments fail for the reasons advanced by court below, Englewood Hosp, 478 N.J. Super. at 645, and by the Attorney General, Rsb 23-27. The second (and more trenchant) of these arguments also fails for the additional reason – hinted at but not made explicit in the Attorney General's merits brief – that the law is clear that New Jersey hospitals have no right to exclude patients or potential patients in the first place, as a matter of longstanding state law and for reasons that arise independently of the charity care statute and regulations. Cedar Point Nursery v. Hassid, 594 U.S. 139, 160 (2021) ("[T]he government does not take a property interest when it merely asserts a 'pre-existing limitation upon the land owner's title.'"), quoting Lucas v. South Carolina Coastal Council, 505 U.S. 1003, 1028-29 (1992); Mansoldo v. State, 187 N.J. 50, 62 (2006) (the state need not pay just compensation if "the court determines that background principles of property . . . law preclude [a property owner's] intended use of the property"). In other words, the Court need not decide whether the hospital owners in this case are more like the broadly public-inviting mall owners in PruneYard, or more like the highly public-restrictive farm owners in Cedar Point, because the property owners in those earlier cases had a cognizable right to exclude, while the hospital owners in this case do not.

There are two separate and complimentary reasons that the hospital owners here lack the relevant right to exclude. First, *all* New Jersey business that serve the

public – including but not limited to hospitals – must take all comers. Second, all New Jersey hospitals have an overarching duty to serve their communities by providing health care without unreasonable discrimination, a duty that parallels the protected interests of New Jersey residents in seeking and obtaining health care at hospitals, and requires hospitals to provide access to their facilities for health care purposes.

New Jersey has long recognized that public accommodations cannot refuse to serve customers (here, patients) based on attributes that the owner of the public accommodation unilaterally determines it does not like.[42] In the seminal case of State v. Shack, 58 N.J. 297 (1971), the Court held that under New Jersey state law, a farm owner could not prohibit individuals intending to provide medical and legal services from reaching farmworkers who lived on the farm. The court reasoned that there was no need to rely on the constitutional rights of the farm workers or the individuals accused of trespass to reach its decision, because New Jersey law simply did not include a property-based right to exclude in these circumstances:

[42] This might, rightly, initially spur one to think about anti-discrimination law. To be sure, New Jersey's Law Against Discrimination, N.J.S.A. 10:5-4, -5(l), -12(f), specifically prohibits exclusion from public accommodations on the basis of membership in a number of protected classes (and provides enhanced remedies for violations and enforcement mechanisms for the Attorney General). *At the same time*, New Jersey common law recognizes an independent common-law right of access that is broader in scope, as several rightly famous decisions of this Court have recognized.

"[W]e are satisfied that under our State law the ownership of real property does not include the right to bar access to [such] services . . . . Property rights serve human values. They are recognized to that end, and *are limited by it*." Id. at 302–03 (emphasis added).[43]

A decade later, the Court revisited the question of the appropriate limitations on business owners' rights to exclude in Uston v. Resorts Int'l Hotel, Inc., 89 N.J. 163 (1982). In Uston, an Atlantic City casino sought to exclude a well-known blackjack player who practiced card counting strategies that, according to the casino, ensured that he would beat the house. Id. at 166. The Court held that the casino could not assert its property rights to prevent him from playing. While recognizing that many jurisdictions in the country had come to "disregard the right of reasonable access" to all public accommodations that once held sway across the

[43] Similar decisions soon followed under the laws of other states. See Folgueras v. Hassle, 331 F. Supp. 615, 624 (W.D. Mich. 1971) ("This court concurs with the New Jersey court [in State v. Shack]"); People v. Rewald, 318 N.Y.S.2d 40, 45 (Cayuga Co. Ct. 1971). And, significantly, the Court in Cedar Point did not repudiate its earlier labor law decision observing that "when the inaccessibility of employees makes ineffective the reasonable attempts by nonemployees to communicate with them through the usual channels, the right to exclude from property has been required to yield to the extent needed to permit communication of information on the right to organize." NLRB v. Babcock & Wilcox Co., 351 U.S. 105, 112 (1956); cf. Cedar Point, 594 U.S. at 163 (Kavanaugh, J., concurring) (noting that Babcock & Wilcox continues to apply under a "necessity" exception to Cedar Point "when the employees live on company property and union organizers have no other reasonable means of communicating with [them]")

country – and that this retreat had its roots in post-Civil War racial discrimination – the Court recognized New Jersey has maintained its broad public access rights:

> [W]hen property owners open their premises to the general public in the pursuit of their own property interests, they have no right to exclude people unreasonably. On the contrary, they have *a duty not to act in an arbitrary or discriminatory manner toward persons who come on their premises*. That duty applies not only to common carriers [and] *to private hospitals*, but to all property owners who open their premises to the public. Property owners have *no legitimate interest in unreasonably excluding particular members of the public* when they open their premises for public use.

Id. at 173 (emphases added), citing, inter alia, Doe v. Bridgeton Hospital Ass'n, Inc., 71 N.J. 478 (1976) (discussed further below); see also Joseph William Singer, No Right to Exclude: Public Accommodations and Private Property, 90 Nw. U. L. Rev. 1283, 1463 (1996) (setting forth arguments in support of legal rules that "public accommodations should be presumptively obligated to serve members of the public who accept their implicit invitation to enter the business for service")

The holdings in the above cases are, as the Court made clear in Uston, broad in their scope – and are not limited to places of public accommodation with unfettered public access (like the common areas of shopping malls). Just as New Jersey casinos cannot exclude blackjack card counters who cost the casino money while using their space (even if the casino only allows active players to be present), and a barber shop cannot exclude customers based on race even if the owner only allows customers with appointments *and* accurately believes the shop would make

more money if it discriminated, New Jersey hospitals simply have no right, even if only some members of the public have access, to pursue heightened profits by asserting a property right to exclude patients they believe are too poor to afford to pay.

In addition to these rights of access to all public accommodations, New Jersey also independently recognizes as a core limitation on hospitals' property rights that hospitals have a duty to provide health care to the communities in which they do business. Thus, in one of its defining decisions, the Court held that a private hospital had no right to exclude a fully-licensed doctor with a degree from a college of osteopathy from staff privileges, focusing on the crucial interests of the physician's patients in access to health care services. As the Court recognized,

> Hospital officials . . . must never lose sight of the fact that the *hospitals are operated not for private ends but for the benefit of the public*, and that their existence is for the purpose of faithfully furnishing facilities to the members of the medical profession in aid of their service to the public.

Greisman v. Newcomb Hosp., 40 N.J. 389, 403–04 (1963) (emphasis added).

The interests of patients in access to health care at hospitals in their community also came to the forefront in Doe v. Bridgeton Hosp. Ass'n, Inc., 71 N.J. 478 (1976), where the Court held that several hospitals could not deny patients access to their facilities because they were seeking abortions. Citing Greisman for the principle that New Jersey hospitals are quasi-public entities with an "obligation

to serve the public," the Court held that hospital rules relating to access can only be "adopted to further . . . medical standards." Id. at 486-89; see also Desai v. St. Barnabas Med. Ctr., 103 N.J. 79, 89, 90 (1986) (Hospitals' "health-care powers are deeply impressed with a public interest and are fiduciary in nature" and "equal access must be assured for low income persons, racial and ethnic minorities, women, handicapped persons, the elderly, and other underserved groups."); New Jersey Ass'n of Health Care Facilities v. Finley, 83 N.J. 67 (1980) (holding that nursing homes are an integral part of the health care system, and can be required to take reasonable steps, including providing beds without receiving full compensation, to meet the care needs in their communities).

The hospitals attempt to argue that Doe and other cases limiting the rights of hospitals and other public accommodations to exclude customers don't apply here because innkeepers and hotel operators at common law sometimes have a right to refuse customers with a demonstrated inability to pay. Pb 43-44. Uston, however, makes clear that under New Jersey law, businesses can't exclude members of the public simply because they know they will not make money from them (and even if they know they will lose money). And, more generally, the hospitals put the cart before the horse for purposes of Cedar Point, since whether or not they have a right to compensation – and if so what that compensation might be – simply does not

arise *unless* they first establish that they have a property-based right to exclude (which here they do not).

An independent reason that New Jersey hospitals lack the relevant right to exclude is that they operate under public trust – here a governmental authorization that is only available when there is a community need. Each hospital in New Jersey undertakes as part of the process of applying for a Certificate of Need that it will operate in a manner that meets the health care needs of its community, as well as agreeing to participate in the charity care program. Even where courts have retreated from broad public access rights to all places of public accommodation (which, as discussed above, has not to date been the case in New Jersey), they have maintained the principle that specific grants of authorization from the government to engage in a business that meets public needs carries with it a sacrifice of the right to exclude at the discretion of the owner. Cedar Point, 594 U.S. at 161 ("[G]overnment health and safety inspection regimes will generally not constitute takings [where] the government conditions the grant of a benefit such as a permit, license, or registration on allowing access."), citing Ruckelshaus v. Monsanto Co., 467 U.S. 986 (1984); see also Raleigh Ave. Beach Ass'n v. Atlantis Beach Club, Inc., 185 N.J. 40, 59 (2005) (under the public trust doctrine, private beach club lacked an unfettered right to "decide who can come onto its property and use its beach").

Additionally, per se takings law arising from the physical right to exclude has long recognized an exception where property owners – like landlords, or the hospitals here – voluntarily invite the presence of the people entitled to the protection of the law they are challenging:

> [W]here—as here—property owners *voluntarily* invite third parties to use their properties, regulations of those properties are "readily distinguishable" from those that compel invasions of properties closed to the public. Cedar Point, 141 S. Ct. at 2077. As the Supreme Court made pellucid in Yee v. City of Escondido, when "a landowner decides to rent his land to tenants" the States "have broad power to regulate housing conditions in general and the landlord-tenant relationship in particular without paying compensation for all economic injuries that such regulation entails." 503 U.S. 519, 528–29, 112 S.Ct. 1522, 118 L.Ed.2d 153 (1992)

74 Pinehurst LLC v. New York, 59 F.4th 557, 563 (2d Cir. 2023), cert. denied, 218 L. Ed. 2d 66 (2024) (upholding New York rent stabilization laws); Stamboulos v. McKee, 134 N.J. Super. 567, 572 (App. Div. 1975) (upholding New Jersey's Eviction for Good Cause Act); Puttrich v. Smith, 170 N.J. Super. 572, 575 (App. Div. 1979) (same).

A final flaw in the hospitals' "right to exclude" argument is that hospitals simply cannot know, in most circumstances involving charity care, who they would choose to exclude if they could. Establishing eligibility for charity care requires a determination based on a detailed application providing information about household income and assets, with an eligibility determination valid for up to a year. N.J.A.C. 10:52-11.13. Legal Services programs in New Jersey have over

the years assisted many clients in completing this process, and observed that by its very nature, it is often not completed until after a given patient with medical needs has been admitted, or even after a patient has been discharged. Excluding an admitted patient before treatment has been completed upon a determination that they are eligible for charity care (a discharge that would presumably be referred to as "against medical advice") would not only be a moral outrage – it would also put the patient at risk of life and limb, raising profound issues under cases holding that such emergency circumstances are an exception to the right to exclude. Restatement (Second) of Torts § 197 (1965) ("One is privileged to enter or remain on land in the possession of another if it is or reasonably appears to be necessary to prevent serious harm . . . ."). Some potential patients may present at New Jersey hospitals within a year of a prior determination of charity care eligibility, and as to this group, the hospitals might be heard to argue that they could exercise their right to exclude by turning them away. Federal law prohibits this for patients presenting at any emergency room, 42 U.S.C. § 1395dd, and LSNJ suggests that would also raise substantial issues of disparate impact discrimination under federal and state anti-discrimination laws. See Cedar Point, 594 U.S. at 156, citing Heart of Atlanta Motel v. United States, 379 U.S. 241, 261 (1964) (rejecting claim that provisions of the Civil Rights Act of 1964 prohibiting racial discrimination in public accommodations effected a taking).

II. HORNE V. DEPARTMENT OF AGRICULTURE IS NOT DISPOSITIVE BECAUSE REQUIRING HOSPITALS TO USE A FRACTION OF THEIR ASSETS TO HELP ENSURE THAT COMMUNTY HEALTH CARE NEEDS ARE MET, WITH PARTIAL COMPENSATION, DOES NOT GIVE RISE TO A TAKINGS CLAIM

In Horne v. Department of Agriculture, 576 U.S. 350, 354 (2015), the Supreme Court held that a federal agency marketing order requiring that "a percentage of a [California raisin] grower's crop must be physically set aside in certain years for the account of the Government, free of charge" was a per se taking. The hospitals place great reliance on the holding in Horne, without, however, addressing the many crucial ways in which providing health care at hospitals differs from growing and selling raisins, and that owning a hospital differs from owning a farm.

As noted above (see supra at 24-26), New Jersey hospitals are quasi-public entities with fiduciary obligations to serve the public. See Comprehensive Neurosurgical, P.C. v. Valley Hosp., 257 N.J. 33, 68 (2024) ("A hospital exercises its [healthcare] powers 'in trust,' 'for the benefit of the public,' and 'in aid of [its] service to the public.'), quoting Berman v. Valley Hosp., 103 N.J. 100, 106 (1986); Falcone v. Middlesex County Med. Soc., 34 N.J. 582, 587, 596–97 (1961) (county medical society in which membership was required for doctors to practice at area hospitals exercised a "fiduciary" role "with which the public is highly concerned and . . . engages in activities vitally affecting the health and welfare of the people"

and could not unreasonably restrict public access to health care). This type of public trust has long been recognized as a sufficient basis for of types of governmental limitations on unfettered property rights. Munn v. Illinois, 94 U.S. 113, 126 (1876) (upholding price regulations for grain elevators in Chicago and other large cities: "[w]hen . . . one devotes his property to a use in which the public has an interest, he . . . grants to the public an interest in that use, and must submit to be controlled by the public for the common good, to the extent of the interest he has thus created."). Thus, not surprisingly, New Jersey law has consistently recognized that hospital pricing is subject to regulation, separate and apart from application of the charity care statute. See, e.g., N.J.S.A. 26:2H-12.52 (limiting hospital charges for uninsured patients with gross family income below 500% of the federal poverty level to "an amount no greater than 115% of the applicable payment rate under the federal Medicare program"); Hackensack Hosp. v. Tiajoloff, 85 N.J. Super. 417, 419 (App. Div. 1964) (requiring hospital seeking to collect from a patient to establish the "reasonable value of [its] services").

Such price regulations are representative of a variety of types of limitations on property rights – including limitations and/or requirements as to the use of some of the property a business uses in the course of its operations – when a business is clothed with a public trust. See Ruckelshaus v. Monsanto Co., 467 U.S. 986, 1007 (1984) (no taking where manufacturers of pesticides, fungicides, and rodenticides

were required to give up their property rights in trade secrets in order to obtain "a valuable Government benefit" – the right to sell their products); John D. Echeverria, What Is A Physical Taking?, 54 U.C. Davis L. Rev. 731, 734 (2020) (noting that while the Court in Horne "ultimately upheld the plaintiffs' physical taking claim based on the specific facts of the case, [the Court] indicated it might well reject a physical taking claim based on different facts"). And, as New Jersey courts have consistently held, appropriate restrictions on property rights to protect key public health, safety, and welfare prerogatives are not takings. Mansfield & Swett v. Town of W. Orange, 120 N.J.L. 145, 152–53 (Sup. Ct. 1938) (zoning ordinance was not a taking: "injury to private property ensuing from governmental action in a proper sphere, reasonably taken for the public good, and for no other purpose, is not necessarily classable as a 'taking' of such property within the intendment of the constitutional guaranties against the deprivation of property without due process of law, or the taking of private property for public use without compensation"); State ex rel. State Bd. of Milk Control v. Newark Milk Co., 118 N.J. Eq. 504, 519 (E. & A. 1935) (no taking where milk producers claimed that minimum price regulations caused them economic harm: "The police power extends to all the great public needs [as in the case of utility and insurance rate regulation, usury limits, and minimum wage laws]; . . . property rights are held subject to this reserve element of sovereignty. . . . The economic interests of the

state may justify its exercise, notwithstanding that the expedient resorted to invades the domain of property rights [when] necessary for the preservation of the public health, morals, comfort, order, and safety."), accord Nebbia v. New York, 291 U.S. 502 (1934), and Abbotts Dairies, Inc. v. Armstrong, 14 N.J. 319, 329–31 (1954) (upholding regulation of maximum as well as minimum milk prices); Chosen Freeholders of Hudson Cnty. v. New Jersey R. & Transp. Co., 24 N.J.L. 718, 721 (E. & A. 1853) (upholding price regulation of ferries "established for the public convenience and private gain"); JWC Fitness, LLC v. Murphy, 469 N.J. Super. 414, 436 (App. Div. 2021) (finding no taking as a result of executive orders limiting business activities during the COVID pandemic in light of "the State's broad power to restrict the uses individuals may make of their property in order to protect the health, safety, and welfare of the public").

Of particular relevance here, the Court in Hutton Park Gardens v. Town Council of Town of W. Orange, 68 N.J. 543, 570–71 (1975) held that rent control ordinances are not unconstitutional, whether or not a housing "emergency" exists, as long as the ordinance does not preclude a "just and reasonable" return on investment. As the Court observed,

> The rate of return permitted need not be as high as prevailed in the industry prior to regulation nor as much as an investor might obtain by placing his capital elsewhere. . . . Rent levels are thus not objectionable merely because they fix returns at a lower scale for inefficient operators, do not reward persons who have paid excessive or inflated purchase prices for their property, or may otherwise work

> hardships on landlords in atypical situations. . . . The burden of proof is heavily upon the parties alleging confiscation to demonstrate it. The fact that costs are increasing faster than permissible rents under a particular ordinance . . . or even that some owners are sustaining operating losses will not Per se suffice to prove unconstitutional confiscation.

See also Block v. Hirsh, 256 U.S. 135, 156 (1921) (Washington, DC, rent control statute was not a taking because "a public exigency will justify the legislature in restricting property rights in land to a certain extent without compensation. . . . Housing is a necessary of life. All the elements of a public interest justifying some degree of public control are present."); Pennell v. City of San Jose, 485 U.S. 1 (1988). More generally, as an influential philosopher and legal scholar observed:

> History is full of examples of . . . justifiable confiscation without compensation. . . . [I]f the large property owner is viewed, as he ought to be, as a wielder of power over the lives of his fellow citizens, the law should not hesitate to develop a doctrine as to his positive duties in the public interest. The owner of a tenement house in a modem city is in fact a public official and has all sorts of positive duties. He must keep the halls lighted, he must see that the roof does not leak, that there are fire-escape facilities, he must remove tenants guilty of certain public immoralities, etc., and he is compensated by the fees of his tenants which the law is beginning to regulate. Similar is the case of a factory owner. He must install all sorts of safety appliances, hygienic conveniences, see that the workmen are provided with a certain amount of light, air, etc. [without seeking compensation from the government].

Morris R. Cohen, Property and Sovereignty, 13 Cornell L. Quarterly 8, 26 (1927).

Also unlike ordinary commercial ventures, hospitals receive a great deal of direct and indirect financial support from the public, above and beyond the

amounts received from customers. The vast majority of hospital care in New Jersey is provided by non-profit entities that enjoy substantial tax advantages, and most if not all hospitals in the state actively solicit financial donations from the general public. Moreover, the limitation on the number of hospitals throughout the state, inherent in the requirement of obtaining a Certificate of Need, gives those hospitals granted the privilege of providing services to their communities a correlative financial advantage that helps to compensate – in addition to their charity care reimbursement payments – for providing the care to those unable to pay. See supra at 26.

Another relevant limitation on hospitals' property rights arises from longstanding and widespread consensus in New Jersey that hospitals should not turn away patients in need of care, and that hospitals should internalize some of the cost of treating patients who can't afford to pay. Our charity care statute codified this consensus in its current form in 1992 – and this has been the law of the land for more than three decades. But charity care obligations in New Jersey have a much longer history, and were part of the fabric within which every (or nearly every) hospital in New Jersey originally took title to its property as a historical matter (see, e.g., Rsb 15-16), as well as being an understanding and obligation that each hospital has reaffirmed as part of the process of obtaining its certificate of need.

An example of such a broad consensus forming a background principle affecting the shape of takings law is the Oregon Supreme Court's recognition that the state's longstanding recognition of public access to dry sand beached abutting the ocean – similar to a public access right that New Jersey courts have recognized:

> When plaintiffs took title to their land, they were on notice that exclusive use of the dry sand areas was not a part of the "bundle of rights" that they acquired, because public use of dry sand areas "is so notorious that notice of the custom on the part of persons buying land along the shore must be presumed." We, therefore, hold that the doctrine of custom as applied to public use of Oregon's dry sand areas is one of "the restrictions that background principles of the State's law of property . . . already place upon land ownership." We hold that plaintiffs have never had the property interests that they claim were taken by defendants' decision and regulations.

Stevens v. City of Cannon Beach, 854 P.2d 449, 456–57 (Or. 1993), quoting State ex rel. Thornton v. Hay, 462 P.2d 671, 675,678 (Or. 1969), and Lucas v. South Carolina Coastal Council, 505 U.S. 1003, 1029 (1992). New Jersey has recognized similar beach access rights for many decades, disallowing both preclusive policies and preclusive access fees. See, e.g., Matthews v. Bay Head Improvement Ass'n, 95 N.J. 306, 326, 328 (1984) (reasoning, based on the Court's decisions upholding public access to health care at hospitals, that "a nonprofit [beach] association . . . is a quasi-public institution [that] holds in trust its powers of exclusive control in the areas of vital public concern" and protecting public "access to and use of privately-owned dry sand areas as reasonably necessary"); Raleigh Ave. Beach Ass'n v.

Atlantis Beach Club, Inc., 185 N.J. 40, 59 (2005) (rejecting for-profit beach club's argument "that it will lose one of the 'sticks' in its bundle of property rights if it cannot charge whatever the market will bear" and prohibiting access fees that would result in an "unreasonable economic burden on the public"); see also Glass v. Goeckel, 703 N.W.2d 58, 74 (Mich. 2005) ("[T]he public has always held a right of passage in and along the lakes."); Gregory S. Alexander, The Social-Obligation Norm in American Property Law, 94 Cornell L. Rev. 745, 805 (2009) (noting the importance of beach accessibility to low-income New Jerseyans); cf. Watuppa Reservoir Co. v. City of Fall River, 18 N.E. 465, 472 (Mass. 1888) ("the grant from the state, of land upon a stream flowing from a great pond, did not convey an unqualified fee, with the right to enjoy the usual and natural flow of the stream, but a qualified right, subject to the superior right of the state to use the pond and its waters for other public uses [such as municipal water supply] if the exigencies of the public, for whom it holds the pond in trust, demand it").

The hospitals also incorrectly assert that "no other profession or industry is required to shoulder a similar burden" to the charity care they provide. See Cert. Pet. at 14. The most obvious counter-example is that New Jersey attorneys must accept court assignments to represent clients who are unable to pay on a pro bono basis, an arrangement that this Court has specifically upheld against a takings clause challenge at least twice. Madden v. Township of Delran, 126 N.J. 591,

602–03 (1992), quoting State v. Rush, 46 N.J. 399, 408 (1966) ("if one accepts the premise that the duty to defend the poor is a professional obligation rationally incidental to the right accorded a small segment of the citizenry to practice law, these [takings] claims fall away"); accord New Jersey Div. of Youth & Fam. Servs. v. D.C., 118 N.J. 388, 402 (1990) (citing State v. Rush with approval); State v. Horton, 34 N.J. 518, 532 (1961) ("While the philosophy of the assigned counsel system is founded on the basic obligation of the bar to render gratuitous services to the indigent, . . . it seems eminently sound [where statute and court rule allowed 'reasonable compensation' in murder defense cases] to say that compensation more than token but less than full rate is intended in order to achieve a desirable sharing of the economic burden between the Bar and the community . . . .") (internal quotation omitted). The highest courts in several other states have agreed that attorneys do not have a constitutional right to just compensation when called upon to represent clients unable to afford their services, including New York, In re Smiley, 330 N.E.2d 53, 58 (N.Y. 1975) (recognizing that "[t]he courts have a broad discretionary power to assign counsel without compensation in a proper case); California, Payne v. Superior Ct., 553 P.2d 565, 574 n.6 (Cal. 1976) (absent appropriation by the legislature, "attorneys must serve gratuitously in accordance with their statutory duty not to reject the cause of the defenseless or the oppressed); Florida, In re Amendments to Rules Regulating The Fla. Bar-1-3.1(a) & Rules of

Jud. Admin.-2.065 (Legal Aid), 573 So. 2d 800, 805–06 (Fla. 1990) ("We also reject respondents' fifth amendment claim that there is a 'taking' when the court requires a lawyer to represent an indigent without compensation. . . . We hold that every lawyer of this state who is a member of The Florida Bar has an obligation to represent the poor when called upon by the courts and that each lawyer has agreed to that commitment when admitted to practice law in this state."), Arizona, Scheehle v. Justices of the Supreme Ct. of the State of Arizona, 120 P.3d 1092, 1103 (2005) ("This Court has the constitutional authority to require active members of the state bar to serve as [pro bono] arbitrators."), and South Carolina, Ex parte Dibble, 310 S.E.2d 440, 442 (S.C. Ct. App. 1983) ("[W]e hold that [the] inherent power [or the court] must necessarily include the power to appoint lawyers to serve without compensation where it appears reasonably necessary for the court to do justice. Under such circumstances, lawyers benefit not only the litigants whom they represent, but all of society as well.") (footnote and citations omitted), accord S.C. Dep't of Soc. Servs. v. Tharp, 439 S.E.2d 854, 857 (S.C. 1994). The U.S. Supreme Court has also recognized that this is the correct result as a matter of federal constitutional law. See Hurtado v. United States, 410 U.S. 578, 588–89 (1973) (identifying "representation of indigents by [a] court-appointed attorney" as an example supporting the proposition that "[t]he Fifth Amendment does not require that the Government pay for the performance of a

public duty it is already owed"), citing United States v. Dillon, 346 F.2d 633, 635 (9th Cir. 1965); and Powell v. Alabama, 287 U.S. 45, 73 (1932) (where defendants in capital cases are "unable to employ counsel," and where it was clear that no compensation from the state would be available if the court appointed counsel, "[a]ttorneys are officers of the court, and are bound to render service when required by such an appointment")

More broadly, statutes and regulations routinely require businesses of virtually every type to use or adapt their supplies, equipment, space, and labor in ways they might not otherwise choose, and for which they have no ability to bring a takings case. For instance, all home improvement contractors are required to display their registration number on, among other things, all of their vehicles. N.J.S.A. 56:8-144(a). While contractors must devote supplies and labor to meeting this requirement, they do not thereby demonstrate a constitutional taking and a right to just compensation for the labor costs of painting their registration numbers on their trucks (and forgoing the possibility of using that space for advertising), or for the cost of the paint and painting equipment they used.

III. MOST IF NOT ALL OF NEW JERSEYS' HOSPITALS LACK THE RELIANCE INTEREST NEEDED TO DEMAND JUST COMPENSATION, THE COURT SHOULD AFFIRM THE APPELLATE DIVISION'S HOLDING THAT THERE IS NO TAKING UNDER THE PENN CENTRAL BALANCING TEST, AND THE COURT NEED NOT ADDRESS THE DISTINCTION BETWEEN FACIAL AND AS-APPLIED CONSTITUTIONAL CHALLENGES

LSNJ and DRNJ adopt the arguments in Point I of the Attorney General's supplemental merits brief that hospitals that acquired title after enactment of the charity care statute in 1992 "cannot now use the Takings Clause to recover a windfall by challenging . . . laws in effect before they acquired their property," Rsb 12-16, and the arguments in Point III of the Attorney General's supplemental merits brief urging the Court to affirm the Appellate Division's holding that New Jersey's charity care program is not a regulatory taking under Penn Central Transportation Co. v. New York City, 438 U.S. 104 (1978). Rsb 30-34. LSNJ and DRNJ also agree with the Attorney General that whether the hospitals' claims are characterized as facial or as-applied constitutional challenges, the outcome of the case should be the same. See Rsb 35-37; 74 Pinehurst LLC v. New York, 59 F.4th 557, 568 (2d Cir. 2023), cert. denied, 218 L. Ed. 2d 66 (2024) ("The character of the regulation does not change whether the [takings] challenge is as applied or facial.").

CONCLUSION

For all of the foregoing reasons, the Court should affirm the decision of the Appellate Division below.

Respectfully Submitted,
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