

# Chapter 7: Counties' Legal Obligation to Provide Care to Remaining Uninsured Residents

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## 7. Counties' Legal Obligation to Provide Care to Remaining Uninsured Residents<sup>1</sup>

After the full implementation of the Affordable Care Act – with the expansion of Medi-Cal to non-disabled adults with no dependent children, subsidized insurance through Covered California, and a single streamlined application and eligibility process – it is estimated there will still be anywhere from 2 to 4 million non-elderly Californians who lack health coverage.<sup>2</sup> For those who remain uninsured, pre-existing state law requires counties to provide safety net health care.

Welfare and Institutions Code section 17000 obligates counties to serve as the provider of “last resort” for indigent Californians who have no other means of support.

**Welfare and Institutions Code § 17000:** "Every county and every city and county shall relieve and support all incompetent, poor, indigent persons, and those incapacitated by age, disease, or accident, lawfully resident therein, when such persons are not supported and relieved by their relatives and friends, by their own means, or by state hospitals or other state or private institutions."<sup>3</sup>

1. This chapter is adapted from an advocate issue brief “Ensuring a Strong Safety Net for the Remaining Uninsured,” co-authored by Abbi Coursolle of the National Health Law Program and Shirley Sanematsu of the Western Center on Law & Poverty and published in March 2015 with funding from the Blue Shield of California Foundation. The full report is available at <http://wclp.org/resource/resources-1/>.
2. See, e.g., Bianca DiJulio et al, "Where are California's Uninsured Now? Wave 2 of the Kaiser Family Foundation California Longitudinal Panel Survey" (2014) (about 2.4 million in 2014), <http://kff.org/health-reform/report/where-are-californias-uninsured-now-wave-2-of-the-kaiser-family-foundation-california-longitudinal-panel-survey/>; Anthony Menacho et al., Health Access California, "Reorienting the Safety Net for the Remaining Uninsured 3" (2015) (2.7 to 3.4 million in 2015), available at <http://www.health-access.org/images/pdfs/CountySafetyNetReportSurveyResults3-12-15.pdf>; *UCLA Center for Health Policy Research & UC Berkeley Center for Labor Research and Education, CalSIM version 1.91 Statewide Data Book: 2015–2019* at 2 (2014) [hereinafter UCLA & UCB Study] (just over 4 million in 2015), available at <http://healthpolicy.ucla.edu/publications/Documents/PDF/2014/calsimdatatobook-may2014.pdf>.
3. Welf. & Inst. Code § 17000; see *Welfare Rights v. Frank*, 25 Cal. App. 4th 415, 420-21 (1994) (describing the legislative history of the statute).

Section 17000 is designed to ensure that low-income Californians who are not eligible for health coverage programs like Medi-Cal or Covered California have access to a safety net that meets their subsistence health care needs. Over the years, the courts have interpreted Section 17000 to allow counties some discretion in the design and scope of their 17000 programs.

When working with an uninsured consumer, it is important for advocates to understand the basic requirements of Section 17000, as well as the eligibility criteria in the particular county where the consumer resides, the county's enrollment policies and practices, and the services the county covers. If the consumer is not eligible for the county's 17000 program, or the services covered by the county do not meet the subsistence needs of indigent residents, the information in this chapter can help advocates assess whether a county's program conforms with Section 17000's intent.

### **A. Financial Eligibility Criteria**

California law gives counties discretion in setting their eligibility criteria for their Section 17000 programs.<sup>4</sup> But that discretion is limited. Welfare and Institutions Code Section 10000 requires that Section 17000 services be provided “promptly and humanely” to satisfy the statutory purpose of “providing appropriate aid and services to all of [the state's] needy and distressed.”<sup>5</sup> Thus, a county's discretion to set eligibility standards “can only be exercised within fixed boundaries . . . consistent, not in conflict with [§17000], and reasonably necessary to effectuate its purpose.”<sup>6</sup> A threshold eligibility criterion that merits close scrutiny is the county's financial

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4. Welf. & Inst. Code § 17001 (“The board of supervisors of each county, or the agency authorized by county charter, shall adopt standards of aid and care for the indigent and dependent poor of the county or city and county”).
  5. Welf. & Inst. Code § 10000 (“The purpose of this division is to provide for protection, care, and assistance to the people of the state in need thereof, and to promote the welfare and happiness of all of the people of the state by providing appropriate aid and services to all of its needy and distressed. It is the legislative intent that aid shall be administered and services provided promptly and humanely, with due regard for the preservation of family life, and without discrimination on account of ancestry, marital status, political affiliation, or any characteristic listed or defined in Section 11135 of the Government Code. That aid shall be so administered and services so provided, to the extent not in conflict with federal law, as to encourage self-respect, self-reliance, and the desire to be a good citizen, useful to society”).
  6. *Robbins v. Superior Court*, 38 Cal.3d 199, 405 (1985); see also *Mooney v. Pickett*, 4 Cal.3d 669, 679 (1971).

eligibility standards to qualify for care.

Section 17000 requires counties to provide health care to “all indigent” residents. With regard to assets, counties may establish their own policies regarding the property a person may have while receiving aid through Section 17000.<sup>7</sup> Counties have generally adopted all or part of the pre-ACA Medi-Cal asset rules, such as allowing up to \$2,000 in assets for an individual and exempting one car and one’s home, but counties may adopt more restrictive policies.

With regard to income, income eligibility limits for indigent health programs span a wide range across California’s counties.<sup>8</sup> For example, in 2014 three counties limited their programs to persons with income at or below 100% of the Federal Poverty Limit (\$11,880 a year for an individual in 2016), while at the high end one county reportedly had an income eligibility limit of 700% of the Federal Poverty Limit (\$83,160 a year for an individual in 2015).<sup>9</sup> The majority of counties – 43 of 58 – set their upper income eligibility limits at 200% of the Federal Poverty Limit, or \$23,760 a year for an individual.<sup>10</sup>

Despite these widely disparate income limits, counties do not have unfettered discretion in setting income eligibility criteria. First, counties must not set their standards to such low levels that they would leave otherwise qualified residents

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7. Welf. & Inst. Code § 17107; see also *id.* § 17111 (allowing recipients to be permitted to keep tools of his trade necessary to continue employment and a car of “reasonable value” in order to enable the aided person to become self-supporting).
  8. Menacho *et al.*, *supra* note 2 at 7-8; see also Cal. Dept. of Health Care Servs., *County Indigent Care Profile (2014)*, available at [http://www.dhcs.ca.gov/provgovpart/Documents/AB%2085/County\\_Profiles\\_ADA.pdf](http://www.dhcs.ca.gov/provgovpart/Documents/AB%2085/County_Profiles_ADA.pdf).
  9. *Id.* The three counties with income eligibility limits of 100% of the Federal Poverty Limit are Merced, Placer and Santa Cruz; Ventura County reports an income eligibility limit of 700% FPL. See *id.*
  10. *Id.* The 43 counties with an income eligibility limit of 200% of the Federal Poverty Limit include eight individual counties - Alameda, Kern, Monterey, Orange, Riverside, San Joaquin, San Mateo, and Santa Barbara - and the 35 rural and/or small counties that make up the County Medical Services Program (CMSP) consortium. See *id.*

without subsistence medical care.<sup>11</sup> Section 17000’s mandate is not limited to assisting only the county’s most destitute individuals; the mandate to care for “all indigents” requires counties to provide care for residents who may have greater means, but who nevertheless are unable to pay for the costs of their own medically necessary care.<sup>12</sup>

A second and related limit on the counties’ discretion in setting income limits centers on a person’s ability to pay for care. A county’s income eligibility standard must take into account an individual’s actual ability to pay for the cost of subsistence care.<sup>13</sup> A third limit on a county’s discretion to establish income criteria requires a county to take into account the cost of basic needs to live in the county, such as housing, utilities, food, transportation, etc., in setting income criteria that may be appropriate for residents.<sup>14</sup> Thus, counties may not set their income eligibility levels so low that residents will not be able to afford subsistence living in the county after paying for medical care.<sup>15</sup>

One red flag regarding a county’s income eligibility criteria is a county that uses a “hard” income cap, meaning that if an uninsured person’s income exceeds it, she is absolutely barred from accessing Section 17000 services, regardless of her medical need or ability to pay. Such caps have been struck down as improper.<sup>16</sup> A county “cannot be considered [a] ‘safety net’ or place of ‘last resort’ for subsistence medical care” if persons “suffering from serious injury or illness, but whose income is \$1 over the income cap...and cannot afford or cannot obtain insurance” are unable to access

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11. *Hunt v. Superior Court*, 21 Cal.4th 984, 1014 (1999) (“[I]n determining a financial eligibility standard for [17000 county health services], the County must consider whether implementation of the standard would leave some residents incapacitated by age, disease, or accident, and whose condition is not relieved through other means, without subsistence medical care”).
  12. See, e.g., *Alford v. County of San Diego*, 151 Cal.App.4th 16, 29 (2007) (noting that “medically indigent persons” includes the “working poor”); *Goodall v. Brite*, 11 Cal.App.2d 540, 548 (1936) (holding that a county hospital must accept beyond the “pauper class” and accept persons “who can pay something towards their care and treatment”).
  13. *Hunt*, 21 Cal.4th at 1015.
  14. *Alford*, 151 Cal. App.4th at 35.
  15. See *id.*; see also *Hunt*, 21 Cal.4th at 1015.
  16. *Alford*, 151 Cal. App.4th at 35 (striking down San Diego’s flat income eligibility cap of \$1,078 a month, or 135% of the Federal Poverty Limit at the time, because the county failed to consider an individual’s ability to pay all or part of their subsistence medical care, even if the person was just \$1 over the cap).

§ 17000 care.<sup>17</sup>

Counties have several options to address this issue, such as having a Section 17000 program that includes a sliding scale fee or share of cost system based on an ability to pay analysis;<sup>18</sup> providing reasonable policies and procedures for residents to request hardship exemptions from such limits; or setting their income eligibility criteria at such a level that persons above the level can afford to pay for care. Advocates should work with their counties to ensure that financial eligibility rules are reasonable and provide access to the remaining uninsured who will not otherwise be able to pay for care.

**Advocacy Tip:** Answering the series of questions below can help you assess whether a county's financial eligibility rules are reasonable.

- What are the income limits for someone to qualify for medically indigent services?
  - If the income eligibility limit is a percentage of the Federal Poverty Limit, does the county update the dollar amount equivalent every year on April 1?
- If there is an income eligibility limit, did the county do a study on the cost of basic necessities (housing, utilities, food, transportation, personal care, etc.) to live in the county in setting its income eligibility limit?
  - How current is the data the county used in assessing the cost of basic necessities? And is the data specific to the county?
- Is there an upper income eligibility cap, and if yes what is it?
- Does the county have an assets or resources eligibility requirement? If yes, what is it based on?
- Are there exemptions from any of the program's eligibility requirements? For example, is there a financial hardship exception to offset income that is otherwise over the income eligibility limit?
  - How does the county notify the general public and applicants for county indigent health of the availability of this exemption?
- When were the county's financial eligibility requirements last updated?
- How many people is your county serving in its 17000 program?

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17. *Id.*

18. Section 17000 programs can include income-tiered categories for care, where services may be available at no cost to persons below a certain income level and some type of cost-sharing arrangement at higher income levels.

## **B. Cost-Sharing**

In addition to setting of financial eligibility limits, some counties may include cost-sharing in their Section 17000 programs. Cost-sharing can take many forms and generally describes anytime a program charges a person for services, such as imposing a fee schedule for services, *i.e.*, \$5 for a primary care visit, \$10 for a specialist and \$20 for emergency room care. Another example of cost-sharing is when participants in a county health program who exceed a certain income or asset limit are required to spend the amount of money they have above the limit in order to access services, a practice commonly referred to as share of cost or spending-down.

Including cost-sharing arrangements in Section 17000 programs is permissible, but there are limits. First, counties are strictly prohibited by statute from charging fees as a prerequisite to receiving Section 17000 services. Specifically, “[n]o fee or charge shall be required of any persons before a county renders medically necessary services to persons entitled to services pursuant to § 17000.”<sup>19</sup> In other words, counties may bill the consumer for 17000 services, but they may not deny people services if they are unable to pay.

And, like income eligibility limits, any cost-sharing system must be related to a person’s ability to pay for care.<sup>20</sup> This means that if a Section 17000 program requires participants over 100% of the Federal Poverty Level to pay according to a fee schedule, for example, the county must have a factual basis to assume all persons above that level can afford to pay the fees. In other words, counties may “implement a *reasonable* sliding fee schedule *based on ability to pay*.”<sup>21</sup> Advocates should evaluate their counties’ cost-sharing rules to make sure they are up-to-date and reflect the current cost-of-living in the county.

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19. Welf. & Inst. Code § 16804.1.

20. See, e.g., *Brown v. Crandall*, 198 Cal. App. 4th 1, 10 (2011) (noting that “the ability to pay for private health insurance does not necessarily demonstrate an ability to pay all of a substantial medical bill. . . . [but] whether a person can afford such care is a factual question that should be decided based on evidentiary proof”); *Poverty Resistance Center v. Hart*, 213 Cal.App.3d 295, 304 (1989) (“[F]actual premises which underpin a standard adopted under Section 17001 must be supported by evidence before the Board and by reasonable inference drawn therefrom”).

21. Welf. & Inst. Code § 16804.1(b) (emphasis added).

**Advocacy Tip:** Is there cost-sharing? Examples of cost-sharing include participant fees, co-pays, sliding scale fees, share of cost, or a percentage of the cost of care to receive services.

If there is cost-sharing, relevant questions include:

- What are the amounts of these fees?
- On what basis did the county develop its cost-sharing system?
- When was the cost-sharing scheme last updated?
- Does the county require participants to pay fees before receiving services?

### C. Timing

Counties have substantial discretion in terms of when they will accept an application for their Section 17000 programs. For example, while some counties operate their programs to accept applications at any time, other counties will only accept applications from individuals who have an existing medical need.<sup>22</sup> Such requirements are most likely consistent with the statutory mandate to relieve and support residents—those without an existing need are presumed not to require the county’s relief and support.<sup>23</sup> Counties may require residents to reapply for help or “renew” enrollment in a Section 17000 program on a regular basis.<sup>24</sup>

Counties may be required to cover bills incurred in the past, but have some discretion to require residents to apply for help within a certain period after the bill was incurred.<sup>25</sup> Some counties use “coverage-like” programs to deliver care to indigent residents, which permits them to stay in the program for an entire year without a need to reapply or demonstrate medical need.<sup>26</sup> Advocates should work

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22. See Health Access California, *supra* note 3, at 4.

23. See Welf. & Inst. Code § 17000.

24. See Health Access California, *supra* note 3, at 11.

25. See *McGrath v. Crandall*, No. A127890, 2011 WL 1085112, at \*4 (Cal. Ct. App. Mar. 24, 2011) (remanding the question of whether a county is obligated to cover past bills).

26. Several counties chose this model following their experience with the Low Income Health Program, the bridge program and precursor to expanded Medi-Cal. See Health Access California, *supra* note 3, at 13.

with their counties to determine whether this type of program design is feasible to ensure broader access to health care coverage by those remaining uninsured.

#### **D. Residency**

Section 17000 limits eligibility for county health care services to individuals who are residents in the county where they are applying for aid. Residents of an Indian Reservation are considered residents of the county in which the Reservation is located.<sup>27</sup> Residence is defined in the law as “the place where one remains.”<sup>28</sup> Like the general rules governing residency in California, “residence” for the purposes of Section 17000 programs requires both physical location and intent to stay in a place.<sup>29</sup> Counties may not, however, refuse services to county residents simply because they don’t have a valid address, such as in the case of people who are homeless.<sup>30</sup> Similarly, a rule requiring applicants to reside in the county for a period of time before accessing services through the 17000 program is likely invalid.<sup>31</sup>

Section 17000 expressly limits the county’s obligation to support those who “*lawfully*” reside in the county. The term “*lawfully*” has been interpreted to allow counties to limit services to individuals with a satisfactory immigration status.<sup>32</sup> Counties therefore have the discretion to aid undocumented immigrants and/or non-residents, although they are not required to do so.<sup>33</sup> Counties also have some discretion as to which specific immigration statuses they consider “*lawfully resident*.” At least one court suggests that counties may follow CalWORKS welfare rules with respect to immigration status, which are generally more restrictive than the immigration status rules for Medi-Cal and Covered California.<sup>34</sup>

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27. *Acosta v. San Diego Cnty.*, 126 Cal. App. 2d 455, 467 (1954).

28. Welf. & Inst. Code § 17101.

29. See *Nelson v. San Diego County Bd. Of Supervisors*, 190 Cal. App. 3d 25, 30 (1987). The general residence rules for the state are set forth at Government Code § 244.

30. *Nelson*, 190 Cal. App. 3d 25 at 31.

31. See *Mem’l Hosp. v. Maricopa Cnty.*, 415 U.S. 250, 269 (1974).

32. *Khasminskaya v. Lum*, 47 Cal. App. 4th 537, 543 (1996); *Bay General Community Hospital v. County of San Diego*, 156 Cal. App. 3d 944, 961 (1984).

33. Welf. & Inst. Code § 17003.

34. See *Khasminskaya*, 47 Cal. App. 4th at 543.

In California, all immigrants regardless of documentation status may be eligible for restricted-scope Medi-Cal, which provides for emergency care and certain pregnancy-related and long-term care services.<sup>35</sup> Immigrants who can establish PRUCOL (Permanently Residing Under Color of Law) status are eligible for full-scope Medi-Cal benefits.<sup>36</sup> In Covered California, immigrants are eligible to purchase a plan as long as they are “lawfully present.”<sup>37</sup> While there is significant overlap between the groups of immigrants who are eligible for Medi-Cal and those who are eligible for Covered California, there will be some immigrants whose immigration status qualifies them for full-scope Medi-Cal, but not Covered California, and vice versa.<sup>38</sup>

For example, immigrants who hold work permits under the Deferred Action Childhood Arrival (DACA) executive order are potentially eligible for Medi-Cal through PRUCOL, but are not eligible for Covered California. If they are ineligible for Medi-Cal due to income, these DACA may be eligible for help from their county’s Section 17000 program. Advocates should be aware of their county’s rules regarding immigrant eligibility, and consider challenging policies that are overly restrictive.

**Advocacy Tip:** Relevant questions regarding a county's residency requirement include:

- Does the county require a person to reside in the county for a certain number of days to be considered a county resident?
- How does the county consider immigration status in its residency definition?
  - Which immigration statuses are eligible for the county’s program?
- Does the county’s program provide services to persons who are undocumented?

35. Welf. & Inst. Code §§ 14007.5(d); 14007.2; 14007.65.

36. Welf. & Inst. Code § 14007.5(b); id. § 11104 (eligibility of immigrants who are PRUCOL); see also Cal. Imm. Policy Center, "Health Program Eligibility Chart for California Immigrants," 2 n.3 (2013) (explaining PRUCOL), *available* at <http://www.caimmigrant.org/wp-content/uploads/2014/10/HPEligibilityChartforCAImmigrants.2013.pdf>;

37. 45 C.F.R. § 152.2 (defining “lawfully present”).

38. Nat’l Imm. Law Center, "Major Benefit Programs Available to Immigrants in California" at p. 3-4 (2014), *available* at <http://nilc.org/document.html?id=481>.

### E. Programmatic Eligibility

Section 17000 limits a county's obligation to provide care to only those individuals who do not have another source of care for the services they request from a county. Practically speaking, this provision is usually used as a legal basis to require applicants for county programs to apply for Medi-Cal, Covered California or other potential sources of health coverage, including other private insurance (like COBRA or employer coverage) before the county will cover their health care costs.

A county's obligation to provide additional, but necessary, services to those enrolled in coverage depends on the type of coverage the person has. The statute explicitly relieves counties of any duty to provide health care to those persons who are enrolled in, or who are eligible for, Medi-Cal—even if a needed service is not covered by Medi-Cal.<sup>39</sup> Counties do have an obligation to provide health care to those who have a Medi-Cal application pending; it may recoup the cost of those services provided from the state Medi-Cal program if the Medi-Cal application is ultimately approved. However, a county may be obligated to cover medically necessary services that are not covered by a person's private insurance.<sup>40</sup>

With regard to uninsured individuals who are eligible for subsidized Covered California plans but are not enrolled, the case law suggests that if subsidized Covered California plans are inaccessible to low-income Californians due to cost, counties could be required to offer services to this population.<sup>41</sup> An alternative model might be for counties to subsidize residents' Covered California plan premiums, which might be more cost-effective than providing the services directly at full county cost. For those remaining uninsured individuals who missed the enrollment period to apply for subsidized insurance through Covered California, case law suggests that the county has an obligation to provide care at least until the person next has an opportunity to enroll.<sup>42</sup> Advocates should seek the best mechanisms to ensure that those eligible for other affordable coverage options are swiftly enrolled, and to

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39. Welf. & Inst. Code § 17030.

40. *Cf. McCormick. v. County of Alameda*, 193 Cal. App. 4th 201 (2011) (General Assistance, the cash aid counterpart to § 17000 health programs, must pay for services when CalWORKs provides no cash assistance).

41. *See id.*

42. *See id.*

provide interim services for those who miss an enrollment period.

**Advocacy Tip:** With the implementation of health reform and expanded coverage options, it is important to understand how a county's section 1700 program fills the gaps. What is the relationship between eligibility for county Section 17000 program health services and eligibility for Medi-Cal or subsidized insurance through Covered California? Does the county require applicants to prove ineligibility for these other two programs to be eligible for county indigent health services?

#### F. Recouping expenses

Counties may require residents to repay the cost of care provided to them through a Section 17000 program, by placing a lien on the recipient's property.<sup>43</sup> In addition, counties may seek repayment from any legally responsible relatives or immigration sponsors of those who receive care from a Section 17000 program.<sup>44</sup> The law contains detailed provisions concerning when a county may enforce such a lien to recoup the cost of care; those provisions are intended to protect consumers from onerous collections.<sup>45</sup> Other consumer debt collection protections may apply if the county attempts to collect on the lien.<sup>46</sup> Advocates should determine whether their county requires residents to sign a lien before receiving services from its Section 17000 program, and where this is the county practice, seek an evaluation of whether this is cost-effective. If not, counties should be asked to alter or eliminate the practice.

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43. Welf. & Inst. Code § 17109.

44. See *id.* § 17300 (responsible relatives); *id.* § 17001.9 (sponsors of immigrants).

45. See *id.* §§ 17400-410; see also *Cnty. of San Diego v. Muniz*, 22 Cal. 3d 29 (1978).

46. See, e.g., *Joseph v. J.J. Mac Intyre Companies, L.L.C.*, 238 F. Supp. 2d 1158 (N.D. Cal. 2002).

### G. Scope of Services

The kind of care counties must provide to their low-income residents is derived from the statutory obligation to “relieve and support.” That phrase has been interpreted to obligate counties to provide “subsistence medical care;” however, it has not been read to require counties to provide their low-income residents with a set benefits package.<sup>47</sup> This standard requires counties must provide “at least...medical services necessary for the treatment of acute life-and-limb threatening conditions and emergency medical services.”<sup>48</sup> In the case of emergency care, counties must pay for that care even if it is provided out-of-network or out-of-county.<sup>49</sup>

But the counties’ obligation clearly extends beyond emergency care. Counties must provide “medically necessary care.”<sup>50</sup> And such care must be “sufficient to remedy substantial pain and infection.”<sup>51</sup> Under this standard, counties have been found liable for urgent dental care to address abscesses, for example, but not routine preventive dental care.<sup>52</sup> While some counties offer only a very limited scope of services in their Section 17000 programs, others offer preventive services and broad access to specialty care; some counties have even implemented innovations like medical homes, and integrated delivery for behavioral health services.<sup>53</sup> Advocates should evaluate whether the services offered by their county are “sufficient to remedy substantial pain and infection,” and also look for opportunities to work with counties to implement cost-effective innovations, including coverage of preventive services, better care coordination through medical homes, and improved integration with county behavioral health delivery systems.<sup>54</sup>

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47. *Hunt*, 21 Cal. 4th at 1012.

48. *Id.* at 1014.

49. *Fuchino v. Edwards-Buckley*, 196 Cal. App. 4th 1128 (2011).

50. *County of Alameda v. State Bd. of Control*, 14 Cal. App. 4th 1096, 1108 (1993).

51. *Cooke v. Superior Court*, 213 Cal. App. 3d 401, 404 (1989).

52. *Id.* at 415 (county is not required to ensure “good teeth and a picture-perfect smile in order to succeed in the workplace. . . [but it must provide a] level of care which remedies the pain and infection which petitioners have needlessly endured”); see also *Harris v. Bd. of Supervisors, Los Angeles Cnty.*, 366 F.3d 754, 765 (9th Cir. 2004) (county may not cut services in a way that will “deprive plaintiffs of medically necessary care, will endanger their health, and will lead to their unnecessary suffering”).

53. See Health Access California, *supra* note 3, at 13-14.

54. *Cooke*, 213 Cal. App.3d at 404.