

Gov. Newsom's Veto of AB 1014 Prevents Greater Regulation over Emergency Department Closures Amidst Loss of Health Access

In California and elsewhere, the closure of emergency departments ("ED") reduces access and negatively affects patient health, particularly to the primary users of EDs, who are often low-income and most affected by the closure. In 2014, the American College of Emergency Physicians (ACEP) observed that California had the lowest number of EDs per capita^[1] and gave California an "F", ranking the state 42nd in the country in terms of access to emergency care.^[2] However, California's latest attempt to strengthen state oversight over ED closures faltered when Governor Newsom vetoed AB 1014, which would have required at least 180 days, instead of the currently mandated 90 days, notice before a planned reduction or elimination of emergency medical service.

To better understand the impact of this veto and policy recommendation for ED regulation, in this month's California Legislative Beat, we briefly examine the state of EDs in California, California's current regulatory scheme and reform attempts, and regulations by other states that may serve as a model for California.

Closure of Emergency Departments Affect Patient Mortality and Low-Income Communities

The primary users of emergency departments in California are Medi-Cal patients, who have limited income and resources. In

2016, 43% of all ED visits were from Medi-Cal patients, compared to 23% of ED visits coming from Medi-Cal patients since 2006.[\[3\]](#) But, as visits to EDs rise, the number of ED closures have affected health access in California, particularly for low-income communities. This is troublesome, especially when emergency departments (“ED”) are considered to be the “safety net of the safety net.”[\[5\]](#)

Between 1999-2010, forty-eight California EDs closed.[\[6\]](#) While this constitutes only about 10% of EDs in California,[\[7\]](#) 24% of all ED admissions were in an area affected by an ED closure.[\[8\]](#) More concerning, California hospitals with more African American and Medi-Cal recipient patients were found to have a higher risk of ED closure.[\[9\]](#)

Researchers warned that “permanent ED closure has substantial consequences on patient [health] outcomes.”[\[10\]](#) One study found that ED closure resulted in “higher odds of inpatient mortality.”[\[11\]](#) Alarming, a patient in an area with ED closure would have a 15% greater chance of dying of a heart attack and 10% greater chance of dying of a stroke.[\[12\]](#) These chances may be more exacerbated for low-income communities, who face a “higher risk of [. . .] deteriorating access” to EDs.[\[13\]](#)

The increased mortality caused by ED closures may be due to increased driving times. In another study, researchers found that when driving time to another ED increased by more than 30 minutes, patients had a 6.58% increase in mortality 90 days after a surgery.[\[14\]](#) Because driving time cannot be mitigated unless another ED opened up nearby, closures of ED, in the absence of nearby EDs, may have an instant negative impact on patient health.

Based on these findings, researchers have encouraged policymakers to “reassess the extent to which market forces are allowed to dictate ED closures and access.” They noted that “market-based approaches to health care will not ensure

access to care is equally distributed” as market factors, such as a hospital in a highly competitive marketplace or being located 15 miles near another ED, increases the risk of ED closure. [\[15\]](#)

AB 1014 and Current California Oversight over Emergency Department Closures

In California, the state legislature has made incremental steps on requiring notice of ED closures, but over the past few decades, several legislative efforts to slow or mitigate ED closures have faltered or failed. In particular, California’s latest attempt to strengthen state oversight over ED closures ended when Governor Newsom vetoed AB 1014, which would have increased notice of a planned reduction or elimination of emergency medical service to 180 days. To understand what kind impact AB 1014 would have had, Table 1 summarizes the current notification periods under California law as well as how the notification period would have changed.

Transaction	Service/Entity Affected by Transaction	Current Notice Requirement (Days Prior to Transaction)	AB 1014 Notice Requirement (Days Prior to Transaction)
Reduction or Elimination	Emergency Medical Services	90 [16]	180
Elimination or Relocation	Supplemental Service [17]	30	90
Closure	Non-County Hospital [18]	30	180

Reasoning for Vetoing AB 1014 and Counter Arguments

In vetoing AB 1014, Governor Newsom agreed that “hospital closures have vast impacts on communities,” but he noted that the “state is not able to force a hospital to stay open when they are financially unable.”[\[19\]](#) However, Health and Safety Code Section 1255.1, even as amended by AB 1014, would have exempted notice of the reduction or elimination of emergency medical services when a hospital’s resources to keep the ED open “substantially threatens the stability of the hospital.”[\[20\]](#) Such an exemption was not included for the closure of non-county hospitals or the elimination or relocation of the supplemental service.

The governor also mentioned in his veto message that AB 1014, in increasing notification periods, would “exacerbate the financial and patient safety concerns,”[\[21\]](#) which echoes the California Hospital Association’s (CHA) position that this bill would prevent hospitals from having the “flexibility to close or adjust services to ensure quality of care.”[\[22\]](#)

CHA’s position to notice has been consistently negative toward notification.[\[23\]](#) When CHA first opposed the enactment of notice for reduction or elimination of medical services, they argued that “financially troubled hospitals cannot be expected to sustain ongoing financial losses for three months [90 days].”[\[24\]](#) CHA asked for and was granted the exemption mentioned above. However, CHA did not ask for such an exemption when Health and Safety Code Section 1255.25 was passed, which created notice for the elimination or relocation of supplemental services and for the closure of non-county hospitals. Instead, CHA opposed the bill completely and argued that this was “another unfunded mandate that prevents hospital personnel from providing quality and efficient services due to unnecessary regulation.”[\[25\]](#)

However, supporters of notification, in the form of AB 1014 and AB 2103 from 1998, have argued that this bill is important

to promote patient safety and ensure health access. The California Nurses Association argued in 1998, when the notifications were first enacted, that the notification promoted safe patient care as there were already not enough emergency services, citing closures in Costa Contra County and shortages in Los Angeles County.[\[26\]](#) Together with Assemblymember O'Donnell, the author of AB 1014, the California Nurses Association argue that the current notification period was insufficient to provide enough time for community engagement or to create a plan to compensate for the loss of services.[\[27\]](#)

Given that closures of emergency rooms are detrimental to patient safety and are permanent obstacles to health access, a solution other than the current regime is desperately needed to ensure there is proper health access.

Alternative Solution: Regulation Authority over EDs to Preserve Health Access

One point the California Nurses Association made was that “downgrade or closure of emergency services [were] associated with hospital mergers and acquisitions.”[\[28\]](#) Yet, under the current regulatory scheme, the California Attorney General, despite having pre-merger approval authority for nonprofit hospitals, cannot intervene in post-merger consequences, such as Sutter Health’s proposed decision to close Alta Bates Medical Center (and its emergency room) in Berkeley in favor of consolidating services at Summit Medical Center in Oakland.

In 2017, the Legislature passed SB 687, which would have required AG approval prior to reduction or elimination of emergency medical services, but Governor Brown vetoed SB 687 with similar concerns as Governor Newsom, stating that the Attorney General rejecting an elimination or reduction of emergency medical services may “hasten the reduction of other

services or closure of the entire hospital.”[\[29\]](#)

This reasoning seems not to be true in Rhode Island or Hawaii, where similar statutes like SB 687 are in place. In Rhode Island, a hospital cannot eliminate or significantly reduce emergency or primary care services without the department of health’s approval.[\[30\]](#) Similarly, in Hawaii, an acquiror would need agency approval to “substantially reduce or eliminate direct patient care services at the hospital below the levels at” the time of acquisition.[\[31\]](#) California should try to implement similar laws given that such laws have been successfully implemented in other states since the late 1990s and have not been repealed or caused noticeable problems for patient safety and quality.[\[32\]](#)

In California, this approval authority could be given to the California Department of Public Health (CDPH), which oversees the suspension or cancellation of ED licenses. In California, when a hospital wants to reduce or eliminate emergency services, it must receive approval from the CDPH, which grants the special licenses.[\[33\]](#) The statute is vague on what criteria, if any, CDPH must consider. What’s clear is that the hospital must submit an impact evaluation on the community for the reduction or elimination of emergency medical services prior to the suspension or cancellation of the special permit. This statute does not seem to bear any teeth, per CDPH’s interpretation, in preventing the reduction or elimination of emergency medical service.[\[34\]](#) Hence, an amendment to something similar to that of Rhode Island’s and Hawaii’s oversight authority could vastly improve oversight over ED closures. In other words, CDPH could be given authority, such as those in Rhode Island and Hawaii, to regulate the closure of EDs by preventing suspension or cancellation of ED licenses if such a closure would harm health access. If California implements this, the state should consider creating a rainy-day fund to ensure hospitals that are financially periled can be sustained as the hospital works with the state and the

community to ensure proper health access.

Conclusion

The closure of emergency departments has an impact on patient health. The impact will only grow each year with an ever smaller number of emergency departments. Yet, AB 1601 in 2019 and SB 637 in 2017 were vetoed by two different governors over the concern of a hospital's well being, despite the bills' effect on promoting health care access. California must find a better solution than simply notification, whether it be preventing ED closure without proper review and approval or propping up EDs and hospitals until alternate centers of care can be arranged. Without a better solution, longer distance to EDs and greater ED waiting times will continue to reduce health access for Californians, particularly those who are uninsured, underinsured, or with low-income.

[\[1\]](#) American College of Emergency Physicians, America's Emergency Care Environment, A State-by-State Report Card 2014 Edition at 25 (2014).

[\[2\]](#) *Id.*

[\[3\]](#) California Health Care Foundation, California Emergency Departments Use Grows as Coverage Expands at 10 (2018).

[\[4\]](#) *Id.* at 7.

[\[5\]](#) Charles Liu, Tanja Srebotnjak, & Renee Y. Hsia, *California Emergency Department Closures are Associated with Increased Inpatient Mortality at Nearby Hospitals*, 33 Health Affairs 1323, 1323 (2014).

[\[6\]](#) *Id.* at 1326. It should be noted that twenty six of the emergency room closures were due to the parent hospital closing.

[\[7\]](#) See Renee Y.Hsia et al., *System-Level Health Disparities in California Emergency Departments: Minorities and Medicaid Patients Are at Higher Risk of Losing Their Emergency Departments*, 59 *Annals of Emerg. Med.* 358 (2012) (stating there are 401 ED at the start of 1998).

[\[8\]](#) Charles Liu, Tanja Srebotnjak, & Renee Y. Hsia, *California Emergency Department Closures are Associated with Increased Inpatient Mortality at Nearby Hospitals*, 33 *Health Affairs* 1323, 1328 (2014).

[\[9\]](#) Renee Y.Hsia et al., *System-Level Health Disparities in California Emergency Departments: Minorities and Medicaid Patients Are at Higher Risk of Losing Their Emergency Departments*, 59 *Annals of Emerg. Med.* 358 (2012). See also Yu-Chu Shen & Renee Y. Hsia, *Association Between Emergency Department Closure and Treatment, Access, and Health Outcomes Among Patients With Acute Myocardial Infarction*, 134 *Circulation* 1595, 1596 (2016).

[\[10\]](#) Yu-Chu Shen & Renee Y. Hsia, *Association Between Emergency Department Closure and Treatment, Access, and Health Outcomes Among Patients With Acute Myocardial Infarction*, 134 *Circulation* 1595, 1596 (2016).

[\[11\]](#) Charles Liu, Tanja Srebotnjak, & Renee Y. Hsia, *California Emergency Department Closures are Associated with Increased Inpatient Mortality at Nearby Hospitals*, 33 *Health Affairs* 1323, 1326 (2014).

[\[12\]](#) *Id.* at 1327.

[\[13\]](#) Yu-Chu Shen & Renee Y. Hsia, *Changes in Emergency Department Access Between 2001 and 2005 Among General and Vulnerable Populations*, 100 *Am. J. Pub. Health* 1462 (2010).

[\[14\]](#) Yu-Chu Shen & Renee Y. Hsia, *Association Between Emergency Department Closure and Treatment, Access, and Health Outcomes Among Patients With Acute Myocardial Infarction*, 134 *Circulation* 1595, 1596 (2016). Cf. Renee Y. Hsia et al., *Is Emergency Department Closure Resulting in Increased Distance to the Nearest Emergency Department Associated With Increased Inpatient Mortality?*, 60 *Annals of Emerg. Med.* 707 (2012) (finding that an increase in small increased distances to the next available ER was not associated with inscreased patient mortality). Additionally, if the next nearest ER was a high occupancy hospital, there was an even greater chance of mortality compared to other bystander hospitals. Renee Y. Hsia & Yu-Chu Shen, *Emergency Department Closures And Openings: Spillover Effects On Patient Outcomes In Bystander Hospitals*, 38 *Health Affairs* 1496, 1502-03 (2019).

[\[15\]](#) RAND, *Why Are Many Emergency Departments in the United States Closing?* (2011).

[\[16\]](#) The notification for emergency medical services is to (1) the California Department of Public Health (“the state department”), (2) the local government entity in charge of provision of health services, (3) all health care service plans, (4) “other entities under contract with the hospital to provide services to enrollees of the plan or other entity,” and (5) “a significant number of residents of that community serviced by that facility.” Cal. Health & Safety Code § 1255.1. As an additional way to notify the public, the health care service plan must notify the enrollees who use that hospital within 30 days of receiving the notice. Cal. Health & Safety Code § 1364.1.

[\[17\]](#) “Supplemental service means an organized inpatient or outpatient service which is not required to be provided by law or regulation.” Cal. Code Regs. tit. 22, § 70067.

[\[18\]](#) County hospitals are required to post a notice of a public hearing fourteen days before. The public hearing is

supposed to happen prior to a board's decision on whether to close, eliminate or reduce medical services, or lease, sell, or transfer the management of a county facility. Cal. Health & Safety Code § 1442.5.

[\[19\]](#) Gov. Newsom, Governor's Veto Message of Assem. Bill 1014 (2019-2020 Reg. Sess.) as enrolled on September 6, 2019.

[\[20\]](#) Cal. Health & Safety Code § 1255.1.

[\[21\]](#) Gov. Newsom, Governor's Veto Message of Assem. Bill 1014 (2019-2020 Reg. Sess.) as enrolled on September 6, 2019.

[\[22\]](#) Sen. Com. on Health, Analysis of Assem. Bill 1014 (2019-2020 Reg. Sess.) as amended on Feb. 21, 2019, p. 4.

[\[23\]](#) CHA stated support for the 90 days notice of reduction or elimination of emergency medical services in their opposition letter for AB 1014. See Sen. Com. on Health, Analysis of Assem. Bill 1014 (2019-2020 Reg. Sess.) as amended on Feb. 21, 2019, pp. 4.

[\[24\]](#) Sen. Com. on Health, Analysis of Assem. Bill 2103 (1997-1998 Reg. Sess.) as amended June 25, 1998, p. 1.

[\[25\]](#) Sen. Com. on Health, Analysis of Assem. Bill 2400 (2007-2008 Reg. Sess.) as amended Mar. 24, 2008, p. 4.

[\[26\]](#) Assem. Com. on Health, Analysis of Assem. Bill No. 2103 (1997-1998 Reg. Sess.) as amended April 16, 1998, p. 6.

[\[27\]](#) Sen. Com. on Health, Analysis of AB 1014 (2019-2020 Reg. Sess.) as amended on Feb. 21, 2019, pp. 2, 4.

[\[28\]](#) Assem. Com. on Health, Analysis of Assem. Bill No. 2103 (1997-1998 Reg. Sess.) as amended April 16, 1998, p. 6.

[\[29\]](#) Gov. Brown, Governor's Veto Message of Sen. Bill 687 (2017-2018 Reg. Sess.) as enrolled on September 20, 2017.

[\[30\]](#) 23 R.I. Gen. Laws Ann. § 23-17.14-18.

[\[31\]](#) Haw. Rev. Stat. Ann. § 323D-82.

[\[32\]](#) Alternatively, California could seek to follow New Jersey's Health Care Stabilization Fund, which provides emergency grants to hospitals to ensure access to health care services at a hospital about to close or reduce services due to financial distress.

[\[33\]](#) Cal. Health & Safety Code § 1300.

[\[34\]](#) Sen. Com. on Health, Analysis of Assem. Bill 1014 (2019-2020 Reg. Sess.) as amended on Feb. 21, 2019, p. 3.