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Health Care Reform and Administrative Law: A Structural Approach

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For the past thirty years, federal health care policy has been characterized by frustration and contradiction. On the one hand, Congress has repeatedly enacted laws to secure consumer access to quality health care at a reasonable cost and has appropriated billions of dollars to achieve these ends.[1] On the other hand, federal statutes and, more frequently, administrative practice have failed to establish effective regulatory control over the providers of health care (doctors and hospitals) who largely determine the use, quality, and price of the publicly funded services,[2] or even over the federal and state officials who administer the programs.[3] Increased public funding has created

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1. *See, e.g.*, Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946) (current version at 42 U.S.C. §§ 291-291*o* (1970 & Supp. V 1975)) (establishing federal funding for construction and modernization of hospitals and other health care facilities) [hereinafter cited as Hill-Burton Act]; Social Security Amendments of 1965, Pub. L. No. 89-97, §§ 1901-1905, 79 Stat. 343 (1965) (current version at 42 U.S.C. §§ 1396-1396d (1970 & Supp. V 1975)) (establishing federal matching funds for state medical assistance) [hereinafter cited as Medicaid Act]; National Health Planning and Resources Development Act of 1974, 42 U.S.C. §§ 300k-300t (Supp. V 1975) (renewed effort to achieve local health planning); Comprehensive Health Planning and Public Health Services Amendments of 1966, 42 U.S.C. § 246 (1970 & Supp. V 1975) (initial effort to coordinate health planning on local and regional level).

2. For discussions of evidence demonstrating that doctors and hospitals exercise dominant control over the use, quality, and price of health care services, and that public programs have largely failed to change this situation, see J. FEDER, MEDICARE: THE POLITICS OF FEDERAL HOSPITAL INSURANCE 33-45, 53-70, 81-102, 111-35 (1977); S. LAW, BLUE CROSS: WHAT WENT WRONG? 161-80, 191-95 (2d ed. 1976).

3. There are many studies focusing on the failure of federal and state officials to carry out their assigned regulatory role. *See, e.g.*, J. FEDER, *supra* note 2, at 33-51 (failure of federal officials to implement or enforce numerous statutory requirements regarding quality and utilization review in Medicare); S. LAW, *supra* note 2, at 117-25, 130-35

the potential for greater public control of the health care system to meet consumer needs, but that potential has been suppressed or distorted in a variety of ways, so that private control has been generally maintained and even strengthened. The absence of effective regulation to increase access to health care services, ensure quality, and control costs has in turn contributed to the well-known features of the "health care crisis": severe inflation of health care costs,[4] maldistribution of facilities and personnel,[5] gross profiteering from public and private

(failure to implement federal statutory provisions regarding utilization review of services under Medicare); Rose, *Federal Regulation of Services to the Poor Under the Hill-Burton Act: Realities and Pitfalls*, 70 NW. U.L. REV. 168, 168, 172-94, 200-01 (1975) (failure of federal and state officials to implement or enforce Hill-Burton Act requirements regarding services to poor).

4. Annual national health care expenditures have increased by almost $100 billion in seven years, from $69.2 billion in Fiscal Year 1970 to an estimated $162.6 billion in Fiscal Year 1977. *See* Gibson & Fisher, *National Health Care Expenditures, Fiscal Year 1977*, SOC. SECURITY BULL., July 1978, at 5 (Table 1), 15 (Table 5). The major cause of the rapid growth in national "outlays" or expenditures for health is, according to the staff of the Health Care Financing Administration of HEW, "the exceptionally rapid rate of increase in health care *prices*," *id.* at 10 (emphasis supplied), as distinct from increases in population or the general cost of living. Data to support this view can be expressed in several ways. First, health care spending has clearly outstripped population growth, with per capita outlays doubling from $334 in 1970 to $737 in 1977. *Id.* at 10, 15 (Table 5). Second, health care spending has increased faster than the growth of the economy as a whole, rising from 7.2% of Gross National Product (GNP) in 1970 to 8.8% in 1977. *Id.* at 10, 14 (Chart 2). Third, annual rates of increases in the medical care component of the Consumer Price Index (CPI) have been significantly higher than the rate of increase for the CPI as a whole, particularly since the ending of wage and price controls in April 1974. For example, in 1976 the percentage increase in the medical care services component of the CPI was 10%, compared with 5.7% for the CPI as a whole; in 1977, the increases were 9.9% for medical care and 6.5% for the CPI. *Id.* at 10; *see* OFFICE OF RESEARCH AND STATISTICS, SOCIAL SECURITY ADMINISTRATION, DEP'T OF HEW, MEDICAL CARE EXPENDITURES, PRICES, AND COSTS: BACKGROUND BOOK 20-26 (1975) (analyzing various items in medical care services component of CPI and discussing CPI methodology) [hereinafter cited as MEDICAL CARE EXPENDITURES: BACKGROUND BOOK]; Somers & Somers, *A Proposed Framework for Health and Health Care Policies*, 14 INQUIRY 115, 116 (1977) (pointing out that medical care inflation rates were even higher before enactment of Medicare and Medicaid in 1965 than in subsequent five-year period).

5. Maldistribution takes two forms: oversupply and undersupply. Oversupply is most commonly measured in terms of "unnecessary" hospital beds, which are determined by comparing an optimal hospital occupancy rate (usually 85%) with actual occupancy rates, which are often much lower. *See* Caress & Kotelchuck, *Politics Makes Strange Beds*, HEALTH-PAC BULL., July-Aug. 1977, at 1. HEW Secretary Califano estimates that "[t]oday there are about 240,000 empty beds in our community hospitals. At least 100,000 of these beds are absolutely unnecessary, as determined by local as well as national authorities. At a maintenance cost of $10,000 to $20,000 per empty bed, the annual cost of 100,000 empty beds is $1 to $2 billion." *President's Hospital Cost Containment Proposal: Joint Hearings on H.R. 6575 Before the Subcomm. on Health of the House Comm. on Ways and Means and the Subcomm. on Health and the Environment of the House Comm. on Interstate and Foreign Commerce*, 95th Cong., 1st Sess. pt. 1, at 9 (1977) [hereinafter cited as *Joint Hearing on President's Hospital Cost Containment Proposal*]; *see* B. ENSMINGER, THE $8 BILLION HOSPITAL BED OVERRUN 1, 5, 15-41 (1975) (concurring in estimate of 100,000 unnecessary beds and estimating an additional $6 billion annual waste from overuse of unnecessary hospital facilities and equipment).

Although oversupply of hospital beds, expensive technology, and medical specialists

funds,[6] and unnecessary, deficient, and often harmful care.[7] Perhaps equally important, if less obvious, has been the impact of government passivity on the experience of citizenship itself. There is now a wide-

(particularly surgeons) is currently the focus of health policy analysis, *under*supply of facilities and personnel, particularly for primary care, is also a major problem. Geographical disparities between urban and rural areas, and between inner cities and the suburbs, remain substantial. For example, in 1972, "the ratio of physicians per 1,000 population in metropolitan areas was 1.73, more than twice the .80 ratio for non-metropolitan areas." SENATE COMM. ON LABOR AND PUBLIC WELFARE, REPORT ON THE HEALTH PROFESSIONS EDUCATIONAL ASSISTANCE ACT OF 1974, S. REP. No. 1133, 93d Cong., 2d Sess. 58 (1974) [hereinafter cited as S. REP. No. 1133]. Disparities between urban and rural states were even more striking, with New York's 238 physicians per 100,000 population about three times Mississippi's ratio of 78 physicians per 100,000 population. *Id.* at 62 (quoting AMERICAN ENTERPRISE INSTITUTE FOR PUBLIC POLICY RESEARCH, INCREASING THE SUPPLY OF MEDICAL PERSONNEL (1973)).

Moreover, such average figures tend to understate the problem of undersupply by failing to take into account quality of care, transportation, economics (*i.e.*, inability to afford care), and racial discrimination. In 1967, a presidential commission stated the problem of rural health care in "starkly depressing" terms:

> We have failed miserably to protect the health of low-income people in rural areas. The health service they get is not only inadequate in extent but seriously deficient in quality. It is badly organized, underfinanced, rarely related to the needs of the individual or the family. Such health service as there is is too often discriminatory in terms of race and income and heedless of the dignity of the individual.

PRESIDENT'S NAT'L ADVISORY COMM'N ON RURAL POVERTY, THE PEOPLE LEFT BEHIND 59 (1967), *quoted in* S. REP. No. 1133, *supra*, at 61. Doctor/patient ratios in the urban ghettos are particularly low; though the national average ratio in 1972 was one physician for every 781 persons, ratios in the ghettos of Chicago and New York City were estimated at one physician for every 9,000 to 10,000 persons. *See* S. LAW & S. POLAN, PAIN AND PROFIT 12-13 (1978); P. DEVISE, SLUM MEDICINE: CHICAGO'S APARTHEID HEALTH SYSTEM 20 (1969).

6. Congressional and journalistic attention has focused on illegal or questionable practices in the Medicaid program, particularly with respect to "Medicaid mills," nursing home reimbursement, and unnecessary surgery. "Medicaid mills" are described by one congressional committee as "unregulated, unlicensed, and poorly equipped storefront units located in ghetto areas of large metropolitan cities." STAFF OF SUBCOMM. ON HEALTH, HOUSE COMM. ON WAYS AND MEANS, AND SUBCOMM. ON HEALTH AND THE ENVIRONMENT, HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, 95TH CONG., 1ST SESS., REPORT ON FRAUD AND ABUSE IN THE MEDICARE AND MEDICAID PROGRAMS 2 (Joint Comm. Print 1977). Nursing home reimbursement has been found to be riddled with fraudulent practices. *Id.* at 7-9. The losses to the Medicaid program from abuse and overutilization are conservatively estimated to be $1 billion per year. *See Problems of Medicaid Fraud and Abuse: Hearing Before the Subcomm. on Oversight and Investigations of the House Comm. on Interstate and Foreign Commerce*, 94th Cong., 2d Sess. 2 (1976) (statement of Congressman Scheuer). Moreover, there is good reason to believe that fraudulent and profiteering practices uncovered in the Medicaid program are only the tip of the iceberg and are by no means absent in the routine operations of prestigious private sector hospitals. An investigation by the *Washington Post* in 1972 found that patient bills at Washington Hospital Center, Washington, D.C.'s largest private nonprofit hospital, were "inflated by a variety of abuses that include conflict-of-interest transactions by trustees and administrators, payments to doctors of profits of the hospital, favoritism, lack of competitive bidding, and free care to the rich." Kessler, *Abuses Pad Cost of Hospital Center Care*, Washington Post, Oct. 29, 1972, at 1.

7. The oversupply of surgeons has coincided with a concern about unnecessary surgery. Relying on professional studies, the Subcommittee on Oversight and Investigations of the House Committee on Interstate and Foreign Commerce (chaired by Congressman John E. Moss and hereinafter referred to as the Moss Subcommittee) estimated that of the 14 million surgical operations performed in the United States in 1974, 17%,

spread belief across the political spectrum that government in our society is inevitably captured by highly organized private interests and is therefore incapable of altering established patterns of health care delivery (or other social services) to benefit either the majority of middle-income citizens or minority groups and the poor.[8]

or 2,380,000 surgical procedures, were unnecessary. Such procedures were estimated to cost $3.92 billion, and to result in approximately 11,900 unnecessary deaths. SUBCOMM. ON OVERSIGHT AND INVESTIGATIONS OF THE HOUSE COMM. ON INTERSTATE AND FOREIGN COMMERCE, 94TH CONG., 2D SESS., REPORT ON COST AND QUALITY OF HEALTH CARE: UNNECESSARY SURGERY 30, 31, 34 (1976) [hereinafter cited as HOUSE REPORT ON UNNECESSARY SURGERY]. The Moss Subcommittee's findings touched off a sharp debate with the American Medical Association (AMA) regarding methodology and even the existence of standards of surgical "necessity." The major, but by no means only, study supporting the Subcommittee was McCarthy & Widmer, *Effects of Screening by Consultants on Recommended Elective Surgical Procedures*, 291 NEW ENG. J. MED. 1331 (1974).

8. The view that government cannot, or is not likely to, serve diffuse, unorganized interests such as consumers or the poor is now a common theme in policy analysis and related studies spanning the political spectrum. At the center of this spectrum, mainstream social scientists increasingly agree that legislatures and particularly agencies are heavily influenced by the most highly organized and well-financed interest groups. Since regulated firms or industries inevitably have the strongest concern with the regulatory programs affecting their interests and also have the greatest economic, political, and informational resources, they are likely to "capture" the regulating agency. *See, e.g.*, Sabatier, *Social Movements and Regulatory Agencies: Toward a More Adequate—and Less Pessimistic—Theory of "Clientele Capture"*, 6 POL'Y SCI. 301, 302-03 (1975) (summarizing social science, legal and journalistic literature); *cf.* Marmor, Wittman & Heagy, *Politics, Public Policy and Medical Inflation*, in HEALTH: A VICTIM OR CAUSE OF INFLATION? 299, 305-11 (M. Zubkoff ed. 1976) (applying this approach to politics of health care delivery). Analysts on the right end of the political spectrum take this point even further by arguing that government in the United States is structurally more responsive to concentrated producer interests, and that therefore diffuse, "public" interests can be best pursued (paradoxically) by inserting financial incentives for socially desirable behavior into the private market. *See* C. SCHULTZE, THE PUBLIC USE OF THE PRIVATE INTEREST 5-6, 21-27, 87-88 (1977); Enthoven, *Consumer Choice Health Plan* (pt. 1), 298 NEW ENG. J. MED. 650, 655 (1978); Havighurst, *Regulation of Health Facilities and Services by "Certificate of Need"*, 59 VA. L. REV. 1143, 1178-88, 1230-32 (1973). On the left, a variety of Marxist analysts see regulatory legislation as serving primarily to reinforce and legitimate the existing class system. Such legislation is said to accomplish this function either by directly serving the instrumental goals of particular ruling class sectors or by creating a general ideological climate in which public needs are defined in ways that are compatible with private ownership of capital and alienated labor. *See, e.g.*, B. EHRENREICH & J. EHRENREICH, THE AMERICAN HEALTH EMPIRE (1970) (analyzing particular benefits flowing to medical school "empires" from increased governmental involvement in health care system); Navarro, *Social Class, Political Power, and the State: The Implications in Medicine*, in MEDICINE UNDER CAPITALISM 183 (1976) (government intervention in health care promotes both particular interests and more general ideological perspective). For a discussion of the relationship between pluralist theory and practice and the collapse of political identity or citizenship, see Wolin, *The State of the Union*, N.Y. REV. BOOKS, May 18, 1978, at 28.

This article addresses the common concern of all of these studies—the tendency of the political system to reinforce the existing distribution of power and resources—from a perspective that recognizes the strength of such reinforcement while focusing on its susceptibility to change. In this view, the question of whether the legal system can have a redistributional impact cannot be answered a priori. Rather, the actual impact of statutes and judicial decisions must be examined in particular contexts, as affected by the consumer struggles, agency responses, and judicial choices that are the subject of this article.

This article analyzes the legal structure of government passivity in the area of health care reform as it has passed through three stages: congressional ambivalence toward the problems, reflected in highly symbolic legislative responses lacking clear mandatory language; executive inaction and abdication of even the minimal administrative enforcement duties created by Congress; and the judicial quandaries faced by courts and often not resolved in consumer challenges to administrative inaction. Part I sets forth the theoretical framework for analyzing the problems that courts have confronted. Parts II through IV apply this framework to three case studies drawn from the health care reform experience and evaluate critically the judicial response to consumer litigation against the agencies. Finally, Part V returns to the concepts of statutory interpretation and judicial review set forth in Part I and concludes that courts should contribute to the restructuring of agency decisionmaking to provide for a more participatory process and more justifiable outcomes.

I. The Legal Structure of Health Care Reform: Creating the Appearance of Public Control

Congress can, and occasionally does, explicitly delegate public regulatory power to private interests.[9] In doing so, it is restricted only by the weak constitutional limits of the delegation doctrine[10] and by the political limits created by popular opposition. More typically, however, private control is maintained by a pattern of "symbolic" public regulation.[11] Under this pattern, social control is apparently created

9. *See, e.g.*, Health Insurance for the Aged Act, 42 U.S.C. § 1395bb (Supp. V 1975) (compliance with statutory quality-of-care deemed to exist if hospital accredited by Joint Commission on Accreditation of Hospitals, a private agency); S. REP. No. 1230, 92d Cong., 2d Sess. 61-62 (1972) (Medicare's result was "almost total and blanket delegation of authority over hospital standards to a private agency").

10. *See, e.g.*, Cook v. Ochsner Foundation Hosp., 559 F.2d 968, 975 (5th Cir. 1977) (upholding provisions of Hill-Burton Act that condition issuance of HEW regulations on approval of Federal Hospital Council composed of private citizens, including representatives of hospital industry and medical profession); Corum v. Beth Israel Medical Center, 373 F. Supp. 550, 552-53 (S.D.N.Y. 1974) (same). For an excellent discussion of the weaknesses of the delegation doctrine, and of suggestions for reviving it, see Gewirtz, *The Courts, Congress, and Executive Policy-Making: Notes on Three Doctrines*, LAW & CONTEMP. PROB., Summer 1976, at 46, 49-65.

11. *See* M. EDELMAN, THE SYMBOLIC USES OF POLITICS 22-25, 35-41, 188-90 (1964). Professor Edelman notes:

> There is virtually unanimous agreement among students of the antitrust laws, the Clayton and Federal Trade Commission acts, the Interstate Commerce acts, the public utility statutes and the right-to-work laws, for example, that through much of the history of their administration these statutes have been ineffective in the sense that many of the values they promised have not in fact been realized.

Id. at 24. Moreover, "[w]hen [this] does happen, the deprived groups [*i.e.*, the groups that anticipate benefits from the regulatory programs, such as consumers] often display

by general statutory and regulatory provisions, but is simultaneously undermined by a lack of enforcement. Federal health care statutes promote government passivity of this sort through two common devices: the statement of substantive goals and powers in general terms, which leaves their implementation to relatively unstructured agency discretion; and the absence of clearly articulated and accessible remedies for consumer beneficiaries. Federal and state agencies continue the process of nonenforcement by failing to translate statutory goals into operational standards, failing to enforce whatever standards exist, and denying consumer beneficiaries access to agency decisionmaking or avenues for complaint and relief.

The persistent gap between statutory promise and administrative reality is rooted in the technology and politics of American medicine, as well as in the dynamics of American interest-group politics.[12] Within medicine itself, physicians' traditional insistence that medical care be treated as a market transaction between doctor and patient[13] has been undermined by the growth of an increasingly technological and specialized medical practice, the costs of which are now beyond the reach of most individuals.[14] By necessity, both providers and con-

little tendency to protest or to assert their awareness of the deprivation." *Id.* at 24-25. These tendencies, Edelman argues, reveal "the largely symbolic character of the entire process" for disorganized, large, uninformed groups such as "consumers" or "the general public." *Id.* at 23. Though powerful, knowledgeable and highly organized interests can and do seek concrete benefits from the political process, many (perhaps most) citizens participate in politics as "spectators" and receive largely symbolic reassurance about threatening forms of economic and social change. *See id.* at 35-41, 188-90.

12. The relationship between administrative nonenforcement of regulatory reform and interest-group politics is treated extensively in M. EDELMAN, *supra* note 11, at 44-72. *See generally* T. LOWI, THE END OF LIBERALISM (1969); Stewart, *The Reformation of American Administrative Law*, 88 HARV. L. REV. 1667, 1682-83, 1713-15 (1975).

13. The classic form of this insistence is organized medicine's defense of "fee-for-service" practice in which the doctor sets a price for each service or medical procedure and the patient pays for each service at or soon after its delivery. *See* W. GLASER, PAYING THE DOCTOR 25, 54-55 (1970). For an account of the AMA's opposition to, and attempts to suppress, other forms of reimbursement, such as prepaid care, see Note, *The Role of Prepaid Group Practice in Relieving the Medical Care Crisis*, 84 HARV. L. REV. 887, 954-60 (1971).

The status of medical care as a commodity was legally confirmed in Hurley v. Eddingfield, 156 Ind. 416, 59 N.E. 1058 (1901), in which the Indiana Supreme Court held that a physician who refused to render emergency aid "without any reason whatever"—the fee having been tendered—did not incur liability for the patient's subsequent death. The doctor, the court reasoned, had only refused to enter a contract of employment; like other private sellers of goods and services, he had complete freedom to set the terms of his contracts or to refuse to enter them altogether. *Id.* at 416, 59 N.E. at 1058.

14. The national average cost of one day's hospital care is now $158, and of the average hospital stay, over $1,300. *Joint Hearing on President's Hospital Cost Containment Proposal, supra* note 5, at 7-8 (statement of Secretary Califano). The Public Health Service defined "catastrophic" health care expenditures in 1970 as gross expenditures of greater than $5,000 (*i.e.*, including amounts covered by insurance), out-of-pocket outlays of $1,000 or more, or out-of-pocket outlays equaling 15% or more of family income.

sumers have pressed for social financing of health services and facilities through taxes and quasi-public insurance such as Blue Cross.[15] But although providers need public funds to finance the rising cost of their services, including profit,[16] they strongly oppose public regulation of their traditional power over the price and other conditions of medical practice.[17] The expansion of government financing and regulation of health care has thus taken place in a political context in which largely unorganized consumers seek relief from the rising costs and declining accessibility of care, while well-organized providers seek public subsidies for a health care system that remains largely under private control.

The government policies that emerge from this context are heavily

See HEALTH RESOURCES ADM'N, PUBLIC HEALTH SERV., U.S. DEP'T OF HEW, HEALTH UNITED STATES 1975, at 48-49 (1976) [hereinafter cited as HEALTH UNITED STATES 1975]. The effects of increased technology and rising costs on health care delivery are explored in Kelman, *Toward the Political Economy of Medical Care*, 8 INQUIRY 30 (1972).

15. For example, both the American Hospital Association (AHA) and the AMA supported federal subsidies for hospital construction under the Hill-Burton program. Beginning in the late 1930s, the AHA and AMA also began to support and actively promote the development of nonprofit, state-regulated Blue Cross and Blue Shield plans. *See* S. LAW, *supra* note 2, at 7-9; T. MARMOR, THE POLITICS OF MEDICARE 9 (1970). The AHA eventually broke its alliance with the AMA and joined numerous consumer groups in supporting the enactment of Medicare and Medicaid, which provided extensive federal and state funding for hospital and physician services. *See* S. LAW, *supra* note 2, at 32-33; T. MARMOR, *supra*, at 24.

16. The extent to which the rising costs of hospital and medical care can be attributed to rising provider profits (or, as it is usually termed with respect to individual practitioners, "income") is a controversial issue. A small number of hospitals are formally organized as proprietary, profitmaking institutions, and are permitted to include a "reasonable return on equity capital" as part of their "reasonable cost" reimbursement under Medicare. *See* 42 U.S.C. § 1395x(v)(1)(B) (Supp. V 1975); 20 C.F.R. § 405.402(c) (1977); S. LAW, *supra* note 2, at 70-72. Private *non*profit hospitals, however, provide about 65% of the patient-days in short-term general hospitals and generate from four to 20 times the expenses of all other ownership categories (*e.g.*, governmental, proprietary). *See* MEDICAL CARE EXPENDITURES: BACKGROUND BOOK, *supra* note 4, at 30-31. Although such hospitals are in theory reimbursed by Medicare, Medicaid, and most Blue Cross programs on the basis of the "reasonable costs" actually incurred in the provision of health care services, *see* 42 U.S.C. § 1395x(v)(1)(A) (Supp. V 1975); S. LAW, *supra* note 2, at 60 n.375, the concept of "reasonable cost" has in fact been administered so as to allow hospitals to generate significant amounts of "net income," *i.e.*, revenues in excess of the direct or operating cost of providing services. For discussions of how revenues in excess of direct costs were included in the Medicare reimbursement formulas, and how the hospitals attempted to justify them as the "cost" of invested capital (which had often been provided at public expense), see J. FEDER, *supra* note 2, at 57-60; S. LAW, *supra* note 2, at 59-72; H. SOMERS & A. SOMERS, MEDICARE AND THE HOSPITALS: ISSUES AND PROSPECTS 177-85 (1967). As a result of these reimbursement policies and other factors, "[a]nnual [net] incomes of nonprofit and for-profit hospitals increased from $29 million in 1950 to $547 million in 1971." MEDICAL CARE EXPENDITURES: BACKGROUND BOOK, *supra* note 4, at 41.

17. *Cf.* American Medical Ass'n v. Weinberger, 522 F.2d 921 (7th Cir. 1975) (upholding injunction sought by AMA against federal utilization review regulations). For detailed discussions of provider resistance to government regulation, see J. FEDER, *supra* note 2, at 1-25; S. LAW, *supra* note 2, at 31-58.

influenced by the distribution of power between providers and consumers at different stages of the political process. Congress will generally act on behalf of consumers only when the issue of health care has achieved high political visibility, creating at least a potential for consumer mobilization.[18] Providers, however, retain considerable legislative influence even during periods of intense consumer pressure. The resulting legislation usually attempts to satisfy both constituencies by stating a general commitment to meet consumer needs while preserving a regulated and subsidized private health care system. The task of developing an operational program of financial inducement and regulatory control is then delegated with little legislative guidance to federal and state agencies, where the crucial policy and enforcement decisions have much less public visibility than the original legislation. At the administrative stage, organized provider interests are better able than unorganized consumers to extract tangible benefits and to shape the programs to their own ends.[19]

The assertion and subsequent denial of public authority to meet consumer need, however, generates political and specifically legal pressures for further change. Politically, the expansion of government funding and regulation undermines the concept of health care as a commodity and creates the potential for public control and bargaining over the nature, distribution, and price of health care services. Moreover, because federal statutes typically promise some public regulation or services or both for the benefit of consumers, they appear to create legal standards for evaluating agency and provider performance and thus encourage consumer claims for judicial relief.

The courts then face a choice of either legitimizing the gap between general statutory goals and specific agency practices or attempting to bring agency and provider performance into line with what appears to be national health care policy. Such decisions are made enormously difficult by the ambiguity of the congressional mandate: was Congress "serious" about the statute's general substantive goals, or was its "real" intention better expressed in its silences and omissions, which, according to the agencies, justify passivity and nonenforcement? In the absence of clear legislative guidance on the issues of enforcement and remedies, courts necessarily rely on their own perspectives about substantive policy and administrative structure, and in particular on

18. *See* T. MARMOR, *supra* note 15, at 111-13.

19. *See id.* at 87-88, 122-24 (documenting increasing provider influence on Medicare policy in administrative as compared to legislative context); Freedman, *Crisis and Legitimacy in the Administrative Process*, 27 STAN. L. REV. 1041, 1054-55 (1975) (linking lack of specific legislative guidance with industry domination of regulatory agencies).

their own conceptions of the judicial role in defining the remedial implication of general statutory terms.

The result is that consumer demands for substantive health care benefits become entwined with judicial decisions about the internal structure of government: whether or not consumer beneficiaries are entitled to participate in agency rulemaking and adjudicative procedures; whether or not consumers can obtain judicial review of agency action and, if so, on what terms; and whether or not consumers can initiate private actions for direct judicial enforcement of federal statutory norms against private health care providers. Stated more generally, the implementation of substantive health care reform tends to become linked to what has been called the jurisprudence of remedies: the standards by which courts decide when "interests" embodied in statutes should be given the type of judicial protection traditionally associated with enforceable individual "rights."[20]

This article focuses on how the courts and agencies have responded to these issues as they relate to three major health care programs that have been the subjects of challenges by low-income consumers to the legality of agency nonenforcement and provider noncompliance: (1) the Hill-Burton hospital construction program, requiring grantee hospitals to provide a community service and a reasonable volume of care to persons unable to pay;[21] (2) the Medical Assistance (Medicaid) program, requiring participating states to provide a reasonable amount of necessary medical services to eligible low-income persons;[22] and (3) the health planning program, requiring the governing boards of local health planning agencies to include a majority of consumers who are broadly representative of the area's social, economic, racial, and linguistic groups.[23] In each of these areas consumers alleged that particular agency and provider practices violated the broadly worded statutory standards and subjected consumers to the types of substantive harms and procedural arbitrariness that Congress intended to prevent. The federal agencies generally responded not by attempting to justify these outcomes in terms of the statutory goals, but rather by arguing that the statutes did not *require* the agencies to reach the results demanded by the consumers, and that therefore the agencies' refusal to

20. *See generally* Katz, *The Jurisprudence of Remedies: Constitutional Legality and the Law of Torts in* Bell v. Hood, 117 U. PA. L. REV. 1 (1968).

21. 42 U.S.C. § 291c(e) (1970), *discussed at* pp. 264-86 *infra.*

22. *Id.* §§ 1396, 1396a(a)(10), (13), 1396d(a) (1970 & Supp. V 1975); *see* 42 C.F.R. § 449.10(a)(5)(i) (1977) (state plan must specify amount or duration of care provided to categories of needy; such amounts and durations shall be sufficient "to reasonably achieve their purpose" and may not be arbitrarily denied or reduced).

23. 42 U.S.C. § 300*l*-1(b)(3)(C)(i) (Supp. V 1975), *discussed at* pp. 304-30 *infra.*

do so was within their delegated discretion. State agency and provider defendants tended to resist reaching the merits even more strongly by arguing that consumers had no standing to seek any type of judicial review of agency and provider decisions.

In evaluating these contentions, the courts have concentrated on the particular statutory language and agency practices at issue, but have also been strongly influenced by one of two general approaches to administrative law. The first, recently revived by the Burger Court and some lower federal courts, discourages judicial review of agency action regarding generally phrased statutory interests by defining narrowly the available sources of law and the inferences that can be drawn from them. The historical basis of this perspective lies in the formalist conception of judicial authority as sharply distinct from legislative and executive authority and as limited to the mechanical application of preordained rules.[24] Since mechanically applicable rules could only be supplied by explicit legislative directives or by the "stable" standards of the common law,[25] the courts often refused to adjudicate controversies regarding the legality of agency action under more broadly defined statutory standards. Under the formalist doctrine of standing in administrative law, if an agency's action or inaction did not invade a private "legal right" as traditionally understood or did not violate a clear statutory directive, it did not raise a justiciable legal issue and was therefore committed to the agency's nonreviewable discretion.[26]

Courts applying the contemporary, "neo-formalist" approach do not usually deny individuals standing on the basis of the traditional private rights doctrine,[27] but achieve the same result through formalist modes of statutory interpretation. From this perspective, generally

24. For historical analysis of the development of formalist approaches in both public and private law, see M. HORWITZ, THE TRANSFORMATION OF AMERICAN LAW 253 *passim* (1977). Formalism as an intellectual tradition emphasizing the mechanical application of rules is discussed extensively in R. UNGER, LAW IN MODERN SOCIETY 194-216 (1976); Kennedy, *Form and Substance in Private Law Adjudication*, 89 HARV. L. REV. 1685 (1976) [hereinafter cited as *Form and Substance*] and Kennedy, *Legal Formality*, 2 J. LEGAL STUD. 351, 358-59 (1973) [hereinafter cited as *Legal Formality*].

25. *See* L. JAFFE, JUDICIAL CONTROL OF ADMINISTRATIVE ACTION 475-76 (1965).

26. *See* Barlow v. Collins, 398 F.2d 398, 400-01 (5th Cir. 1968), *vacated*, 397 U.S. 159 (1970); Associated Indus. v. Ickes, 134 F.2d 694, 700-01 (2d Cir.), *vacated as moot*, 320 U.S. 707 (1943); L. JAFFE, *supra* note 25, at 501-14; Stewart, *supra* note 12, at 1675-76. There is some irony in the fact that the formalist doctrine of standing in administrative law was developed not by judicial conservatives seeking to justify decisions favoring free enterprise, but largely by judicial liberals seeking to minimize legal challenges by industry against New Deal regulatory programs. *See Form and Substance, supra* note 24, at 1753, 1756-60.

27. *But see* Simon v. Eastern Ky. Welfare Rights Organization, 426 U.S. 26 (1976); Evans v. Lynn, 537 F.2d 571, 589 (2d Cir. 1976), *cert. denied*, 429 U.S. 1066 (1977).

worded statutory or constitutional provisions are not seen as the basis for the inference of affirmative judicial relief. Courts have held, for example, that statutory mandates excluding corporate funds from campaign financing, requiring states to raise their welfare standards, and prohibiting discrimination in federally financed programs do not create private rights amenable to judicial protection, but rather are public interests largely consigned to the agencies for enforcement.[28] Even when an individual is recognized as having a legally protected interest, the scope of that protection is narrowly confined to the enforcement of explicit legislative directives.[29] Legislative silence is thus often decisive; unless an agency can be shown to have violated a clear statutory command, its action or inaction will tend to be upheld as within its valid discretion.[30] Since Congress rarely casts health care and other social legislation in explicitly mandatory terms, the effect of this judicial perspective is to uphold most agency decisions and to deny supplementary judicial relief.

The neo-formalist approach coexists, however, with a second set of doctrines encouraging judicial enforcement both of substantive statutory goals and of principles of administrative due process. From this perspective, the courts are not seen as sharply separated from the administrative and political process or limited to protecting a narrow range of common law and explicit statutory rights. Rather, they are perceived as sharing responsibility with the legislative and executive branches for furthering general statutory and constitutional values of a necessarily mixed, public and private character.[31] The courts have performed this function on the basis of three broad doctrinal traditions: (1) the concept of "legal right" or "entitlement," and its sub-

28. *See* Cort v. Ash, 422 U.S. 66 (1975) (campaign financing); Cannon v. University of Chicago, 559 F.2d 1063, 1071-75, 1077-83 (7th Cir. 1977), *cert. granted*, 98 S. Ct. 3142 (1978) (No. 77-926) (discrimination in federally funded programs); Rosado v. Wyman, 414 F.2d 170, 176-77 (2d Cir. 1969), *rev'd*, 397 U.S. 397 (1970) (welfare grants).

29. *See* New York Dep't of Social Servs. v. Dublino, 413 U.S. 405, 421-22 (1973) (state work rules restricting eligibility more narrowly than federal statute upheld as not contravening any "expressly provided" federal eligibility standards).

30. *See* Batterton v. Francis, 432 U.S. 416 (1977); Knebel v. Hein, 429 U.S. 288 (1977).

31. *See, e.g.*, Lloyd v. Regional Transp. Auth., 548 F.2d 1277, 1286 (7th Cir. 1977); Gomez v. Florida Employment Serv., 417 F.2d 569 (5th Cir. 1969); Stewart, *supra* note 12, at 1716, 1723-30. For analogous developments in constitutional law, see Monaghan, *Constitutional Adjudication: The Who and When*, 82 YALE L.J. 1363, 1368-71 (1973) (constitutional adjudication is not merely incidental to resolution of private disputes; Supreme Court has "special function" of interpreting and promoting constitutional values); Monaghan, *The Supreme Court, 1974 Term—Foreword: Constitutional Common Law*, 89 HARV. L. REV. 1, 18-30 (1975) (courts have authority to create "common law substructure" to implement constitutional values, subject to legislative revision). *But see* Schrock & Welsh, *Reconsidering the Constitutional Common Law*, 91 HARV. L. REV. 1117, 1118, 1126-45 (1978) (subconstitutional rulemaking raises questions of legitimacy and constitutional authority).

stantive and procedural implications;[32] (2) the requirements of administrative procedure embodied in the federal Administrative Procedure Act (APA);[33] and (3) the implications of particular regulatory statutes for both the substance and process of agency decisionmaking.[34] Drawing on these sources, the courts have fashioned individual rights to receive tangible benefits or results, and also "process rights" that require agencies to exercise their discretion according to procedures that promote fair and rational policymaking.

Taken together, these doctrinal traditions comprise a "structural due process" approach that defines broadly both the sources of applicable law and the nature of the rights that can be inferred from them. For example, in constitutional law, individual rights such as the right to travel have been inferred not only from constitutional text and legislative history, but also from governmental structures and relationships established or envisioned by the Constitution.[35] A similar development has occurred in administrative law. In *J.I. Case Co. v. Borak*[36] and in *King v. Smith*,[37] for example, the Supreme Court relied on substantive standards embodied in administrative structures as the basis for fashioning individual remedies for statutory violations.[38]

32. *See* Board of Regents v. Roth, 408 U.S. 564, 569-72 (1972) (procedural due process protection extends to liberty interests and to property interests with regard to which person has "legitimate claim of entitlement"); Goldberg v. Kelly, 397 U.S. 254 (1970) (welfare benefits as protected entitlement).

33. 5 U.S.C. §§ 551-557 (1976).

34. *See, e.g.*, Mobil Oil Corp. v. FPC, 483 F.2d 1238, 1258-60 (D.C. Cir. 1973) (rulemaking procedures inferred from Natural Gas Act); International Harvester Co. v. Ruckelshaus, 478 F.2d 615, 630-31 (D.C. Cir. 1973) (rulemaking procedures inferred from Clean Air Act).

35. *See* C. BLACK, STRUCTURE AND RELATIONSHIP IN CONSTITUTIONAL LAW 15 *passim* (1969) (discussing Crandall v. Nevada, 73 U.S. (6 Wall.) 35 (1868)).

36. 377 U.S. 426 (1964).

37. 392 U.S. 309 (1968).

38. In *Borak* the Supreme Court permitted a private federal action for damages based on section 14(a) of the Securities Exchange Act of 1934, 15 U.S.C. § 78n(a) (1976), which prohibits solicitation of proxies "in contravention of such rules and regulations as the [Securities and Exchange] Commission may prescribe as necessary or appropriate in the public interest or for the protection of investors." The Commission had in turn prohibited solicitation of proxies by statements that are "false or misleading with respect to any material fact," 377 U.S. at 429 n.4 (quoting 17 C.F.R. § 240.14a-9 (1964)), but did not have the resources to make an independent examination of the representations contained in proxy statements submitted to it. The Court held that although the statute made no mention of private rights of action, the limited availability of administrative enforcement resources, considered in the light of the Act's substantive purpose of "protecting investors," made private judicial remedies "necessary to make effective the congressional purpose." *Id.* at 432-33; *see* Bivens v. Six Unknown Fed. Narcotics Agents, 403 U.S. 388, 402 n.4 (1971) (Harlan, J., concurring) (discussing *Borak*). In *King*, the Supreme Court upheld an injunction against a state welfare regulation sought by individual recipients on the basis of §§ 402(a)(9) [now § 402(a)(10)] and 406(a) of the Social Security Act, 42 U.S.C. §§ 602(a)(9), 606(a) (1970), which define federal requirements for approval of state welfare programs by HEW. The Court skirted the question of the relationship between private rights of action to enforce federal statutory requirements and the ad-

The structural due process approach perceives a statute as an interrelated whole consisting of structures and substantive standards designed to achieve one or more congressional goals. These goals may themselves be framed both as structures and as substantive results. Even when a statute does not dictate a particular substantive result or tangible benefit, it may bear on what Professor Laurence Tribe has termed "the structures through which policies are both formed and applied, and formed in the very process of being applied."[39] Statutory provisions requiring agency hearings, and requiring decisions based upon substantial evidence, have thus been interpreted as requiring agencies to engage in a public and accountable process of decisionmaking.[40]

Operational standards based on these procedural values have emerged from a decade of intense litigation centered largely, but not exclusively, in the District of Columbia Circuit. The standards require agencies engaged in rulemaking and other regulatory decisions to articulate their aims and their factual assumptions, to examine available evidence and alternative solutions, and to submit their hypotheses and proposals to meaningful scrutiny by the affected parties.[41]

ministrative structure designed to enforce them, *see* 392 U.S. at 312 n.3, but in a later case explicitly ruled that private remedies were available to enforce substantive norms in the absence of accessible administrative remedies, *see* Rosado v. Wyman, 397 U.S. 397, 405-06, 406 n.8, 420-21 (1970). In both *Borak* and *King* the Court inferred private rights from substantive standards enacted as parts of administrative structures.

39. Tribe, *Structural Due Process*, 10 HARV. C.R.-C.L. L. REV. 269, 269 (1975) (emphasis deleted). The term "structural due process" will be used in this article in largely the same sense as it is used by Professor Tribe, except that it is (i) being applied to administrative law; (ii) referring to statutory as well as constitutional interpretation; and (iii) including the concept of "structure" as a *source* as well as an *object* of legal interpretation. *See* L. TRIBE, AMERICAN CONSTITUTIONAL LAW 1137-46 (1978); Sager, *Insular Majorities Unabated*: Warth v. Seldin *and* City of Eastlake v. Forest City Enterprises, Inc., 91 HARV. L. REV. 1373, 1411-23 (1978) (theory that certain types of legislative decisions must be made by "deliberative" as opposed to plebiscitary process, thus promoting "due process of lawmaking").

40. *See* Mobil Oil Corp. v. FPC, 483 F.2d 1238, 1258-60 (D.C. Cir. 1973) (requiring additional rulemaking procedures to permit judicial review under Natural Gas Act "substantial evidence" standard); International Harvester Co. v. Ruckelshaus, 478 F.2d 615, 630-31 (D.C. Cir. 1973) (compelling additional rulemaking procedures to satisfy Clean Air Act requirement of agency hearing). The structural due process approach may also result in a denial of individuals' claims for administrative hearings and judicial review. Analysis of a statute's substantive and structural provisions may convince a court that Congress meant to commit the matter to agency discretion, or to preclude judicial review, or that the matter is not appropriate for judicial intervention. *See* Morris v. Gressette, 432 U.S. 491 (1977); Langevin v. Chenango Court, Inc., 447 F.2d 296 (2d Cir. 1971); Hahn v. Gottlieb, 430 F.2d 1243, 1249-51 (1st Cir. 1970). For a proposed restrictive use of structural analysis in determining the reviewability of administrative action, see Note, *The Supreme Court's Use of Statutory Interpretation*: Morris v. Gressette, *APA Nonreviewability, and the Idea of a Legislative Scheme*, 87 YALE L.J. 1636 (1978).

41. *See* Scenic Hudson Preservation Conference v. FPC, 354 F.2d 608, 620-24 (2d Cir. 1965), *cert. denied*, 384 U.S. 941 (1966); *cf.* National Welfare Rights Organization v. Mathews, 533 F.2d 637, 645-48 (D.C. Cir. 1976) (agency regulations must "be reasonably

Authority for these standards derives from the substantive and procedural requirements of the agencies' governing statutes,[42] the rulemaking requirements of the APA,[43] and the limitations imposed by the due process clause of the Constitution.[44] The judicial commitment to participatory and rational procedure has overlapped with the substantive concern that agencies dedicated to functional missions—such as licensing power plants or television stations—must not disregard important public values. Thus the pioneering cases, *Scenic Hudson Preservation Conference v. FPC*[45] and *Office of Communica-*

related to the purposes of the enabling legislation" and must follow procedural requirements of APA and others imposed by agency itself); Environmental Defense Fund, Inc. v. Ruckelshaus, 439 F.2d 584, 597-98 (D.C. Cir. 1971) (courts more willing to review agency decisions and less deferential to agency judgment). *See generally* Stewart, *supra* note 12, at 1756-60 (reviewing vast amount of litigation, statutory development, and academic treatment of this trend); J. Skelly Wright, *The Courts and the Rulemaking Process: The Limits of Judicial Review*, 59 CORNELL L. REV. 375, 379-81 (1974) (discussing APA).

42. *See, e.g.*, Portland Cement Ass'n v. Ruckelshaus, 486 F.2d 375, 390-92 (D.C. Cir. 1973), *cert. denied*, 417 U.S. 921 (1974); International Harvester Co. v. Ruckelshaus, 478 F.2d 615, 628-29 (D.C. Cir. 1973); Scenic Hudson Preservation Conference v. FPC, 354 F.2d 608, 613-20 (2d Cir. 1965), *cert. denied*, 384 U.S. 941 (1966); J. Skelly Wright, Book Review, 81 YALE L.J. 575, 591 (1972).

43. 5 U.S.C. § 553 (1976) (requiring federal agencies to give public notice of terms or substance of proposed rule, to permit interested persons to participate in rulemaking through submission of written data and views, and to give statement of rule's basis and purpose after consideration of relevant matter presented); *see* National Welfare Rights Organization v. Mathews, 533 F.2d 637, 648-49 (D.C. Cir. 1976) (calling for adequate agency notice to permit "informative, responsive comments" by interested parties to agency regulations); Wright, *supra* note 41, at 379-81. In its recent opinion in Vermont Yankee Nuclear Power Corp. v. Natural Resources Defense Council, Inc., 435 U.S. 519 (1978), the Supreme Court held that the APA provisions generally establish "the maximum procedural requirements" for agency rulemaking, *id.* at 524, and that absent extraordinary circumstances, the federal courts have no authority to require agencies to use additional procedural techniques such as discovery or cross-examination, *id.* at 524, 543-45. Many of the operational standards for agency rulemaking articulated by the District of Columbia Circuit and other courts of appeals, however, have been framed as *interpretations of*, rather than additions to, the APA rulemaking requirements, or have been derived from the substantive statutes governing agency operations. *See, e.g.*, National Welfare Rights Organization v. Mathews, 533 F.2d 637 (D.C. Cir. 1976) (interpreting APA); International Harvester Co. v. Ruckelshaus, 478 F.2d 615, 629-31 (D.C. Cir. 1973) (interpreting public hearing provision of Clean Air Act). The impact of the *Vermont Yankee* decision on judicial review of agency rulemaking is thus somewhat uncertain, particularly in areas such as health care where agency practices often fall below the APA minimum requirements. *See* pp. 322-25 *infra*.

44. *See* Thompson v. Washington, 497 F.2d 626 (D.C. Cir. 1973) (due process requires that public housing tenants have right to notice and opportunity for written comment prior to rent increases); National Welfare Rights Organization v. Finch, 429 F.2d 725, 734 n.33 (D.C. Cir. 1970) (welfare recipients' due process claims to participate in HEW compliance procedures noted but not reached; equivalent relief granted under APA, 5 U.S.C. § 702 (1976)). Formalizing procedural guarantees may lead to requirements of rulemaking when discretion was previously allowed. *See* United States v. Barbera, 514 F.2d 294, 302-04 (2d Cir. 1975) (Fourth Amendment may require police rulemaking); K. DAVIS, ADMINISTRATIVE LAW OF THE SEVENTIES § 6.13, at 224-27 (1976); Amsterdam, *Perspectives on the Fourth Amendment*, 58 MINN. L. REV. 349, 416-28 (1974); Wright, *supra* note 42, at 588.

45. 354 F.2d 608 (2d Cir. 1965), *cert. denied*, 384 U.S. 941 (1966).

tions of the United Church of Christ v. FCC,[46] stressed the need for public participation in agency licensing proceedings in order to promote the values of environmental protection and racial equality.

The differences between the neo-formalist and the structural due process approaches to administrative law are most striking in the responses each approach makes to the dilemma of agency nonenforcement of regulatory reform. The dilemma arises from the tension between broad legislative commitments to intervene in the private market for the benefit of unorganized consumers and actual agency practices that remain largely responsive to organized providers or firms. The neo-formalist approach is less a resolution of this tension than a denial of its existence; generally expressed congressional mandates are interpreted to be unenforceable or legally irrelevant, or the generality itself is interpreted to confer virtually unreviewable agency discretion. Neo-formalism thus ratifies the results of the market in administrative choice in much the same way that formalist doctrines of contract law ratified the results of the economic market: the outcome of political bargaining in administrative decisionmaking, like economic bargaining in the marketplace, may be judicially altered only on the authority of an explicit legislative rule that can be mechanically applied.[47] Since organized vested interests can usually block the enactment of explicit and mechanically applicable rules for market intervention, the formalist preclusion of judicial reliance on general standards results in the ratification of private power even in derogation of statutory goals.

The structural due process approach recognizes the tension between statutory goals and agency practice and attempts a resolution. In contrast to the neo-formalist approach, general statutory standards are interpreted as "law" to apply to the case at hand. Such standards are not "law" that can be applied in a wholly traditional fashion, since they do not mandate specific results. They do, however, require a process of decisionmaking that takes statutory interests into account in a justifiable fashion. This sort of mandate is sufficient authority to allow courts to overturn agency decisions without simply usurping the legislative or administrative function. A court employing structural analysis recognizes that broadly worded statutes permit an agency to reach more than one permissible policy outcome and that a court should not substitute its judgment for that of the agency by dictating what that outcome should be. The structural due process approach

46. 359 F.2d 994 (D.C. Cir. 1966) (Burger, J.).

47. *See Form and Substance, supra* note 24, at 1761 (discussing relationship between formalism and market transactions).

does, however, involve a court in examining the agency's explanation or justification of its policy in terms of the statutory goals, and also in examining the process by which it reached the decision. The crucial difference between structural analysis and more conventional statutory interpretation is the use of general statutory goals as the basis for inferring the type of process the agency must use in rendering its decisions and the type of reasoning needed to justify them.[48]

The central thesis of this article is that the courts can and should use the techniques of structural due process to check agency nonenforcement of health care reform. The appropriateness of such a judicial role depends on two related factors: whether it is *legitimate* for courts to resolve disputes between agencies and citizens regarding broadly defined statutory interests, and whether the courts are *competent* to make such judgments in areas of complex social policy. These issues have been traditionally examined in the jurisprudential context noted above: whether courts have authority to invoke broad principles in addition to determinate rules as a basis for judicial decision.[49] They have also arisen in the doctrinal contexts of standing,[50] implied rights of action,[51] the extent of nonreviewable agency discretion,[52] and the scope of judicial review of agency action.[53] Though analysis at

48. The leading, albeit confused example of this approach is Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402 (1971). The Court interpreted § 138 of the Federal-Aid Highway Act of 1968, 23 U.S.C. § 138 (1970), as prohibiting the Secretary of Transportation from approving the use of parkland in constructing federally assisted highways unless he finds that there "are no feasible alternative routes or . . . [that] alternative routes involve uniquely difficult problems." 401 U.S. at 416. Although the Court ruled that the Secretary did not have to make "formal findings," *id.* at 417, the effect of the decision is to create a strong incentive for contemporaneous agency findings by permitting, in the absence of some agency explanation, judicial examination of "the decisionmakers themselves." *Id.* at 420. Justices Black and Brennan would have converted this indirect incentive for hearings and agency explanation into a direct requirement based on the Act's substantive and structural provisions. *See id.* at 421-22 (separate opinion of Black, J., joined by Brennan, J.).

For other examples of cases relying on general statutory goals as the basis for inferring required procedures or justifications, see Thompson v. Washington, 497 F.2d 626 (D.C. Cir. 1973) (public housing held to be entitlement requiring limited procedural due process in agency decisions raising rents); Brown v. Lynn, 385 F. Supp. 986 (N.D. Ill. 1974) (general goals of National Housing Act require agency to avoid mortgage foreclosure policies that harm low-income beneficiaries without substantial justification).

49. For major contemporary examples of jurisprudential debate over this and related questions about the nature of law, see H.L.A. HART, THE CONCEPT OF LAW (1961); Dworkin, *The Model of Rules*, 35 U. CHI. L. REV. 14 (1967). For a critique of formalist concepts as the basis of judicial authority, see *Legal Formality, supra* note 24, at 387-88.

50. *See* Simon v. Eastern Ky. Welfare Rights Organization, 426 U.S. 26 (1976); Evans v. Lynn, 537 F.2d 571, 589 (2d Cir. 1976), *cert. denied*, 429 U.S. 1066 (1977) (en banc).

51. *See, e.g.*, Securities Investor Protection Corp. v. Barbour, 421 U.S. 412, 423-25 (1975).

52. *See* Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 410-13 (1971); Hahn v. Gottlieb, 430 F.2d 1243, 1249-51 (1st Cir. 1970); Saferstein, *Nonreviewability: A Functional Analysis of "Committed to Agency Discretion"*, 82 HARV. L. REV. 367 (1968).

53. *See, e.g.*, Texas ACORN v. Texas Area 5 Health Sys. Agency, Inc., 559 F.2d 1019, 1025 (5th Cir. 1977); L. JAFFE, *supra* note 25, at 569-75.

these levels remains important, this article addresses the issues of legitimacy and competency in a specific policy context: the effort to extend public control over public resources for the benefit of health care consumers. It argues that the text and structure of health care reform legislation, together with the agencies' actual performance, call into question the neo-formalist approach to administrative law and justify the type of judicial protection of health consumer interests that has already emerged in a number of health law decisions.[54] In developing this argument, each case study focuses on a particular source of structural inference: legislation for the benefit of a consumer class (Hill-Burton); legislation creating a statutory entitlement to benefits for eligible individuals (Medicaid); and standards of administrative procedure and judicial review contained in the APA (health planning).

The advantages of the structural due process approach over the neo-formalist approach are apparent at a number of levels explored in detail in the case studies. First, the role of government has changed enormously since formalist administrative law doctrines were developed in the early decades of the twentieth century. Increased government involvement in complex social policy and the dynamics of interest-group politics have often led to legislation specifying factors to be weighed and structures of decisionmaking, rather than particular results. Doctrines that discount the importance of structural statutes as sources of individual rights run the risk of undermining democratic choices by ratifying less visible administrative passivity.

Second, the neo-formalist approach, in its most mechanical form, focuses artificially on a statute's remedial provisions or omissions and ignores the substantive and structural provisions that usually receive far more congressional attention. Third, and in a related vein, the structural due process approach gives legal effect to the important statutory goals of redistribution and consumer accountability in health care services, while the neo-formalist approach tends to deny their effect simply because they were not cast in a particular legal form.

Fourth, the tendency of the neo-formalist approach to ratify agency nonenforcement seriously undermines democratic values by creating zones in which legislative provisions can be given little or no weight, for no articulated reason and with little effective review. The converse danger of the structural due process approach—that a court will misinterpret congressional intent in granting affirmative relief—has much greater visibility, and hence is more likely to be remedied by

54. *See, e.g.*, Euresti v. Stenner, 458 F.2d 1115 (10th Cir. 1972) (Hill-Burton program); Dodson v. Parham, 427 F. Supp. 97 (N.D. Ga. 1977) (Medicaid program).

legislative action.[55] Finally, the structural due process approach contributes to the task of value choice that lies at the heart of most major social programs. When, as is often the case, Congress has granted an agency discretion to weigh competing values, there is serious danger that one or more values will be disregarded through low-visibility nonenforcement.

Under the structural due process approach, an agency charged with balancing competing interests has a duty to recognize that there is more than one interest to be weighed,[56] to give the interests their appropriate weight in the light of legislative intent and the agency's own articulated policies,[57] to permit public participation in the balancing process by providing notice and a meaningful opportunity to comment,[58] and to justify the consequences of its decisions in light of the statutory goals.[59] The case studies examined in this article strongly suggest that without judicial enforcement of such duties, agencies can and will disregard their responsibilities to low-income consumers and thereby cause a great deal of human suffering and harm to the legal system as a whole.

Despite the advantages of the structural due process techniques—

55. For a clear example of such legislative reaction, see H.R. REP. No. 500, 95th Cong., 1st Sess. (1977), *reprinted in* [1977] U.S. CODE CONG. & AD. NEWS 580, *quoted in* Texas ACORN v. Texas Area 5 Health Sys. Agency, Inc., 559 F.2d 1019, 1025 n.13 (5th Cir. 1977), *discussed at* p. 320 & note 359 *infra; cf.* Note, *Judicial Control of Systemic Inadequacies in Federal Administrative Enforcement*, 88 YALE L.J. 407, 434-35 (1978) (court activity will highlight enforcement problems and stimulate congressional action).

56. *See* Scenic Hudson Preservation Conference v. FPC, 354 F.2d 608, 624 (2d Cir. 1965), *cert. denied*, 384 U.S. 941 (1966) (requiring FPC to consider "preservation of natural beauty" as well as cost in proceedings to license power plant).

57. *See, e.g.*, Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 411-13 (1971) (rejecting argument by government that Secretary of Transportation is "to engage in a wide-ranging balancing of competing interests"; holding that very existence of statutes restricting building of highways in parks "indicates that protection of parkland was to be given paramount importance"); Office of Communication of United Church of Christ v. FCC, 425 F.2d 543 (D.C. Cir. 1969) (Burger, J.) (setting aside decision of Federal Communications Commission granting full-term television license on grounds that FCC had failed to give appropriate weight to viewer complaints of unfair programming regarding racial discrimination). *But see* Note, *supra* note 40, at 1656-65 (criticizing Court's interpretation of legislative scheme in *Overton Park* and arguing that Court's approach involved revision of legislative scheme rather than reasonable interpretation of it).

58. *See, e.g.*, National Welfare Rights Organization v. Mathews, 533 F.2d 637, 648 n.17, 649 (D.C. Cir. 1976) (calling for adequate notice to permit "informative, responsive comments" by interested parties to agency regulation); Thompson v. Washington, 497 F.2d 626, 634-40 (D.C. Cir. 1974) (public housing tenants entitled to notice and opportunity to respond in writing to proposed rent increases).

59. *See* National Welfare Rights Organization v. Mathews, 533 F.2d 637, 646-48 (D.C. Cir. 1976) (HEW regulation defining available income to include gross market value of recipient-owned property without regard to encumbrances violates objectives of Social Security Act); Dodson v. Parham, 427 F. Supp. 97 (N.D. Ga. 1977) (proposed state system of restricting available drugs under Medicaid program results in denial of necessary medical care and services, thereby violating Social Security Act).

public participation, rational decisionmaking, and adequate consideration of statutory values—a number of substantial criticisms have been voiced. It is argued that when the legislature has failed to choose between or assign weights to competing values, neither the agencies nor courts have sufficient guidance to develop operational standards of "adequate consideration."[60] There is concern that elaborate procedural requirements for agency rulemaking and other decisionmaking may actually reduce agency accountability by increasing the complexity of the decision, the number of actors and considerations, and the opportunities for delay.[61] Even if designed to elicit public participation, complex proceedings may overwhelm the resources of all but the most skilled consumer groups.[62] Moreover, the direct and indirect costs of such proceedings to the agency and the parties are often thought to outweigh the practical benefits and to divert limited resources from a program's substantive goals.[63] Finally, a restructuring of agency procedures may ultimately have little effect on the balance of forces influencing the agency, and hence, slight impact on its decisions.[64] From the perspective of consumers and other traditionally weak groups, procedural techniques may be dangerous because they merely secure access to a highly unequal political arena. Without a concrete redistribution of power, or at least of advocacy skills and resources, such access is likely to be a sham creating only the appearance of due process and pluralist democracy. One version of this argument focuses on the limited impact of doctrinal change; new definitions of legal rights or changes in the standard of judicial review may have no practical value for welfare recipients, low-income health care consumers, and others under intense pressure to waive their rights and to accommodate more powerful professionals and agency officials.[65]

These arguments reflect the real obstacles to significant social change and the practical limits of judicial authority. It is clear that administrative nonenforcement of health care reform is rooted in the political system as a whole and can be fully remedied only by changes outside, as well as within, the legal system. Nevertheless, the case

60. *See* Stewart, *supra* note 12, at 1779, 1781-84.

61. *See id.* at 1776-79.

62. *See, e.g.*, Trubek, *Environmental Defense, I: Introduction to Interest Group Advocacy in Complex Disputes*, in PUBLIC INTEREST LAW 154-57, 185-86 (B. Weisbrod, J. Handler & N. Komesar eds. 1978) (examples from case studies of environmental policy disputes).

63. *See* Stewart, *supra* note 12, at 1770-76.

64. *See id.* at 1776-77; Handler, *Public Interest Law: Problems and Prospects*, in LAW AND THE AMERICAN FUTURE 106-09 (M. Schwartz ed. 1976).

65. *See* Handler, *Controlling Official Behavior in Welfare Administration*, 54 CALIF. L. REV. 479, 494-97 (1966).

studies examined in this article suggest that if structural due process doctrines were clearly articulated and acted upon, the courts could contribute significantly to the implementation of substantive health care reform. The advantages of this doctrinal development should not be foregone even though its ultimate success requires additional changes. Moreover, the arguments against the structural due process approach, though suggesting real problems, tend in several ways to misunderstand the actual and potential relationships among courts, agencies, and Congress, particularly in the area of health care delivery.

First, the state of the bureaucratic art of health care reform is primitive, with the basic policymaking and participatory structures still embryonic. As the case studies reveal, the types of legal claims at issue in health care litigation frequently involve difficult choices among competing statutory values—about which Congress has often given inadequate guidance—and more fundamental procedural questions about how such decisions should be made. At this second level, Congress has usually defined, at least in rough form, the factors and structures for decisionmaking—but seldom with much impact on actual agency practices. At this stage of development Congress has sufficiently indicated to the courts that consumers are indeed meant to be beneficiaries of health care legislation, and that agencies must consider consumer interests in a rational and defensible fashion. In performing this structural compliance function, the courts can rely on statutory texts and structures to legitimate, as well as to render manageable, their intervention. The objection that Congress has not provided adequate guidance for judicial decision may well be valid as to some issues, but not as to the frequent dispute over whether public control on behalf of consumers should be exercised at all.

A second set of objections focuses on the complexity and costs of structural due process techniques and on their asserted failure to produce benefits in terms of informed, accountable, and swift decisions. To some extent, such objections merely reflect a reasonable concern that decisionmaking procedures should be efficiently suited to their functions. The appropriate response to this concern, however, is not to dismiss process techniques altogether, but rather to shape them, as several courts and agencies have done, and indeed as Congress originally intended,[66] to the particular types of decisions at issue.[67] This

66. *See* S. REP. No. 752, 79th Cong., 1st Sess. 14-15 (1945) (noting that although notice and comment rulemaking procedures specified in § 4 of APA represent "the minimum requirements of public rule making," "[m]atters of great import, or those where the public submission of facts will be either useful to the agency or a protection to the public, should naturally be accorded more elaborate public procedures").

67. *See* Dodson v. Parham, 427 F. Supp. 97 (N.D. Ga. 1977); Newsom v. Vanderbilt

kind of pragmatic adjustment of the costs of due process is particularly appropriate in the area of health care reform, where decisionmaking procedures are still at an early stage of development, and where providers and agencies are still contesting the preliminary question of whether consumers are entitled to any procedural rights or tangible benefits.

At a more fundamental level, objections concerning complexity and cost raise the question of whether rights of participation and explanation can actually illuminate the difficult value choices involved in health care reform and can result in more responsive and equitable decisions. A similar question is raised by those concerned with the unequal distribution of power: even assuming a legislative and judicial intent to benefit unorganized interests, is increased "legalization" of the administrative process an effective way to accomplish that goal? The existing inequality of resources between providers and consumers undoubtedly puts consumers at a disadvantage in a legal as well as in a political context. The open question, however, is whether groups such as consumers receive at least a net gain in terms of benefits or influence from more structured techniques of agency decisionmaking. Although a complete answer to that question requires much more empirical evidence than is currently available, the case studies examined in this article tentatively suggest an affirmative answer.

Requirements of public notice, participation, and explanation create at least the conditions for consumer influence: knowledge that a decision is being made, and a framework in which to attempt to influence the decisionmakers' values and perceptions.[68] In each of the three case studies, consumers actually succeeded, with judicial assistance, in changing the agency's perception of its own role and in increasing the extent of public regulation in support of consumers' needs. Furthermore, legal efforts to restructure relationships between agencies and consumer-beneficiaries need not, and in fact do not, occur in a political vacuum. In each of the three case studies such legal efforts were, to varying extents, part of, or stimulation for, new forms of consumer organization and political participation.[69]

Univ., No. 75-126-NA-CV (M.D. Tenn. June 1, 1978); Ho v. Chang, [1977-1978 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 28,433 (D. Hawaii Apr. 27, 1977); Benton v. Rhodes, [1976-1977 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 28,025 (S.D. Ohio May 11, 1976), *rev'd*, No. 76-2177 (6th Cir. Aug. 10, 1978).

68. The value of even such rudimentary avenues of influence is highlighted by the difficulties caused by their absence. *See* Borosage, *Para-Legal Authority and Its Perils*, LAW & CONTEMP. PROB., Winter 1976, at 166, 174-77 (discussion of Central Intelligence Agency and other national security agencies).

69. Prominent examples of Hill-Burton organizing efforts include the work of the Rhode Island Workers Association (RIWA), the Philadelphia Unemployment Project,

Finally, it is important to remember that the value of consumer participation and agency explanation does not lie solely in the opportunity to secure a different outcome. What Professor Tribe has termed "the right to be heard from, and the right to be told why . . . express the elementary idea that to be a *person*, rather than a *thing*, is at least to be *consulted* about what is done with one."[70] Expressed in political terms, this root concept of human dignity highlights the need for a reconstruction of the democratic process, in which consultation over fundamental human needs is not made meaningless by a labyrinthine bureaucracy. By offering unorganized interests the *right* to participate in programs for their own benefit, the traditions of structural due process also help to encourage its exercise and thereby help to strengthen democratic capacity.

Potential of this sort is, of course, not easily realized; "due process" can reinforce inequality and passivity as well, and the legal system can play only a contributory role in changes of this magnitude. The point of this article is that such a role is possible, and that the costs of not pursuing it are high.

II. Hill-Burton: Identifying the Beneficiaries and Their Remedies

The Hospital Survey and Construction Act (Hill-Burton Act) of 1946,[71] which established federal and state regulatory systems to finance the construction of hospitals for the ultimate benefit of health care consumers, was a response to the serious economic and geographic barriers to health services that had been highlighted during the Depression

and the Cape Cod (Mass.) Health Care Coalition. For description and discussion, see R.I. HEALTH ADVOCATES BULL., July, 1976, at 4 ("RIWA Opens Hill-Burton Campaign in Providence"); PHILADELPHIA UNEMPLOYMENT PROJECT, HILL-BURTON ORGANIZING GUIDE (1976); Pastreich, *A Report on Health Care Organization in Massachusetts*, HEALTH L. PROJECT LIB. BULL., Apr. 1977, at 2; Sparer, *Legal Services and Social Change: The Uneasy Question and the Missing Perspective*, 34 NLADA BRIEFCASE 58 (1976-77). For descriptions of extensive consumer organizing efforts concerning health planning, see *Consumer Issues Around HSAs* (series), in HEALTH L. PROJECT LIB. BULL. (June-July 1977 to present).

The relationship of litigation to consumer organizing efforts is complex. Although legal advocacy has helped to support and stimulate consumer and other popular movements, it has also on occasion " 'lawyerized' the issues . . . raised in ways that undercut potential grass roots political organization." Bellow, *Turning Solutions Into Problems: The Legal Aid Experience*, 34 NLADA BRIEFCASE 106, 107 (1977); *see* Wexler, *Practicing Law for Poor People*, 79 YALE L.J. 1049, 1054 (1970); Comment, *The New Public Interest Lawyers*, 79 YALE L.J. 1069, 1075-88 (1970). This article does not attempt to address the issue of when it is appropriate, from the point of view of consumers or their organizations, to seek judicial relief, as opposed to or in conjunction with other advocacy efforts. Rather, it focuses on how courts should respond to consumer requests for judicial relief once presented.

70. L. TRIBE, *supra* note 39, at 503.

71. *See* note 1 *supra*.

and World War II.[72] Many individuals and even whole communities could not afford the going market price for needed care.[73] Economic inequality resulted in widely varying availability of hospitals and doctors, widely varying use of health services according to economic class and geographic area, and, according to a prominent medical historian, "hundreds of thousands" of needless, preventable illnesses and "thousands" of premature deaths.[74]

A. *Congressional Intent: Hospital Access and Public Regulation*

The Hill-Burton Act emerged from a clash between two opposing perspectives on how to respond to this problem. The approach adopted by the Truman Administration with the active support of organized labor advocated public financing of health services through national health insurance.[75] The hospital industry, represented by the American Hospital Association, its affiliates, and the medical profession, wanted public funding to pay the costs of increasingly sophisticated facilities, but without significant public regulation.[76] The industry's solution,

72. The lead sponsor of the Hill-Burton Act, Senator Lister Hill, noted that the Senate's Subcommittee on Wartime Health and Education had assembled an enormous quantity of information leading "to the inescapable conclusion that in the wealthiest country in the world, we have not yet organized our efforts to the end that scientific health care is readily available to all our people." *Hospital Construction Act: Hearings on S.191 Before the Senate Comm. on Education and Labor*, 79th Cong., 1st Sess. 7 (1945) [hereinafter cited as *1945 Senate Hearings*]. As specific examples, Senator Hill noted that

> about 40 percent of the counties of the United States have no recognized hospital facilities . . . that health centers or modern facilities for the practice of preventive medicine or public health are almost nonexistent . . . , [and that] nearly 40 percent of our young men of draft age were found to be physically unfit for military duty.

Id.

73. *See* COMMITTEE ON THE COSTS OF MEDICAL CARE, MEDICAL CARE FOR THE AMERICAN PEOPLE 2-35 (1972) [hereinafter cited as MEDICAL CARE FOR THE AMERICAN PEOPLE]; S. LAW, *supra* note 2, at 6-11.

74. Sigerist, *Socialized Medicine*, 27 YALE REV. 463, 465 (1938), *reprinted in* HENRY E. SIGERIST ON THE SOCIOLOGY OF MEDICINE 39, 41 (M. Roemer ed. 1960).

75. For President Truman's proposed health legislation, see *Health Legislation*, [1945] U.S. CODE CONG. & AD. NEWS 1143. A brief history of national health insurance proposals under the Roosevelt and Truman administrations can be found in Falk, *Proposals for National Health Insurance in the USA: Origins and Evolution, and Some Perceptions for the Future*, 55 MILLBANK MEMORIAL FUND Q. 161 (1977). The differences between the national health insurance perspective and that of the hospital industry and medical profession appeared most clearly in *1945 Senate Hearings, supra* note 72, and in the Senate floor debate on the Hill-Burton Act, in which Senator Murray offered seven amendments, all of which were defeated. 91 CONG. REC. 11,716-20 (1945) (Sen. Murray); *see* S. REP. No. 674, 79th Cong., 1st Sess. 17, 21 (1945) (personal statement and reservations of Sen. Murray) (stating need to create social insurance for health care).

76. See, for example, the questions and answers on the Hill-Burton bill developed by the AHA for the guidance of its member hospitals. *1945 Senate Hearings, supra* note 72, at 16-20. Of the 30 questions and answers, 10 concerned the extent and limits of federal and state regulatory authority. *Id.*

embodied in a 1945 bill introduced by Senator Lister Hill,[77] was to limit federal funding to construction grants (as opposed to payment for services) and to surround the program with a series of devices designed to suppress the potential for public, and especially federal, control. Thus Senator Hill's original bill provided that federal construction funds be given to state agencies for distribution to the hospitals without any legislative standards regarding services to consumers beyond the general goal of "furnishing adequate [health] services to all of the people."[78] More specific standards were to be prescribed by the Surgeon General, but only with the approval of a "Federal Advisory Council" composed of eight members "outstanding in fields pertaining to hospital and health activities, [a majority of whom] shall be authorities in matters relating to the operation of hospitals."[79]

Although Senate liberals were not sufficiently powerful to substitute their national health insurance approach for the hospital industry's plan, they were able to extract some significant concessions in favor of service for low-income consumers. The Act as finally passed contained two substantive federal standards applicable both to the "state plans," in which the states were to set out their regulatory framework for the distribution of funds and hospital operations, and to the individual facilities themselves. First, hospital facilities constructed with Hill-Burton funds were to be made available to all persons in the community without discrimination on account of race or creed.[80] Second, Hill-Burton hospitals were to make available "a rea-

77. *See 1945 Senate Hearings, supra* note 72, at 7-8 (Senator Hill noting that in drafting bill, he sought "best possible technical advice" from AHA, its affiliated groups, Catholic and Protestant hospital associations, and American Public Health Association). When introducing the revised bill to the Senate floor, Senator Hill stated that the special subcommittee of the Senate Committee on Education and Labor appointed to revise the original bill was particularly appreciative of the advice of Mr. George Bugbee, executive secretary of the AHA, who had participated in the subcommittee's executive sessions. 91 CONG. REC. 11,713 (1945).

78. S. 191, 79th Cong., 1st Sess. § 601 (1945), *1945 Senate Hearings, supra* note 72, at 1.

79. *Id.* § 633(b), *1945 Senate Hearings, supra* note 72, at 5; *see id.* § 612(3), *1945 Senate Hearings, supra* note 72, at 2 (power of Advisory Council to approve regulations).

80. Section 622(f) of the original Hill-Burton Act authorized the United States Surgeon General to require such an assurance, and the Surgeon General did so in the program's first regulations, 12 Fed. Reg. 6176, 6179, § 53.62 (1947). Section 622(f) also provided, however, for an "exception" to the nondiscrimination requirement "in cases where separate hospital facilities are provided for separate population groups, if the [state] plan makes equitable provision on the basis of need for facilities and services of like quality for each such group," and the Surgeon General duly incorporated such an exception into the regulations. *Id.* The Act's "separate-but-equal" clause was declared unconstitutional in Simkins v. Moses H. Cone Hosp., 323 F.2d 959 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964), and Congress amended the Hill-Burton Act in 1964 to remove all reference to racial discrimination. As amended, the Hill-Burton Act authorized the federal agency

sonable volume of hospital services to persons unable to pay," at least to the extent of the hospital's financial ability to do so.[81]

The Surgeon General was to prescribe by regulation "requirements as to lack of discrimination on account of race, creed, or color, and for furnishing needed hospital services to persons unable to pay therefor."[82] These requirements were to be enforced through the "assurances" of compliance that could be, and were, required from all applicant facilities[83] and through the withholding of funds from state agencies or particular projects upon a finding that "any assurance given in an application . . . is not being or cannot be carried out."[84] Although the Surgeon General's regulations were still subject to the approval of the renamed "Federal Hospital Council," the Council was now to be composed of four industry experts and four members "appointed to represent the consumers of hospital services . . . [who are] familiar with the need for hospital services in urban or rural areas."[85]

Although the free care obligation was stated in general terms, the text and legislative history of the Act indicated that Congress expected it to be given operational effect. First, the Act referred to the "requirement," binding on both state agencies and individual grantee hospitals, of "*furnishing* needed hospital services to persons unable to pay therefor."[86] Second, the text of the Act authorized an exception to the hospitals' free care assurance "if such a requirement is not feasible from a financial standpoint"[87] or, in the words of the Senate Report, if "the hospital is financially unable to undertake such a commitment."[88] The implication was that the hospital would have to devote some of its own resources to providing free care. Third, the legislative history frequent-

to require assurances from grantee hospitals that they would be "made available to all persons residing in the territorial area of the applicant." 42 U.S.C. § 291c(e) (1970). The legislative intent behind this provision appeared to be acquiescence in the *Simkins* prohibition of racial discrimination without explicit statutory language reaching that result. *See Extension and Revision of Hill-Burton Hospital Construction Program: Hearings on H.R. 10041 Before the House Comm. on Interstate and Foreign Commerce*, 88th Cong., 2d Sess. 53-54 (1964) (colloquy between HEW Secretary Celebrezze and Representative Oren Harris, chairman of the Committee).

81. Section 622(f) of the original Hill-Burton Act authorized the Surgeon General to require such an assurance, and he did so in the program's first regulations, 12 Fed. Reg. 6176, 6179, § 53.63 (1947).

82. Hill-Burton Act, *supra* note 1, §§ 622(f), 623(a)(4).

83. *Id.* § 622(f). Such assurances were required from all applicants (subject to waivers for states with "separate-but-equal" plans and for hospitals that could demonstrate financial unfeasibility) in the Surgeon General's initial regulations. 12 Fed. Reg. 6176, 6179, §§ 53.62, .63 (1947).

84. Hill-Burton Act, *supra* note 1, § 632(a)(3).

85. *Id.* § 633(b).

86. *Id.* § 623(a)(4)(D) (emphasis supplied).

87. *Id.* § 622(f).

88. S. REP. No. 674, 79th Cong., 1st Sess. 9 (1945).

ly referred to the problem of community need for subsidized or charitable care. Under pointed questioning about whether grantee hospitals could restrict their services to those who could afford to pay, the president of the American Hospital Association assured the Senate Committee on Education and Labor that low-income people "who get into [grantee hospitals] will be taken care of at the local level,"[89] and that the state plan would have to locate hospitals primarily according to the needs of "people that cannot get hospitalization on their own means."[90]

Finally, the legislative history reflected reliance on the private nonprofit (or "voluntary") hospitals' tradition of community service and charitable care.[91] Some congressional ambivalence is apparent in other provisions of the Act that restricted the scope of federal regulation by delegating the establishment of minimum hospital standards to the states,[92] by providing for appeals and judicial review at the initiative of the state agencies,[93] and by prohibiting federal officials from exercising "any supervision or control" over the administration or operation of grantee hospitals "[e]xcept as otherwise specifically provided."[94] It was also evident, at least to the senators at the Committee on Education and Labor hearings, that charitable services by grantee hospitals could not meet all of the need of low- and moderate-income consumers of hospital care.[95] It would thus be fair to say that Congress intended to accomplish a substantial but partial solution to the problem of providing hospital services to lower-income patients through a limited extension of federal funding and regulation over hospitals, and broader federal supervision over the state agencies who were expected to perform the primary regulation. At the same time, it is clear that Congress

89. *1945 Senate Hearings, supra* note 72, at 30 (statement of Dr. Smelzer, president of AHA).

90. *Id.* at 34.

91. *See, e.g., id.* at 24 (statement by Dr. Smelzer that assets of voluntary hospitals would not be distributed for private gain "because [the voluntary hospital] really is a public asset, even though it is not controlled by a branch of the Government"); 91 CONG. REC. 11,724 (1945) (Senator Taft, who helped draft final bill, arguing for granting federal funds to "private charitable hospitals not operated for profit," because their performance of public function in health care services relieved "the States and cities of enormous expense which they would have had to meet if they had operated the hospitals as general [*i.e.*, public] hospitals"); *1945 Senate Hearings, supra* note 72, at 190 (Senator Taft estimating that private nonprofit hospitals typically allocated at least 20% of services to charitable care for poor).

92. Hill-Burton Act, *supra* note 1, § 623(a)(7).

93. *Id.* § 632(b).

94. *Id.* § 635.

95. *See 1945 Senate Hearings, supra* note 72, at 64-65 (Senator Pepper); *id.* at 194-95 (Senator Taft).

intended the nondiscrimination and free care requirements to mean something more than the mere filing of paper "assurances." Congress had established state regulation under federal supervision in order to translate the federal requirements of nondiscrimination and free care into concrete policy.

The Act's provisions supporting hospital construction were implemented with enthusiasm. From 1947 to 1973, the federal government granted $3.9 billion to 5,986 hospital construction projects. These funds provided about one-third of the cost of 358,000 general hospital beds, which in turn composed one-third of all the beds in the nation.[96] The federal agency administering the Act, HEW,[97] published meticulous "project registers" giving the details of every grant made and analyzing aggregate program accomplishments according to types of facilities and construction.[98] Geographical disparities in the supply of hospitals—as measured by bed-to-population ratios—were reduced, which achieved one of the chief goals of the legislation.[99]

The Act's provisions requiring nondiscrimination and service to those unable to pay received dramatically different treatment from the administering federal and state agencies. From the program's inception in 1947 until 1972, the federal and state agencies completely failed to perform this task. The Surgeon General's initial regulations, issued in September 1947,[100] provided no criteria for determining who was "unable to pay" or how to measure a hospital's "reasonable volume" of free care.[101] The otherwise elaborate Hill-

96. S. REP. No. 1285, 93d Cong., 2d Sess. 22 (Table 9), *reprinted in* [1974] U.S. CODE CONG. & AD. NEWS 7842, 7862 [hereinafter cited as S. REP. No. 1285, with page citations to [1974] U.S. CODE CONG. & AD. NEWS].

97. Both the original Hill-Burton Act of 1946 and the 1964 amendments, Pub. L. No. 88-443, 78 Stat. 447 (1964), assigned administrative responsibility for Hill-Burton to the Surgeon General of the United States Public Health Service. The functions of the Surgeon General were transferred to the Secretary of HEW by § 1(a) of Reorganization Plan No. 3 of 1966, 31 Fed. Reg. 8855 (1966).

98. *See* PUBLIC HEALTH SERV., U.S. DEP'T OF HEW, HILL-BURTON PROJECT REGISTER (1971) (summarizing data and listing projects approved from July 1, 1947 to June 1, 1971) [hereinafter cited as HILL-BURTON PROJECT REGISTER].

99. *See* S. REP. No. 1285, *supra* note 96, at 7863-64, 7881-82.

100. 12 Fed. Reg. 6176 (1947).

101. *See id.* at 6179, § 53.63. In addition to the absence of operational standards or enforcement provisions, this regulation also contained a major substantive ambiguity. The sentence defining "free patient care" referred to "hospital service offered *below cost* or *free* to persons unable to pay therefor," *id.* (emphasis supplied), which suggests that the essential criterion for "free patient care" was some financial loss to the hospital. The next sentence, however, stated that "[s]uch care may be paid for *wholly or partly* out of public funds or contributions of individuals and . . . organizations . . . *or* may be contributed at the expense of the hospital itself." *Id.* (emphasis supplied). Under this language, a hospital might be paid in *full* by public funds for services to the indigent, and still be

Burton program statistics were entirely silent on how much or what types of care to the poor had been provided, or what types of patients had been served.[102] Even worse, the state agencies were not required to develop statewide eligibility standards, or even to issue guidelines to help hospitals make their own policies. Nor were the state agencies required to collect any information on services for the poor, much less "plan" to meet their needs. The hospitals were not required to report any information to the state, nor were the states required or even urged to monitor what the hospitals were doing with regard to charitable care. Under the supervision of the Surgeon General and the state agencies, the nondiscrimination and free care "assurances" were reduced to a set incantation filed with an application for funds and thereafter apparently ignored.[103]

B. *Developing a Right to Agency Enforcement*

After more than twenty years of agency nonenforcement, consumers began active litigation in the federal courts and documented numerous cases of seriously ill persons denied necessary hospital care because they were recipients of Medicaid[104] or because they did not have cash

able to claim credit toward its Hill-Burton obligation, however defined, for services to *persons* unable to pay therefor. This latter interpretation, which seems inconsistent with the text and legislative history of the Hill-Burton Act, was not eliminated until 1972, when HEW issued new regulations defining " 'services to persons unable to pay therefor' " as "uncompensated services." *See* 37 Fed. Reg. 14,721 (1972) (codified in 42 C.F.R. § 53.111 (b)(7) (1977)).

102. *See* HILL-BURTON PROJECT REGISTER, *supra* note 98. At a 1972 press conference held by HEW to explain interim regulations that, for the first time, set quantitative standards for compliance with the free care obligation, the administrator of the Health Services and Mental Health Administration, Dr. Vernon Wilson, admitted: "There is no well documented body of infromation on the national level as to the amount of services which are being provided to people unable to pay. It is interesting that there simply is not a national reservoir of this kind of information." U.S. Dep't of HEW, Press Conference on Hill-Burton Regulations, Washington, D.C., at 5 (July 21, 1972) (unedited transcript).

103. The extreme nature of the agencies' nonenforcement, and of the hospitals' noncompliance, was revealed in the *Newsom* litigation against Vanderbilt University Hospital, one of the major teaching hospitals of the South:

> Mr. Hewitt Rogers, who served as Director for Patient Admissions and Patient Accounting for Vanderbilt Hospital for approximately *20 years* prior to assuming his present position as the hospital's Director of Admissions in the Spring of 1976, testified in his deposition that the first time he had ever heard of the Hill-Burton Act and of the hospital's obligation to provide free services was in the latter part of 1972.

Newsom v. Vanderbilt Univ., No. 75-126-NA-CV, slip op. at 17 n.11 (M.D. Tenn. June 1, 1978).

104. *See* Cook v. Ochsner Foundation Hosp., 61 F.R.D. 354, 364 (E.D. La. 1972) (poor women told by admitting personnel at three Hill-Burton grantee hospitals in New Orleans "that the hospitals did not accept welfare or Medicaid patients").

deposits,[105] a private physician,[106] or sufficient funds.[107] The consumer plaintiffs sought to enjoin exclusionary hospital admission practices and to require hospitals to fulfill their Hill-Burton commitments to provide a reasonable volume of care to persons unable to pay.

In the agency and provider responses to these claims, the most fiercely litigated issue was whether low-income consumers had a judicially enforceable right to any explanation or justification for the refusal of hospital care. Relying on formalist conceptions of statutory interpretation and administrative law, the agencies and hospitals commonly argued that the Hill-Burton Act's generally worded provisions and its lack of explicit consumer remedies precluded any judicial recognition of consumers' statutory interest in hospital care. Given the text and legislative history of the Act, most courts rejected this extreme and implausible reading of the statute.[108] Having done so, the courts were faced with the precise problem identified by the agencies and providers: how to extract from the Act's general language any specific rights or duties on which to base concrete relief.[109] In order to

105. *See* Cloud v. Regenstein, No. C77-599 (N.D. Ga. Apr. 29, 1977) (upholding public hospital requirement of advance cash deposits against Hill-Burton challenge); Complaint at ¶¶ III.27-.28, Cook v. Ochsner Foundation Hosp., No. 70-1969 (E.D. La. July 24, 1970), *reprinted in* 2 HEALTH LAW PROJECT OF THE UNIVERSITY OF PENNSYLVANIA LAW SCHOOL, MATERIALS ON HEALTH LAW: THE HOSPITAL 71 (rev. ed. 1972) (alleging that two named indigent black residents of New Orleans, suffering from congestive heart failure, were refused hospital care at public Charity Hospital because of lack of facilities, and at three private Hill-Burton hospitals because of failure to provide cash deposits of $200 to $250) [compilation hereinafter cited as THE HOSPITAL].

106. *See* Campbell v. Mincey, 413 F. Supp. 16 (N.D. Miss. 1975) (upholding, on grounds of lack of emergency, public hospital's refusal to treat indigent black woman giving birth; no Hill-Burton claim raised); Cook v. Ochsner Foundation Hosp., 61 F.R.D. 354, 364-65 (E.D. La. 1972) (poor women told by admitting personnel at three Hill-Burton hospitals in New Orleans that "the hospitals would not treat them because they did not have private physicians").

107. *See* Plaintiff's Post Trial Brief at 12, Newsom v. Vanderbilt Univ., No. 75-126-NA-CV (M.D. Tenn. June 1, 1978) (describing Vanderbilt University Hospital's "Weekly Summary of Patients Denied Admission for Financial Reasons" as "replete with such candid entries as 'Insufficient finances, sent out,' 'No money, or insurance, sent out,' . . . 'Insufficient insurance, could not make deposit' ").

108. *See* Saine v. Hospital Auth., 502 F.2d 1033, 1034-35 (5th Cir. 1974); Euresti v. Stenner, 458 F.2d 1115, 1118-19 (10th Cir. 1972); Corum v. Beth Israel Medical Center, 359 F. Supp. 909, 914 (S.D.N.Y. 1973); Organized Migrants in Community Action, Inc. v. James Archer Smith Hosp., 325 F. Supp. 268, 271 (S.D. Fla. 1971); Cook v. Ochsner Foundation Hosp., 319 F. Supp. 603, 606 (E.D. La. 1970). *But see* Stanturf v. Sipes, 224 F. Supp. 883 (W.D. Mo. 1963), *aff'd on other grounds*, 335 F.2d 244 (8th Cir. 1964), *cert. denied*, 379 U.S. 977 (1965) (dictum).

109. *See, e.g.*, Perry v. Greater Southeast Community Hosp. Foundation, No. 725-71 (D.D.C. June 28, 1972), *reprinted in* THE HOSPITAL, *supra* note 105, at 81-82 (denying injunction to enforce community service and free care obligations); Yale-New Haven Hosp. v. Mathews, 32 Conn. Supp. 539, 343 A.2d 661 (C.P. App. Div. 1974), *cert. denied*, 164 Conn. 694, 341 A.2d 432, *cert. denied*, 423 U.S. 1024 (1975) (low-income hospital patients did not have standing or right to assert Hill-Burton Act as defense to hospital collection action on unpaid bill).

realize the substantive goals of the Act, the courts began, in an uneven and hesitant fashion, to develop the concept of a consumer right not to a particular level of benefits, but rather to a process that defined and allocated those benefits and that justified the program's results.

The first step in this development was the rejection of the formalist approach advocated by the hospitals and adopted by the district court in the early Hill-Burton case of *Euresti v. Stenner.*[110] Since the Hill-Burton Act focused on relations among the federal and state agencies and grantee hospitals, and provided no explicit remedies for consumers, the district court concluded that the Act's free-care requirement was a governmental or "public" interest enforceable only by administrative sanctions.[111] Private individuals, the court held, lacked standing to enforce a governmental right absent specific congressional authorization.[112]

Rejecting the district court's sharp distinction between public and private interests, the Tenth Circuit reversed.[113] The Hill-Burton Act, the circuit court held, "was passed to ensure that the indigent would be supplied sufficient hospital services when needed."[114] Given "this clear intent,"[115] and the manifest inadequacy of HEW's administrative sanctions, it was both necessary and appropriate to infer private legal remedies in order to secure enforcement of the hospitals' public obligations.[116]

The shift in reasoning and result between the district and appellate courts in *Euresti* reflects something deeper than differing modes of statutory interpretation. For the district court, the private autonomy of the hospital was paramount and demanded a limited judicial role; the court was willing to intervene in the hospital-patient relationship only on authority of a clear legislative command. For the appellate court, the statute's general substantive goal was paramount and defined a beneficiary class entitled to judicial protection. The decision in *Cook v. Ochsner Foundation Hospital,*[117] cited with approval by the Tenth Circuit in *Euresti,*[118] stated the point unequivocally: "the only real beneficiaries of a hospital program are the people who need

110. 327 F. Supp. 111 (D. Colo. 1971), *rev'd,* 458 F.2d 1115 (10th Cir. 1972).
111. *Id.* at 114.
112. *Id.* at 115.
113. 458 F.2d 1115 (10th Cir. 1972) (Retired Associate Justice Clark sitting by designation).
114. *Id.* at 1118.
115. *Id.*
116. *Id.*
117. 319 F. Supp. 603 (E.D. La. 1970).
118. 458 F.2d at 1119.

or may need medical treatment."[119] This statement indicates the merging of public purposes with private nonprofit hospital status that is inherent in the Hill-Burton program and was indeed the very premise on which the funds were disbursed.

The contradiction between private and public control reappears, however, when one considers the issue of relief: what substantive standards should courts apply to enforcing a private right to "community service" and to a "reasonable volume" of free care? The difficulties with direct judicial enforcement of these provisions quickly emerged in two important contexts.

First, an increasing number of low-income consumers, facing collection actions in state courts for large, unpaid hospital bills, attempted to raise the hospitals' lack of compliance with the reasonable volume of free care requirement as a defense or set-off to the hospitals' claims. Many hospitals, upon receipt of lengthy Hill-Burton motions and interrogatories from the defendant-patient, simply dropped their claims rather than pay the high costs of litigation, but several contested the patients' right to assert such a defense. In the only reported opinion, a Connecticut intermediate appeals court ruled that low-income consumers did not have standing to raise the Hill-Burton Act as a defense in a collection action, primarily because the statutory and pre-1972 regulatory standards of hospital compliance were judicially unmanageable.[120]

Second, even in affirmative litigation, consumer-plaintiffs encountered difficulty in obtaining concrete relief. The problems appeared most clearly in *Perry v. Greater Southeast Community Hospital Foundation*.[121] The consumer plaintiffs alleged that a Hill-Burton

119. 319 F. Supp. at 606.

120. Yale-New Haven Hosp. v. Mathews, 32 Conn. Supp. 539, 343 A.2d 661 (C.P. App. Div. 1974), *cert. denied*, 164 Conn. 694, 341 A.2d 432, *cert. denied*, 423 U.S. 1024 (1975). The *Yale-New Haven* case was decided under the pre-1972 regulations that, being largely identical to the original 1947 regulations, gave virtually no guidance to hospitals or courts as to what constituted compliance with the free care obligation. *See* note 101 *supra*. Since the issuance of more detailed federal regulations between 1972 and 1974, *see* p. 277 *infra*, at least one state lower court has ruled, in an unreported opinion, that a patient who was unemployed at the time that hospital services were rendered has standing to raise as an affirmative defense to a hospital collection action the issue of the hospital's noncompliance with the Hill-Burton free care obligation. *See* Alexian Bros. Hosp. v. Brunette, No. 217473, Order at 2 (Dist. Ct., Union County, N.J. Dec. 9, 1977). In Newsom v. Vanderbilt Univ., No. 75-126-NA-CV (M.D. Tenn. June 1, 1978), a federal district court issued a temporary restraining order prohibiting the University Hospital and its collection agent from prosecuting a collection action in state court against the low-income consumer plaintiff, pending a federal trial on the hospital's compliance with federal regulations. *See id.*, slip op. at 5.

121. No. 725-71 (D.D.C. June 28, 1972), *reprinted in* THE HOSPITAL, *supra* note 105, at 80 [subsequent page citations to THE HOSPITAL].

hospital in southeast Washington, D.C. disproportionately served suburban patients and effectively excluded city residents, many of whom were Black and eligible for Medicaid. Although the plaintiffs claimed that the defendant hospital was not delivering a reasonable amount of free care, the focus of their complaint was on the community service standard and on whether it required a Hill-Burton hospital to take steps to ensure that various types of patients were not excluded.[122] Unlike many Southern hospitals, the defendant hospital was not charged with flatly refusing to serve Medicaid and minority patients, but rather with serving a much smaller proportion of such patients than was justified by their population in the community. Plaintiffs alleged that this disproportionate availability of services was due to a specific set of hospital practices: Cafritz limited its admission privileges largely to physicians practicing in the suburbs, refused to establish outpatient clinics, and refused to enter into affiliation agreements with public clinics serving the poor.[123] The plaintiffs also sought affirmative relief requiring the federal and state agencies to enforce the community service and free care standards.[124]

Identifying the issues raised by the *Perry* complaint to be "of paramount consequence to this community,"[125] Judge Gerhard Gesell found that the plaintiffs had standing and critically characterized the existing health policy process as reflecting "a somewhat indecisive and casual approach to problems relating to hospital care."[126] Nevertheless, he found it "impossible . . . to evaluate the meaning" of the key regulatory term: "community service."[127] The statute simply provided for assurances that "the facility . . . will be made available to all persons residing in the territorial area of [the hospital]."[128] HEW's implementing regulation in turn required grantee hospitals to provide an assurance that they would "furnish a community service."[129] The regulations further explained that a community service meant that

122. *See id.* at 80-81.

123. *Id.* at 80-83. To remedy these asserted violations, the plaintiffs sought an order under the community service standard requiring the hospital to distribute its patient services in ratios roughly proportional to the geographic—and therefore economic and racial—composition of the surrounding community. This would have been accomplished in part by an expansion of outpatient clinic care. The plaintiffs also sought implementation of the free care requirement through an order requiring the hospital to devote at least five percent of its operating costs to free or below-cost services to persons unable to pay. *Id.*

124. *Id.*

125. *Id.* at 80.

126. *Id.*

127. *Id.* at 81.

128. 42 U.S.C. § 291c(e) (1970).

129. 42 C.F.R. § 53.112(a)(1) (1972) (current version at 42 C.F.R. § 53.113(c) (1977)).

"the services furnished are available to the general public" or that "admission is limited only on the basis of age, medical indigency, or type or kind of medical or mental disability."[130] The plaintiff Medicaid recipients argued that since payment for their care was guaranteed by a government program, they could not be excluded on grounds of medical indigency and had to be served under the regulation as members of the general public. Judge Gesell held, however, that even if these arguments were valid, he could find no guidance in the statute and regulations concerning the plaintiffs' claims for proportional patient service and expanded clinic care:

> There are no standards by which the Court could determine whether whatever community services the hospital performs are or are not reasonably related to the standard; and without that, there is no way that the Court can function except by considering itself some kind of an administrative agency in a rule-making and administrative process, which is not the role of the Court.[131]

The judge pointed out that

> [t]he legislative history does not in any way encourage court interference with the day-to-day operations of a complex urban hospital. Indeed, there is much in the statute which would point rather substantially the other way . . . . [W]hat Congress had in mind [in passing the Hill-Burton Act] was not a decision to be made hospital-by-hospital, . . . but that the approach was to be made rather through regulations which the Secretary [of HEW] would develop at least of a citywide character, if not of a regional character, in consultation with the local state agencies that are involved.[132]

Because of the absence of such regulations—which, in June 1972, HEW was finally in the process of developing—Judge Gesell declined to grant any relief against the hospital. And in spite of his criticism of the agencies' inaction, he also denied relief against the agencies themselves because of the lack of statutory guidance.[133]

130. *Id.* § 53.1(s) (current version at 42 C.F.R. § 53.113(d)(1)(ii) (1977)).

131. Perry v. Greater Southeast Community Hosp. Foundation, No. 725-71 (D.D.C. June 28, 1972), *reprinted in* THE HOSPITAL, *supra* note 105, at 81.

132. *Id.* at 83.

133. The *Perry* plaintiffs originally sought injunctive and declaratory relief against HEW and the local District of Columbia agency for failure to implement and enforce the reasonable volume and community service requirements of the Hill-Burton Act. *See id.* at 80. When HEW began to develop reasonable volume regulations in the spring of 1972, the plaintiffs narrowed their motion for summary judgment against HEW to focus on HEW's failure to promulgate community service regulations. *See* Memorandum of Points and Authorities in Support of Plaintiffs' Motion for Summary Judgment at 22-23,

Judge Gesell was correct in noting that courts were not the appropriate institutions to resolve, at least in the first instance, the major policy issues involved in defining the hospitals' obligations under the Hill-Burton Act. The general statutory language does not provide manageable standards for decisions about particular hospitals. The issues are not within the courts' traditional areas of competence since they involve difficult questions of fact and value, and Congress clearly intended the federal and state agencies to be responsible for the definition and enforcement of the standards. But conceding all this to be true, Judge Gesell's opinion falls curiously in between recognition and denial of the statutory goals as "law." On the one hand, the generally phrased statutory provisions are treated as law for purposes of defining the beneficiary class. This establishes standing and an implied cause of action. On the other hand, the same provisions are treated as too unclear to support even a declaratory judgment that the Secretary has a duty to issue regulations. Having jettisoned the formalist model of mandatory duty for purposes of standing, Judge Gesell then re-adopted it for the purpose of denying relief. The decisive issue was thus seen as whether the Secretary is *required* to accept the types of policies advocated by the plaintiffs, rather than whether his actual failure to adopt policies complied with the Act. Judicial standards for testing the Secretary's actions began to develop more quickly, however, as HEW began to issue more detailed regulations.

C. *The Role of the Courts in Defining the Agency's Function*

Hill-Burton lawsuits by low-income consumers, originally designed to secure "compliance" with federal law by grantee hospitals, con-

Perry v. Greater Southeast Community Hosp. Foundation, No. 725-71 (D.D.C. June 28, 1972). In mid-June 1972, however, plaintiffs also sought a temporary restraining order against procedural defects in the development of the reasonable volume regulations. As summarized by one of the plaintiffs' attorneys:

> The defects alleged were (1) the [Federal Hospital] Council [with statutory authority to approve regulations proposed by the Secretary] was composed of only seven members instead of the [statutorily] required 12; (2) although the comment period was still open, the Council was determining the final regulation prior to the closing date; and (3) Executive Order 11671, 36 Fed. Reg. 11307 (1971), requires advisory committee meetings to be open to the public, while this meeting was closed—in fact, one attorney representing poor people was specifically refused admission.

Rose, *The Hill-Burton Act—The Interim Regulation and Service to the Poor: A Study in Public Interest Litigation*, 6 CLEARINGHOUSE REV. 309, 311 n.22 (1972). Judge Gesell conceded that the plaintiffs had raised a "serious" question about the numerical composition of the Federal Hospital Council, but denied their request for a temporary restraining order and their motion for summary judgment because he believed that the statute provided inadequate guidance for judicial intervention. *See* Perry v. Greater Southeast Community Hosp. Foundation, No. 725-71 (D.D.C. June 28, 1972), *reprinted in* THE HOSPITAL, *supra* note 105, at 83-84.

tinually confronted the inadequacy of the federal regulations themselves, and HEW was soon joined as a defendant in most suits.[134] The effect of this litigation was to induce the federal agency, without any formal court order, to begin drafting new regulations defining a reasonable volume of free care. From 1972 to 1975, under continuous litigation pressure from consumers, HEW gradually issued new Hill-Burton regulations requiring the state agencies to establish an annual dollar amount of uncompensated care for each grantee hospital.[135] However, this amount could be limited, at the hospital's option, to a maximum annual figure of ten percent of the hospital's Hill-Burton grants during the previous twenty years.[136] The regulations contained some standards regarding income eligibility criteria[137] and billing procedures[138] for persons unable to pay, yet HEW resolutely maintained that it had

134. *See, e.g.*, Saine v. Hospital Auth., 502 F.2d 1033, 1034 (5th Cir. 1974); Cook v. Ochsner Foundation Hosp., 61 F.R.D. 354, 355 (E.D. La. 1972).

135. *See* 42 C.F.R. § 53.111(h) (1977). This regulation was originally promulgated in an "interim" form on July 22, 1972, 37 Fed. Reg. 14,719, 14,722 (1972), and in a final form, with changes said to be only "technical," on June 22, 1973, 38 Fed. Reg. 16,353 (1973). *But see* Rose, *supra* note 3, at 174-78 (discussing promulgation process and significance of "technical" changes).

136. The regulations permit the hospital to select one of three levels of service constituting "presumptive compliance" with the free care obligation: (1) uncompensated services valued at three percent of operating costs, (2) uncompensated services valued at 10% of federal assistance received under the Hill-Burton Act, or (3) certification that the hospital would admit and serve any person seeking admission "without charge or at a charge . . . which does not exceed . . . such person's ability to pay" as determined by state-defined criteria. 42 C.F.R. § 53.111(d) (1977). The presumptive compliance guidelines in turn operate as a ceiling on the state agency's power to set a dollar amount of uncompensated service for any grantee hospital in any fiscal year. *See id.* § 53.111. The applicability of the free care obligation is also limited to 20 years after the completion of construction subsidized by Hill-Burton grants or guaranteed loans. *Id.* § 53.111(a). Both the presumptive compliance guidelines and the 20-year limitation were upheld as consistent with the statute in Corum v. Beth Israel Medical Center, 373 F. Supp. 550, 554-57 (S.D.N.Y. 1974). *Accord*, Cook v. Ochsner Foundation Hosp., 559 F.2d 968, 973-74 (5th Cir. 1977).

137. *See* 42 C.F.R. § 53.111(g)(1) (1977) (first promulgated at 37 Fed. Reg. 14,719, 14,721 (1972)) (requiring state Hill-Burton agencies to set forth "criteria for identifying persons unable to pay for services," based on such factors as family size and income, extent of insurance coverage, and generally recognized standards of need, subject to HEW approval). *But see* Rose, *supra* note 3, at 181-86 (discussing widespread state agency failure to implement this regulation).

138. *See* 42 C.F.R. § 53.111(f) (Oct. 1972) (amended 1975) (permitting hospitals to include as uncompensated services only those services to individuals whose eligibility under Hill-Burton standards had been determined in writing "prior to any collection effort other than the rendition of bills"). The effect of this provision was to permit hospitals to choose a portion of their unpaid bills to write off as Hill-Burton free care, without any prior notice to low-income patients that such a program was available. This result was declared to be in violation of the statutory requirement to aid persons *unable* (as opposed to unwilling) to pay in Corum v. Beth Israel Medical Center, 373 F. Supp. 550, 557-58 (S.D.N.Y. 1974). The provision as amended requires hospitals to make the determination of eligibility "prior to the provision of such services." 42 C.F.R. § 53.111(f) (1977).

no duty to low-income consumers to clarify or enforce its own regulations,[139] much less to respond to repeated evidence of their inadequacy. The result was that hospitals generally continued their pre-1972 practices: exclusion of Medicaid patients,[140] failure to give effective notice of the program's existence,[141] failure to make advance written determinations of eligibility,[142] and writing-off of various types of losses (*e.g.*, refusal of third-party payors to reimburse for unnecessary care) as "community service" to the poor.[143]

The need for judicial standards to evaluate agency and hospital performance, and the difficulty of articulating them, was apparent in the *Cook* litigation in New Orleans. During the two years following the initial 1970 complaint, which had documented the exclusion from Hill-Burton hospitals of Medicaid beneficiaries in urgent need of care,[144] the responsible division of HEW—the Health Care Facilities Service—had done nothing even to ascertain "the accuracy of the factual allegations."[145] At the same time, HEW lawyers argued that the court had no jurisdiction to order administrative enforcement of the community service regulation, since enforcement "is a discretionary function."[146] Judge Comiskey responded to this bureaucratic callousness by ruling that the Secretary's failure to prescribe regulations protecting low-income consumers from discriminatory exclusion was "in disregard of the provisions and intent of the Hill-Burton Act."[147]

In reaching this result, Judge Comiskey took pains to use the vocabulary of the formalist approach to administrative law. As noted above, HEW's community service regulation required grantee hospitals to furnish "a community service," defined by the agency as services "available to the general public."[148] The Secretary argued that this only prohibited " 'discriminatory admission practices resulting in an absolute exclusion of certain segments of the public' "[149] and did not speak to the issue of serving Medicaid patients. Responding in equally

139. *See, e.g.*, Newsom v. Vanderbilt Univ., No. 75-126-NA-CV (M.D. Tenn. June 1, 1978); Lugo v. Simon, No. C74-345 (N.D. Ohio Apr. 21, 1978).
140. *See* Cook v. Ochsner Foundation Hosp., 61 F.R.D. 354, 358 (E.D. La. 1972).
141. *See* Newsom v. Vanderbilt Univ., No. 75-126-NA-CV, Memorandum at 24-28, 42-50 (M.D. Tenn. June 1, 1978), *discussed at* pp. 282-84 *infra*.
142. *See id.*
143. *See id.* at 28-31; Corum v. Beth Israel Medical Center, 373 F. Supp. 550, 557-58 (S.D.N.Y. 1974).
144. *See* notes 104-06 *supra* (discussing plaintiffs' allegations in *Cook*).
145. Cook v. Ochsner Foundation Hosp., 61 F.R.D. 354, 366 (E.D. La. 1972).
146. *Id.* at 359.
147. *Id.* at 361.
148. 42 C.F.R. § 53.112 (1977) (nondiscrimination).
149. 61 F.R.D. at 360.

formalist terms, Judge Comiskey noted that HEW's standard of " 'absolute exclusion of certain segments of the public' " seemed to apply precisely to the exclusion of 100,000 New Orleans Medicaid recipients from hospital services, and held that the Secretary had misinterpreted his own regulations.[150] In August 1974, fifteen months after this ruling, HEW finally acquiesced and issued an amended community service regulation requiring grantee hospitals to accept payment from governmental programs (such as Medicaid and Medicare) that reimburse for services on the basis of actual or "reasonable" costs.[151]

In form, Judge Comiskey's ruling purported to find a mandatory duty in the language of the statute and regulation. Responding to HEW's argument that "enforcement" was a discretionary function, Judge Comiskey pointed out that HEW itself had adopted a regulation requiring Hill-Burton hospitals to "furnish a community service."[152] Having done so, he continued, HEW had a duty to enforce this obligation, which he understood "clearly" to prohibit exclusion of Medicaid recipients from federally funded hospitals.[153] The Hill-Burton Act itself provided that the Surgeon General, with the approval of the Secretary "*shall* by general regulations prescribe" the requirements of the community service and free care assurances,[154] and the Secretary's failure to do so, the court held, violated the Hill-Burton Act and was therefore a basis for judicial enforcement.[155]

Judge Comiskey's opinion reflects a bizarre dialogue between HEW and the court in which each side remained committed to the vocabulary of mandatory duty. The Secretary steadfastly maintained that the regulatory text had virtually *no* meaning and therefore allowed complete discretion, while the court held that the vague terms had a plain meaning and dictated a specific result. The advantage of the court's approach is its incorporation of the myth that the judge is not making a policy decision, but it neglects a middle range of interpretation that far more convincingly supports the court's conclusion.

Such an analysis would concede that, in enacting the original 1946 nondiscrimination provision and its successor 1964 requirement that grantee hospitals be made available "to all persons residing in the territorial area,"[156] Congress obviously had no intent with respect to

150. *Id.*
151. 42 C.F.R. § 53.113(d)(2)(i) (1977) (promulgated at 39 Fed. Reg. 31,765, 31,767 (1974)).
152. 61 F.R.D. at 360.
153. *Id.*
154. 42 U.S.C. § 291 (1970) (emphasis supplied).
155. 61 F.R.D. at 361.
156. Hospital and Medical Facilities Amendments of 1964, Pub. L. No. 88-443, § 603(e), 78 Stat. 447, 451 (1964) (codified at 42 U.S.C. § 291c(e) (1970)).

Medicaid, which was not established until 1965.[157] Nevertheless, the legislative history of the 1964 amendment indicates congressional awareness that the generally stated requirement of availability to "all persons" might be interpreted, in later years, to refer to issues other than racial discrimination.[158] Moreover, the legislative history of the 1946 Act reflected Congress's expectation—and the hospital industry's assurance—that Hill-Burton hospitals would function as quasi-public entities—*i.e.*, as public assets performing a public, charitable function.[159] Given this background, a court could easily conclude that the Secretary had abused his discretion by permitting federally funded hospitals to exclude with no apparent justification the beneficiaries of a federally funded health care program. This, indeed, was the real basis of Judge Comiskey's decision, and glimpses of it occasionally came to light in the midst of unconvincing assertions about the plain meaning of the regulatory text.

The problem of discrimination against Medicaid recipients by hospitals receiving Hill-Burton funds is complicated both by hospitals' economic incentives *not* to treat Medicaid patients and by the failure of Hill-Burton legislation to anticipate the later passage of Medicaid. Why do hospitals refuse to participate in the Medicaid program, if indeed it pays them for their services on approximately the same basis as Blue Cross and Medicare? No study of this question has been done, but some hypotheses can be offered. Although federally funded state Medicaid programs are required by federal law to reimburse hospitals for *inpatient* services on the basis of industry-defined "reasonable cost,"[160] there are effectively no federal requirements on minimum state Medicaid reimbursement for hospital *outpatient* services and physicians' fees.[161] In many states Medicaid pays far less than

157. *See* note 1 *supra.*

158. *See Hearings on H.R. 10041 Before the House Comm. on Interstate and Foreign Commerce,* 88th Cong., 2d Sess. 53-54 (1964).

159. *See* p. 268 *supra.*

160. 42 U.S.C. § 1396a(a)(13)(D) (1970); *see* 42 C.F.R. § 450.30(a)(2) (1977). *See also* S. LAW, *supra* note 2, at 59-114 (discussing and criticizing "reasonable cost" as basis for hospital reimbursement).

161. *See* 42 C.F.R. § 450.30(a)(7) (1977) (requiring state Medicaid programs to establish fee structures "which are designed to enlist participation of a sufficient number of providers of services in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population"). This provision would appear to require the states to set fees for physicians' and hospital outpatient services at levels at least roughly comparable to prices paid by the general population; in fact many states do not come close to meeting this standard, and many Medicaid recipients have great difficulty finding physicians who will accept their Medicaid cards. *See* MEDICAID BUREAU, HEALTH CARE FINANCING ADM'N, DEP'T OF HEW, DATA ON THE MEDICAID PROGRAM: ELIGIBILITY, SERVICES, EXPENDITURES: FISCAL YEARS 1966-77, at 22 (1977) (39 of 52 Medicaid programs limit reimbursement to physicians by fee

the going market rate for outpatient and physician care, and this generates a large financial disincentive for hospitals and doctors to serve the Medicaid-eligible poor.[162] Moreover, many hospitals are organized around physicians' private practices, which involve a network of financial and social relationships in which the poor are not welcome.[163] In particular, physicians and others involved in the hospital may oppose the diversion of resources into the outpatient clinics and salaried positions that might be needed to provide services to the poor.

In enacting the Hill-Burton Act in 1946, Congress probably did not intend the federal government to be directly involved in these types of decisions. At that time, Congress's dominant concern was the small community with a single hospital, in which all economic classes would be treated under the prevailing tradition of charitable care.[164] If admissions policies and patterns of medical practice needed to be regulated, it was to be done by the state agencies, subject to federal supervision. But by the late 1960s, the economic, social, and administrative basis of this vision had largely collapsed. The enormous growth in third-party payment for hospital care (through Blue Cross, Medicare,

schedules and maximum payments in manner different from "customary and prevailing charges" reimbursement used in Medicare program) [hereinafter cited as MEDICAID DATA]; Rosenblatt, *Lurching Toward the Abyss: Medicaid Cutbacks and Health Care Inflation*, HEALTH L. PROJECT LIB. BULL., Nov. 1975, at 1, 3 (New Jersey Medical Society expects most physicians to phase out their Medicaid practices after state reduction of 10%). HEW itself admits that under its current regulations, "while there is an effective ceiling on payment, there is no corresponding floor." MEDICAID DATA, *supra*, at 18; *cf.* 42 C.F.R. § 450.30(a)(4)-(b) (1977) (establishing upper limits for state payment for services); *id.* § 450.30(b) ("The State agency may pay less than the upper limits.")

162. *See* MEDICAID DATA, *supra* note 161, at 19 (13 Medicaid programs pay for hospital outpatient services on basis of "fee schedule"); *id.* at 22 (39 programs limit reimbursement to physicians in manner different from Medicare). In Pennsylvania, for example, the Medicaid fee is $12 for a hospital emergency room or outpatient visit, and $200 for surgery "during any one illness." *See* 2 MEDICARE-MEDICAID GUIDE (CCH) ¶ 15,632, at 6589-7, 6590 (1978).

163. *See, e.g.*, Campbell v. Mincey, 413 F. Supp. 16 (N.D. Miss. 1975), *aff'd mem.*, 542 F.2d 573 (5th Cir. 1976) (woman giving birth refused treatment because not patient of one of hospital's staff physicians); Cook v. Ochsner Foundation Hosp., 61 F.R.D. 354, 364-65 (E.D. La. 1972) (poor women denied treatment because they "did not have private physicians"); *cf.* Meyer v. Massachusetts Eye & Ear Infirmary, 330 F. Supp. 1328 (D. Mass. 1971) (physician prohibited by hospital from informing low-income clinic patients about availability of "private" treatment).

164. *See* p. 264 *supra*. In 1947, the AHA's model hospital constitution and bylaws provided that the "Attending Medical Staff shall have the care of all charity patients in the hospital"; the Association's model rules and regulations provided that "[f]ree patients shall be attended" by appropriate members of the medical staff and that "[n]o physician shall receive any compensation for the care of any patient who is receiving free care by the hospital." *See* Rose, *supra* note 3, at 171 n.18 (quoting AMERICAN HOSP. ASS'N, MODEL CONSTITUTION AND BYLAWS FOR VOLUNTARY HOSPITALS AND RULES AND REGULATIONS FOR THE MEDICAL STAFF (1947)). The current AHA MODEL BYLAWS no longer contain these provisions. *Id.* at 196 n.157.

Medicaid, and private insurance)[165] and the sharply rising costs of such care,[166] together with increased professional specialization and urbanization, had undermined the personalized, charitable relationships of American small towns and medium-sized cities, which had been the ideal, if not the reality, of an earlier era. The state agencies, moreover, had proved totally incapable of addressing the modern problems of health care delivery. The question for the courts was whether, in the face of such changes, the federal agency had an obligation to low-income consumers to revise its substantive and procedural standards in a manner consistent with the statute's general goals.

The answer emerging in the most recent Hill-Burton litigation is consistent with the concepts of entitlement and due process that have already been developed in the areas of public assistance and public housing.[167] Under this approach, the courts claim little authority to determine the substance of the redistributive obligation (*i.e.*, the actual dollar amount of the hospital's "reasonable volume" of free care), but do claim the authority to regulate the process by which the obligation is defined and administered. Thus two federal district courts have ruled that regardless of the fact that hospitals can limit their annual dollar volume of free care to ten percent of their Hill-Burton grants, the resulting benefits must be distributed in accordance with publicly defined service priorities and eligibility criteria.[168]

The case confronting these issues most explicitly is *Newsom v. Vanderbilt University*,[169] in which a class of low-income consumers challenged the common hospital practice of deciding who was to receive Hill-Burton subsidies without the knowledge of the applicants themselves and without any public standards for making the selection. For example, the Director of Admissions of Vanderbilt University Hospital admitted that an applicant was almost never told that he or she was even being considered for uncompensated care. The reason, he said, was that if people were told of the existence of such a program,

165. In Fiscal Year 1974, third-party payments accounted for 89.6% of expenditures for hospital care, and 64.6% of total health care expenditures. In contrast, in 1950 third-party payments comprised only 31.7% of total health care expenditures. HEALTH UNITED STATES 1975, *supra* note 14, at 41-42.

166. *See* note 14 *supra*.

167. *See, e.g.*, Goldberg v. Kelly, 397 U.S. 254 (1970) (termination of welfare benefits); Thompson v. Washington, 497 F.2d 626 (D.C. Cir. 1973) (public housing rent increases).

168. *See* Corum v. Beth Israel Medical Center, 359 F. Supp. 909, 916-18 (S.D.N.Y. 1973); Newsom v. Vanderbilt Univ., No. 75-126-NA-CV, slip op. at 50-52 (M.D. Tenn. June 1, 1978); *cf.* Gordon v. Forsyth County Hosp. Auth., Inc., 409 F. Supp. 708, 722 (M.D.N.C. 1975), *modified*, 544 F.2d 748 (4th Cir. 1976) (requiring exhaustion of administrative remedies).

169. No. 75-126-NA-CV (M.D. Tenn. June 1, 1978).

they would tend to falsify information to make themselves eligible for reduced fees.[170] Although this might be a realistic concern, the court pointed out that it should be balanced against two other factors. First, the record was "replete with evidence that applicants for admission are led to believe, and realistically so, that they will be turned away if they are perceived to be unable to pay."[171] This led patients to *overstate* their resources and thereby complicate the process used by the hospital to allocate care to those most in need. Second, many people who were eligible under the Hill-Burton standards were in fact denied admission for financial reasons, with "nowhere else to turn for needed treatment"[172] and with no notice of the existence of a program that could possibly help them secure it.

Judge Morton ruled that the Hill-Burton income eligibility standards, as established by the states under federal guidelines, created a consumer "entitlement" at least to a fair process for allocating limited, subsidized care.[173] Such a fair process would, at a minimum, include effective notice of the program's existence, written and public standards of decision, and an opportunity for a fair hearing regarding the application of the standard to the individual case.[174] The court conceded that a hospital might be able to convince the administering agencies that the disproportion between need and available resources was so great that eligibility should be limited to particular kinds of cases, services, or residents of particular areas, but ruled that such decisions had to be made publicly and had to be made pursuant to criteria defined by the agency.[175] This position is consistent with the Supreme Court's decision in *Morton v. Ruiz*,[176] in which the Court held that the Secretary of the Interior had the authority to restrict eligibility for cash welfare assistance on Indian reservations more narrowly than the outer confines of the statute, but that he had to promulgate such restrictions publicly, with opportunity for comment, through the rulemaking procedures of the APA.[177]

Like other due process decisions concerning welfare[178] and public housing,[179] the *Newsom* decision does not expand the resources avail-

170. *Id.*, slip op. at 27.
171. *Id.* at 27-28.
172. *Id.* at 28.
173. *Id.* at 38-40.
174. *Id.* at 41-42, 50-52.
175. *Id.* at 39-43, 50-51.
176. 415 U.S. 199 (1974).
177. *Id.* at 231-36; *see* p. 256 & note 43 *supra* (APA rulemaking procedures).
178. *See, e.g.*, Goldberg v. Kelly, 397 U.S. 254 (1970).
179. *See, e.g.*, Thompson v. Washington, 497 F.2d 626 (D.C. Cir. 1973); Holmes v. New York City Hous. Auth., 398 F.2d 262 (2d Cir. 1968).

able to subsidize expensive hospital services. It is certainly possible that, in the hands of a hostile or insensitive bureaucracy, due process techniques could degenerate into empty rituals preceding the inevitable denial of care. On the other hand, articulated standards and fair procedures have never been tried, and it is also possible that their use will more fairly allocate limited resources to those patients most in need. More importantly, by raising the visibility of the need for hospital care, due process techniques may contribute to political efforts to increase the amount of resources available. In this sense, structural due process functions as a mode of political participation by requiring the agency to expose itself and the community to the facts and values inherent in its decisions. This may in turn encourage the development of an adequately funded, substantive entitlement to hospital care.

D. *The Contributions and Limitations of Judicial Relief*

A structural due process approach to the Hill-Burton Act developed from an initial recognition of consumers as intended statutory beneficiaries to the more complex decisions about the process through which consumer interests should be considered. These seemingly procedural doctrinal developments have also contributed, at least to some extent, to increases in tangible benefits to consumers.

At the local level, litigation has occasionally resulted in agreements by hospitals to supply specified amounts of free care or to establish new types of community-oriented health care services.[180] Even greater benefits in some localities have been achieved without litigation when organized low-income consumers have persuaded hospitals and state agencies to adopt programs and procedures responding to consumer needs.[181] The fact that negotiations with hospitals and state agencies, coupled with organized community pressure, have had success highlights, rather than reduces, the importance of the doctrinal development of structural due process. The judicial recognition of consumer interests under the Hill-Burton Act and the consequent threat of

180. *See* Cook v. Ochsner Foundation Hosp., 61 F.R.D. 354, 356 n.1 (E.D. La. 1972) (eight defendant hospitals ordered in consent decree to supply free and below-cost services to persons unable to pay therefor in amounts ranging from $34,000 to $230,000 annually); National Health Law Program, *Hospital Staff Physicians Agree to Accept Hospital Medicaid Patient Referrals to Fulfill Hill-Burton "Community Service" Requirement*, 10 CLEARINGHOUSE REV. 787 (1977). *But see* Claire v. Centre Community Hosp., No. 78-636 (Ct. C.P. Centre County, Pa., filed Mar. 15, 1978).

181. For discussions of various organizing efforts see Pastreich, *A Report on Health Care Organization in Massachusetts: Union and Community Unite Around Health Care*, HEALTH L. PROJECT LIB. BULL., Apr. 1977, at 1; Sparer, *Legal Services and Social Change*, HEALTH L. PROJECT LIB. BULL., Feb. 1977, at 1.

litigation have strengthened the position of consumers in nonjudicial negotiation.

At the national level, consumer litigation and advocacy concerning the Hill-Burton Act have resulted in several important new legislative provisions. In enacting the National Health Planning and Resources Development Act of 1974,[182] Congress phased out Hill-Burton's original grant program and established a new health facilities construction program as Title XVI of the Public Health Service Act.[183] The Hill-Burton requirements that grantee institutions provide a community service and a reasonable volume of free care remain in the new act,[184] and the administrative and judicial enforcement mechanisms are strengthened. Recognizing the massive failure of HEW and the state agencies to enforce the Hill-Burton requirements,[185] Congress shifted most enforcement responsibilities to the federal government[186] and explicitly recognized a private right of action to enforce provider compliance.[187] Yet even this explicit and strengthened legislative mandate does not eliminate the need for judicial development of due process techniques. For nearly four years after the effective date of the new act, HEW again failed to develop even proposed regulations for its implementation. This failure ended in a consent decree in *Lugo v. Simon*,[188] in which HEW committed itself to issue new regulations according to a definite timetable and in consultation with consumers.[189]

The Hill-Burton experience thus shows some consumer success in gaining new legislation, regulatory specificity, and due process protec-

182. 42 U.S.C. §§ 300k-300t (Supp. V 1975).
183. *Id.* §§ 300*o* to 300*o*-3.
184. *Id.* § 300*o*-3(b)(1)(J).
185. S. REP. No. 1285, *supra* note 96, at 7900 (citing GAO report indicating "sorry performance by the Department [of HEW] and the State Hill-Burton agencies in implementing a provision which has been in law for over 20 years").
186. *See* 42 U.S.C. § 300p-2(c) (Supp. V 1975) ("Secretary [of HEW] shall investigate and ascertain, on a periodic basis . . . the extent of compliance . . . with the assurances required to be made" when assistance received); *id.* § 300*o*-1:

> The Secretary shall by regulation . . . prescribe the general manner in which each entity which receives financial assistance under this subchapter or has received financial assistance under [the new or the old Hill-Burton provisions] shall be required to comply with the assurances required to be made at the time such assistance was received and the means by which such entity shall be required to demonstrate compliance with such assurances.

187. *See id.* § 300p-2(c) ("[a]n appropriate action to effectuate compliance" with Hill-Burton assurances "may be brought by a person other than the Secretary [of HEW]" only if complaint was filed with Secretary and rejected or "Attorney General has not brought a civil action for compliance" within six months of date complaint filed with Secretary).
188. No. C 74-345 (N.D. Ohio Aug. 31, 1978) (stipulation between plaintiffs and defendant Secretary of HEW).
189. *Id.*

tions, as well as in increasing the amount of available hospital care. It is nevertheless clear that major problems remain: agency delay and nonenforcement continue, as do exclusionary practices regarding Medicaid patients, requirements of cash deposits for hospital admission, and failure to inform patients of potential eligibility for Hill-Burton benefits.

In the long run, it is clear that the Hill-Burton program cannot function as a substitute for a progressively financed system of public subsidy and regulation. The receipt of a construction grant years ago does not supply a hospital with current operating funds, and even Hill-Burton "write-offs" must be paid for, usually by inflating charges to increasingly small categories of privately paying patients.[190] The long-term significance of the Hill-Burton program is thus not as a source of funds, but as a source of a principle—that government agencies and publicly funded hospitals are not islands of standardless discretion and autonomy, but rather institutions accountable to the beneficiaries of their operations.

III. Medicaid: Entitlement and the Right to Participate in Policymaking

The federal medical assistance program (Medicaid), enacted in 1965 as Title XIX of the Social Security Act,[191] represented, together with Medicare,[192] the second generation of major federal health care legis-

190. In Fiscal Year 1976, only 9% of the $55.4 billion spent for hospital care was paid directly by patients; the remaining 91% was paid by government, private health insurance, philanthropy, and industry. HEALTH RESOURCES ADM'N, PUBLIC HEALTH SERVICE, DEP'T OF HEW, HEALTH UNITED STATES 1976-1977 CHARTBOOK 4 (1977). The practice of charging privately paying patients (including some patients covered by private health insurance plans) fees in excess of "reasonable cost" was upheld in Borland v. Bayonne Hosp., 122 N.J. Super. 387, 300 A.2d 584 (Super. Ct. Ch. Div. 1973), *aff'd per curiam*, 136 N.J. Super. 60, 344 A.2d 331 (Super. Ct. App. Div. 1975), *aff'd*, 72 N.J. 152, 369 A.2d 1 (1977), *cert. denied*, 434 U.S. 817 (1977). *Cf.* Borland v. McDonough, 135 N.J. Super. 200, 343 A.2d 97 (Super. Ct. App. Div. 1975), *aff'd*, 72 N.J. 152, 369 A.2d 1 (1977) (upholding decision of commissioners of health and insurance to exclude costs of indigent care from "reasonable costs" paid by Blue Cross to hospitals and permitting costs of indigent care to be imposed by hospitals solely on privately paying patients).

191. Medicaid Act, *supra* note 1.

192. Social Security Amendments of 1965, Pub. L. No. 89-97, §§ 1801-1875, 79 Stat. 286 (1965) (current version at 42 U.S.C. §§ 1395-1395pp (1970 & Supp. V 1975)). Medicare is a program of hospital and medical insurance for the aged, financed by federal payroll taxes and administered by the Health Care Financing Administration (HCFA), in part through contracts with "fiscal intermediaries" such as Blue Cross. *See generally* S. LAW, *supra* note 2, at 31-50. Medicaid is a program of medical assistance for the poor, financed by general revenue taxes at the federal, state, and local levels, and administered by the federal Medicaid Bureau (within HCFA) and by state Medicaid agencies. *See generally* R. STEVENS & R. STEVENS, WELFARE MEDICINE IN AMERICA (1974); Rosenblatt, Book Comment, 44 U. CIN. L. REV. 643, 647-57 (1975).

lation for the benefit of low-income consumers. Like the Hill-Burton program, Medicaid was a response to perceived failures in the economic and political "market" of health care delivery: the economic inability of poor persons to purchase quality health services and the political inability of state and local governments to establish rational, comprehensive medical assistance programs. In enacting the Medicaid statute, Congress sought to provide adequate health care for the poor and, more ambitiously, to end the traditional segregation of poor patients in understaffed, fragmented, and generally inferior institutions. Following the administrative pattern developed in the Hill-Burton and other federal-state social welfare programs, Medicaid was to remedy these problems by providing federal matching grants to state agencies conditioned on important reforms in the financing and practice of health care for the poor.

A. *Congressional Intent and Judicial Response: Health Care as a Substantive and Procedural Entitlement*

Prior to 1965, governmental health care programs for the poor were primarily a local function, often linked conceptually and organizationally to cash welfare assistance. State statutes typically authorized, but did not require, counties and municipalities to spend a portion of their tax revenues on health care for the poor, either by constructing and operating public hospitals or by purchasing care in the private sector.[193] Decisions about who to make eligible, what services to provide, and how much to pay for them were generally discretionary with each locality, and the outcomes were determined not by assessment of the medical needs of the poor, but rather by consideration of the limitations in the local welfare budget and of prevailing concepts of appropriate care for deserving indigent patients.[194]

The result of such government programs and of practices in the private market was a health care system explicitly stratified along the lines of social and economic class. The larger cities often had (and continue to have) two separate sets of health care institutions: public hospitals and clinics for the poor, and private, nonprofit hospitals (with associated private physician practices) for those who could

193. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1445 (West 1970); N.J. STAT. ANN. §§ 44:5-1 to -18 (West 1940 & Supp. 1978). *But cf.* MASS. ANN. LAWS ch. 117, § 24A (Michie/Law. Co-op 1965) (amended 1969) (town boards liable for the necessary medical expenses of indigents until 1969, after which Commonwealth became directly liable).

194. *See, e.g.*, Higdon v. Boning, 121 N.J. Super. 276, 296 A.2d 569 (Juv. & Dom. Rel. Ct. 1972) (court overrules township welfare director's determination that needed physical therapy is too "sophisticated" for coverage by local welfare program).

afford to pay.[195] Even if a private hospital admitted poor patients, as many did, there were sharp distinctions made within the institution, with poor patients in the ward, middle-income patients in semi-private rooms, and elite patients in private accommodations. Whether the tracking took place among or within institutions, the consequences were similar: underfunded, fragmented, crisis-oriented care for the poor—often organized around the educational needs of the medical profession—compared with, at least in theory, comprehensive, patient-centered care for the middle and upper classes.[196]

The original goal of the Medicaid program was nothing less than the eventual elimination of inferior, dual track health care for the poor and the incorporation of the poor into mainstream or middle-class patterns of hospital and medical service.[197] The program's general strategy was to provide poor persons with the equivalent of a voucher or credit card enabling them to leave the traditional charity wards and clinics and to purchase high quality services in the private health care market. The precise terms of these health care benefits were to be set by state Medicaid agencies operating under two related types of federal standards: substantive provisions defining the scope of eligibility and services and procedural provisions establishing how the states were to exercise their policy discretion.

The administrative centerpiece of this complex reform effort was the statutory requirement that each participating state establish a uniform, state-wide medical assistance program embodied in a federally approved "state plan." Unlike prior medical assistance programs, the basic elements of the state plan were mandated by federal law, and its optional features were regulated by federal standards. For example,

195. *See* Rosenblatt, *supra* note 192, at 644-45; E. Sparer, Class Medicine, Part II (forthcoming book 1978); *cf.* Rev. Rul. 69-545, 1969-2 C.B. 117 (tax-exempt status of hospital upheld, even though no indigent patients served).

196. *See, e.g.*, Greater Washington D.C. Area Council of Senior Citizens v. District of Columbia Government, No. 275-71 (D.D.C. Sept. 11, 1975) (public hospital, serving indigents, "fell far short of recognized and acceptable standards in this community"); Meyer v. Massachusetts Eye & Ear Infirmary, 330 F. Supp. 1328, 1330 (D. Mass. 1971) (physician-plaintiff alleges that "[i]n contrast to the quality personalized attention afforded private patients," "clinic" patients receive inferior treatment and are exposed to greater risks for experimental and educational purposes without their informed consent).

197. Congressional concern that the state programs should provide comprehensive, high-quality benefits was embodied most prominently in § 1903(e) of the original federal statute, which required the states to broaden available services and eligibility under their plans so as to provide by 1975 "comprehensive care and services to substantially all individuals who meet the plan's eligibility standards." Medicaid Act, *supra* note 1, § 1903(e), 42 U.S.C. § 1396b(e) (1970) (repealed 1972). HEW interpreted this and other provisions of the Act to mean that "the medical and remedial care and services made available to recipients . . . [should] be of high quality and in no way inferior to that enjoyed by the rest of the population." HEW, Handbook of Public Assistance Adm'n, Supplement D, Medical Assistance Program § 5140 [hereinafter cited as Supplement D].

the state plans were required to include five basic services (inpatient hospital, outpatient hospital, laboratory and x-ray, skilled nursing home care, and physicians' services) and could, at the state's option, include a wide range of additional services (*e.g.*, drugs, dental services, eyeglasses, and hearing aids).[198] The states still had some discretion to set physician fees in the light of limited funds, but reimbursement had to be at least high enough "to enlist participation of a sufficient number of providers in the program so that eligible persons can receive the medical care and services included in the plan at least to the extent these are available to the general population."[199] Similarly, although the states had some discretion to limit the amount of service within any given category (*e.g.*, the number of physician office visits, hospital days, etc.), HEW regulations required that all services included in the state plan be "sufficient in amount, duration and scope to reasonably achieve their purpose."[200] The states' discretion, in other words, had to be exercised in a manner consistent with the substantive goals of the program, described by HEW in terms of Congress's "very clear . . . intent that the medical and remedial care and services made available to recipients under Title XIX be of high quality and in no way inferior to that enjoyed by the rest of the population."[201]

To achieve this ambitious goal, the Medicaid statute relied on open-ended federal matching funds and on two legal devices: administrative enforcement and individual entitlement. Administrative enforcement was to be achieved by federal agency review of state plans and operations, with a possible sanction of withdrawal of federal funds following notice, a hearing, and an HEW finding of state noncompliance with federal law.[202] Individual recipients were given some degree of entitlement to program benefits through requirements that the state agencies provide program benefits "with reasonable prompt-

198. 42 U.S.C. §§ 1396a(a)(13)(B), 1396d(a) (1970 & Supp. V 1975).

199. Supplement D, *supra* note 197, at § D-5320.

200. 42 C.F.R. § 449.10(a)(5)(i) (1977); *see* Butler, *State Limits on the Amount, Scope, and Duration of Services under Medicaid*, 11 CLEARINGHOUSE REV. 456 (1977) (general discussion of regulation).

201. Supplement D, *supra* note 197, at § D-5140.

202. To obtain funds, a state had to submit its state plan to the Secretary of HEW for approval. Medicaid Act, *supra* note 1, § 1901, 42 U.S.C. § 1396 (1970) (amended 1973). The Secretary was directed to approve a state plan if it met numerous substantive and administrative requirements, and maintained the level of state funding for medical assistance established in prior programs. *Id.* §§ 1902(b), (c), 42 U.S.C. §§ 1396a(b), (c) (1970). After initial federal approval, the Secretary was required to discontinue all or part of the federal funding if he found, after notice and a hearing, that the state plan no longer conformed to federal standards, or if in its administration it failed "to comply substantially" with federal law. *Id.* § 1904, 42 U.S.C. § 1396c (1970).

ness to all eligible individuals"[203] and grant a "fair hearing" to any individual whose claim for medical assistance was denied or not acted upon.[204] State agencies were also required by HEW regulation to include Medicaid recipients and other consumers (as well as providers) in the policymaking process through formation of "medical care advisory committees," which were to be given "adequate opportunity for meaningful participation in policy development and program administration."[205]

On its face, the Medicaid statute thus distinguished between two types of interests with different methods of enforcement. Federal requirements for state programs were defined as a federal governmental interest to be enforced through administrative findings and sanctions and to be subject to judicial review at the request of the state agency involved.[206] In contrast, factually accurate application of federal and state standards in individual cases was seen as a recipient interest to be enforced through administrative appeals known as "fair hearings."[207] But the statute did not clearly address a crucial intermediate issue: the extent to which state compliance with federal law is not only a federal governmental interest, but also a recipient interest to be protected by administrative due process and judicial relief.

In *Goldberg v. Kelly*[208] and *Rosado v. Wyman*,[209] the Supreme Court addressed this question in the context of Aid to Families with Dependent Children, a program with entitlement and enforcement provisions that are very similar to those of Medicaid.[210] In *Goldberg* the Court held that the federal and state statutes defining welfare eligibility created a "statutory entitlement"[211] and that, as a result, state agency procedures for terminating or reducing individual grants had to comply with the constitutional norms of procedural due process. As interpreted by the Supreme Court in *Goldberg* and implemented by HEW regulations,[212] procedural due process in this context in-

203. *Id.* § 1902(a)(8), 42 U.S.C. § 1396a(a)(8) (1970).
204. *Id.* § 1902(a)(3), 42 U.S.C. § 1396a(a)(3) (1970).
205. 42 C.F.R. § 446.10(a)(3) (1977).
206. *See* 42 U.S.C. § 1396c (1970) (Secretary's enforcement powers).
207. *Id.* § 1396a(a)(3) (1970); *cf.* Mashaw, *The Management Side of Due Process: Some Theoretical and Litigation Notes on the Assurance of Accuracy, Fairness, and Timeliness in the Adjudication of Social Welfare Claims*, 59 CORNELL L. REV. 772 (1974) (argument that fairness in social welfare adjudications requires not only hearings, but better management); Project, *Procedural Due Process and the Welfare Recipient: A Statistical Study of AFDC Fair Hearings in Wisconsin*, 1978 WIS. L. REV. 145 (empirical study questioning effectiveness of adjudicatory hearings as presently conducted in welfare context).
208. 397 U.S. 254 (1970).
209. 397 U.S. 397 (1970).
210. *See* 42 U.S.C. §§ 601, 602(a) (1970 & Supp. V 1975); note 202 *supra*.
211. 397 U.S. at 262.
212. 45 C.F.R. § 205.10 (1977).

cludes a right to prior notice of agency action to terminate or reduce benefits, and to a hearing prior to agency action in which to present evidence and argument, to cross-examine adverse witnesses, and to receive a decision based on the evidence and applicable law.

In *Rosado v. Wyman,* the Court took the concept of statutory entitlement one step further, and held that recipients had an affirmative federal cause of action to enforce the federal statute against noncomplying state legislation and policy.[213] The Court rejected the view that federal statutory standards were simply commands to federal and state agencies, and held that since HEW had failed to provide recipients with any remedial process for challenging either state or federal agency decisions,[214] exhaustion of (nonexistent) administrative remedies was not required and administrative sanctions could be supplemented with direct judicial relief.[215] In two later cases, federal district courts applied *Rosado*'s reasoning to the Medicaid program and enjoined the state of New York from reducing its medical benefits without complying with federal statutory standards.[216]

What neither *Goldberg, Rosado,* nor the subsequent Medicaid cases made clear, however, was whether the federal standards meant that the state agencies had to follow any procedural requirements when engaged in policymaking, as distinguished from adjudication. Under the APA, affected individuals and organizations have the right to participate in *federal* agency policymaking prior to final decisions in a variety of specific ways.[217] Does the concept of entitlement mean that recipients also have a right to participate in the *state* policymaking process prior to final decision in addition to the right granted in *Rosado* to challenge the state's decision after the fact in federal court? As long as the federal Medicaid statute tightly constrained state discretion, the right to federal court action against noncomplying state policy was at least roughly sufficient protection for recipient interests. But as Congress granted the states greater leeway in the late 1960s and early 1970s the question of what procedures, if any, the states must follow in exercising their discretion—particularly, how much opportunity they must give recipients to participate in their decisionmaking and to comment on proposed action—became important to the future

213. 397 U.S. at 405-06, 420-23.

214. *Id.* at 406; *cf.* National Welfare Rights Organization v. Finch, 429 F.2d 725 (D.C. Cir. 1970) (ordering HEW to permit welfare recipients to participate in federal review of state agency compliance with federal law).

215. 397 U.S. at 405-06 & n.8.

216. *See* Bass v. Richardson, 338 F. Supp. 478 (S.D.N.Y. 1971); Bass v. Rockefeller, 331 F. Supp. 945 (S.D.N.Y. 1971).

217. *See* note 370 *infra.*

of the Medicaid program. Since the APA requirements of public participation in rulemaking do not apply to the state agencies, the answers had to be derived either from constitutional sources or from the Medicaid statute itself.[218]

B. *Congress's Revised Intent: Cost Control and State Agency Decisionmaking*

In the Social Security Amendments of 1972,[219] Congress significantly modified its earlier goal of improving health care for the poor and focused instead on ways of limiting federal and state expenditures. Reliance was placed primarily on two devices: "utilization review"—*i.e.*, programs to review physicians' decisions to treat patients in hospitals and nursing homes[220]—and expanded state discretion to eliminate covered services, to impose cost-sharing charges on recipients, and to reduce provider reimbursement.[221]

The shift in Medicaid's main goal from expansion to retrenchment has roots in the program's two major structural features: significant state and local financing and reliance on the private health care market. Regressive property and sales taxes created pressures in most states to keep eligibility levels low and provided a potent political base for

218. State administrative procedure acts may also provide recipients with a right to notice of and participation in state agency rulemaking. In many states, however, such rights are not accorded to Medicaid and welfare recipients either as a matter of law or practice. Ashman, *Representation for the Poor in State Rulemaking*, 24 VAND. L. REV. 1, 21-23, 24-27 (1970); *see* Gray Panthers v. Yeldell, No. 3017-76 (D.C. Apr. 22, 1976), *reprinted in* 10 CLEARINGHOUSE REV. 137 (1976) (challenging Medicaid program reductions on grounds of failure of local agency to comply with District of Columbia Administrative Procedure Act).

219. Pub. L. No. 92-603, 86 Stat. 1329 (1972).

220. *See* Price, Katz & Provence, *An Advocate's Guide to Utilization Review*, 11 CLEARINGHOUSE REV. 307, 308 n.6 (1977) (discussing provisions of 1972 Amendments concerning utilization review). Such programs have become enormously complex. Although the thrust of the 1972 Amendments was to require hospitals and physicians' organizations under contract to HEW (known as Professional Standards Review Organizations (PSROs)) to assess the necessity of hospital or nursing home care prior to, or concurrently with, its delivery, state Medicaid agencies and fiscal intermediaries such as Blue Cross continue to deny payment retrospectively (*i.e.*, after services have been rendered) on the ground that the care or type of institution was not "medically necessary." *Id.* at 314-15; *see* S. LAW, *supra* note 2, at 115-44; Havighurst & Blumstein, *Coping with Quality/Cost Trade-Offs in Medical Care. The Role of PSROs*, 70 NW. U.L. REV. 6, 58-60 (1975).

221. *See* Social Security Amendments of 1972, Pub. L. No. 92-603, § 208(a), 86 Stat. 1329, 1381 (1972) (codified at 42 U.S.C. § 1396a(a)(14) (Supp. V 1975)) (authorizing the states to impose nominal cost-sharing charges on recipients); *id.* § 230 (codified at 42 U.S.C. § 1396b(e) (Supp. V 1975)) (repealing § 1903(e)) (states no longer required to broaden scope of services and eligibility); *id.* § 231 (codified at 42 U.S.C. § 1396a(d) (Supp. V 1975)) (repealing § 1902(d), which had required states to obtain HEW ruling that they had implemented utilization review program as defined by federal standards before being permitted to reduce scope of services under their plans).

periodic campaigns against the program's escalating costs.[222] Reliance on the private sector for delivery of services, however, insured that these costs would be high; between 1967 and 1971, for example, physicians' fees rose 6.7% annually, 50% ahead of the general consumer price index, while hospitals' "reasonable costs" rose 13.5% annually, 200% ahead of the index.[223] Cost inflation and the rising numbers of recipients caused Medicaid expenditures nearly to double from fiscal years 1968 to 1971.[224]

The concern of the federal and state legislatures with rising costs was compounded by the administrative incapacity of the state agencies and of HEW itself. The report of HEW's own prestigious Task Force on Medicaid and Related Programs, issued in June 1970, sharply pointed out the weaknesses of the federal Medicaid agency: understaffing, a posture of "passive monitoring" of the state programs, and a general failure to use Medicaid's purchasing power to expand access, control costs, or improve the quality of health care for the poor.[225] The consequences of these failures were serious. In 1969, after three years of Medicaid, New York City's Piel Commission found conditions in the city's hospitals and clinics still to be "deplorable" and part of a "double standard of medical care: a reasonably adequate standard for the well-off and a desperately inadequate standard for the poor."[226]

In these circumstances, the loudly voiced concern of the federal and state legislatures for "cost control" is highly ambivalent. On the one hand, many legislators are simply interested in holding down government expenditures by the quickest and politically easiest means—*i.e.*, reducing the number of eligible persons and the scope of services provided under the program.[227] On the other hand, many other legislators are aware that the program's high costs are caused primarily by waste, inefficiency, and inflation, and that health care providers are overwhelmingly responsible for these problems.[228] From this per-

222. *See, e.g.*, R. STEVENS & R. STEVENS, *supra* note 192, at 111-12, 124 n.38.

223. On inflation rates, see C. SCHULTZE, E. FRIED, A. RIVLIN & N. TEETERS, SETTING NATIONAL PRIORITIES: THE 1973 BUDGET 227 (1972). On rising Medicaid expenditures, see R. STEVENS & R. STEVENS, *supra* note 192, at 183-94, 261.

224. *See* MEDICAID DATA, *supra* note 161, at 26, 29 (excluding administrative costs, increase in combined federal-state expenditures was from $3.2 billion in 1968 to $6.35 billion in 1971, during which period recipients increased from 12 million to 17.9 million persons). By 1976, program expenditures totaled $13.9 billion for 23.8 million recipients. *Id.*

225. HEW, REPORT OF THE TASK FORCE ON MEDICAID AND RELATED PROGRAMS 63-64 (1970) [hereinafter cited as TASK FORCE REPORT].

226. REPORT AND STAFF STUDIES OF THE COMMISSION ON THE DELIVERY OF PERSONAL HEALTH SERVICES, COMMUNITY HEALTH SERVICES FOR NEW YORK CITY 19 (1969).

227. *See* R. STEVENS & R. STEVENS, *supra* note 192, at 115, 213 (discussing examples).

228. *Id.* at 214.

spective, the appropriate method of cost control is not to reduce benefits to the poor, but rather to seek to use Medicaid's purchasing and regulatory power to reform the health care delivery system.[229] The ambivalent mood was reflected in the Senate Finance Committee's report on the 1972 amendments giving the states greater discretion to reduce program benefits. The Finance Committee stated that it

> does not expect that [this amendment] will result in large-scale cut-backs in benefits under the medicaid program, but it does believe that [it] will provide States with greater flexibility to design their programs to meet effectively the needs of their people for medical care within the fiscal constraints faced by given States from time-to-time.[230]

In theory, at least, Congress was still committed to a preference for cost control through improved efficiency in health care delivery, and the requirement that the states provide mandatory and optional services in sufficient amount, duration, and scope reasonably to achieve their purpose remained in force. Political pressures in the states for fast savings, however, resulted in a widespread policy of cost control through program reductions.[231] As the states began to cut back Medicaid benefits in the mid-1970s, low-income consumers sought judicial relief against alleged arbitrariness of agency procedures and asserted their right to participate in state Medicaid decisionmaking. In making these claims, consumers argued that their "right" to have state actions conform to federal law extends not only to the substance of state policy, but to the policymaking process as well.

C. *The Application of Structural Due Process to Medicaid Policy: The 1975-1976 Cutbacks*

The limits of the states' new discretion were tested in 1975 and 1976, when twenty-three states undertook reductions in their Medicaid programs.[232] Despite the Senate Finance Committee's professed expectations, these cutbacks were on a large scale and had severe consequences for low-income consumers. Connecticut, for example, sought to save

229. The clearest official expression of this view appeared in TASK FORCE REPORT, *supra* note 225, at 2-4, 26-52.

230. S. REP. No. 1230, 92d Cong., 2d Sess. 245 (1972) (discussing repeal of Medicaid Act § 1902(d)). In a similar vein, Senator Long, chairman of the Finance Committee, defended the amendment on the grounds that it would allow states to reduce their program expenditures when, "by good administration and careful review of patient care, . . . they can give better care at less cost." 118 CONG. REC. 33,899 (1972).

231. *See* MEDICAID DATA, *supra* note 161, at 14-18.

232. *See id.*

$2.3 million by a ten-percent across-the-board reduction in fees to most health care providers, the elimination of all adult dental care except in emergencies, and the elimination of adult benefits for eyeglasses, podiatry, and private duty nursing.[233] Ohio went even further, seeking to eliminate all nonprescription drugs and therapeutic tranquilizers such as Valium, most medical supplies, all transportation except emergency ambulance services, and a wide range of other benefits including dental, optometric, psychological, and physical therapy services.[234]

The Ohio cutbacks were challenged in federal court in *Benton v. Rhodes*,[235] which presented a typical clash of views between Medicaid recipients and the state agency. The Ohio Medicaid recipients challenged the announced reductions on numerous grounds: the inadequacy of the state's notice to recipients, the failure to provide an opportunity for hearings prior to implementation of the reductions, the failure to consult with the Medical Care Advisory Committee, the elimination of arguably mandatory services, and the restriction of optimal and mandatory services to levels insufficient in amount, duration, and scope reasonably to achieve their purposes. The state agency took issue with all of these contentions, and argued in particular that its notice had been adequate, that the Medical Care Advisory Committee had been consulted, and that no hearings were mandated by federal law.

Faced with the recipients' claim for individualized trial-type hearings prior to state program changes, and the state's argument that no hearing was required either before or after such changes, the district court in *Benton*, and federal district courts in similar cases brought in other states naturally looked to the HEW notice and hearing regulations to resolve the issue. As to notice, the federal regulations clearly require the state agencies to provide advance individual notice to all Medicaid recipients regarding program changes.[236] The rationale for individual notice about program changes is partly to convey necessary information to recipients about the scope of their medical cov-

233. *See* Robinson v. Maher, [1976-1977 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 27,707, at 9051-52 (D. Conn. Jan. 19, 1976).

234. *See* Benton v. Rhodes, [1976-1977 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 28,025 (S.D. Ohio May 11, 1976), *rev'd*, No. 76-2177 (6th Cir. Aug. 10, 1978). The consequences of these reductions were alleged to be serious by recipients who challenged them: without Valium, for example, patients with spinal cord injuries would be unable to control muscle spasms that, according to a specialist physician "could be violent enough to throw a person out of a chair." Brief of Plaintiff-Appellees at 2, Benton v. Rhodes, No. 76-2177 (6th Cir. Aug. 10, 1978).

235. [1976-1977 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 28,025 (S.D. Ohio May 11, 1976), *rev'd*, No. 76-2177 (6th Cir. Aug. 10, 1978).

236. 45 C.F.R. § 205.10(a)(3)-(5) (1977).

erage and to give recipients who are relying on existing benefits at least some opportunity "to plan for the cut, and to the extent possible adjust to it."[237] But the notice requirement is also designed to inform recipients about the opportunity for a hearing, and the question of whether pre-reduction hearings should extend to issues of policy as well as to disputes about individual circumstances has been difficult and controversial.

The applicable HEW regulations are not, as one court put it, "examples of clarity."[238] The pertinent regulations contain a general rule that a hearing shall be granted "to any recipient who is aggrieved by any agency action resulting in . . . reduction . . . or termination of assistance." "A hearing need not be granted," however, "when either State or Federal law require [*sic*] automatic grant adjustments for classes of recipients unless the reason for an individual appeal is incorrect grant computation."[239] The regulations also state that agencies may consolidate individual hearing requests into a group hearing "only [in] cases in which the sole issue involved is one of State or Federal law or policy or changes in State or Federal law."[240] This provision supports an argument that recipients are entitled at least to a "group hearing" even when individual circumstances are not at issue, and that hearings may only be denied for a limited subclass of changes in state or federal law that can be characterized as "automatic grant adjustments."[241] The issues are further complicated by the regulation's focus on "grant computation," which by its terms applies only to cash assistance programs,[242] and by confusing statements in the preface to the regulation about whether or not hearings need to be held concerning policy changes.[243]

Despite the lack of clarity in the HEW regulations, the federal district court in *Benton* concluded that Ohio's cutbacks violated them in several ways. The court found that Ohio's notice had been deficient because it had failed to inform affected recipients of an opportunity for a hearing in which to show "that the facts of [the recipient's] case

237. Rochester v. Baganz, 479 F.2d 603, 606 (3d Cir. 1973).

238. Jennings v. Solomon, [1976-1977 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 28,105, at 10,397 (D. Md. Nov. 4, 1976).

239. 45 C.F.R. § 205.10(a)(5) (1977).

240. *Id.* § 205.10(a)(5)(iv).

241. *See* Budnicki v. Beal, 450 F. Supp. 546, 553-54 & n.3 (E.D. Pa. 1978).

242. *See* 45 C.F.R. § 205.10(a)(5) (1977), *discussed in* Jennings v. Solomon, [1976-1977 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 28,105, at 10,396 (D. Md. Nov. 4, 1976).

243. *See* Jennings v. Solomon, [1976-1977 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 28,105, at 10,396-97 (D. Md. Nov. 4, 1976) (describing regulations and comments of HEW, on issue, *see* 38 Fed. Reg. 22,005 (1973), as "not examples of clarity").

are not caught by the proposed changes" in the state program,[244] and that the state's Medical Care Advisory Committee "was not adequately and timely informed by the Department concerning the proposed policy changes, nor given adequate input into the policy-making process."[245] As to hearings, the court held in effect that the issuance of a state rule reducing Medicaid benefits was nearly simultaneous with "application" of the rule to individuals receiving ongoing treatment, since providers would probably respond to the reduction by terminating services or by demanding payment for them. In this context, individuals had a *Goldberg* right to prior notice and a hearing, not on the validity or wisdom of the rule itself, but on its application to their individual circumstances.[246] Since the state agency had not provided notice of or opportunity for such a prior hearing, the court enjoined any Medicaid reductions until adequate notice had been given and until the Medical Care Advisory Committee had been given an "adequate opportunity for meaningful participation in the reduction decision."[247]

The district court's ruling in *Benton* was a response to three types of recipient claims raised in the case that are typical of challenges to state program reductions. Some recipients argue that a reduction does not in its own terms apply to their individual circumstances. For example, a recipient might present factual evidence to show that a needed medical device is a "brace," and therefore covered under the state program, rather than an "orthopedic shoe" no longer included as a Medicaid benefit.[248] Other recipients argue that although the new regulation in terms applies to them, it cannot *validly* be so applied because of their legal status or other legally relevant facts based on their individual circumstances. Thus a child might contend that she is eligible for dental services not provided to adults because the federal Medicaid Early and Periodic Screening, Diagnosis and Treatment program makes such services mandatory for her.[249] Finally, many recipients

244. Benton v. Rhodes, [1976-1977 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 28,025, at 10,142 (S.D. Ohio May 11, 1976), *rev'd*, No. 76-2177 (6th Cir. Aug. 10, 1978).

245. *Id.* at 10,143.

246. Although the plaintiffs argued that the HEW regulations required prior hearings on policy issues, *see* Motion for Preliminary Injunction at 10, Benton v. Rhodes, [1976-1977 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 28,025 (S.D. Ohio May 11, 1976), the district court ruled that such hearings were only needed for the application of policy to individual circumstances, Benton v. Rhodes, [1976-1977 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 28,025; at 10,142 (S.D. Ohio May 11, 1976), *rev'd*, No. 76-2177 (6th Cir. Aug. 10, 1978).

247. *Id.* at 10,144; *accord*, Budnicki v. Beal, 450 F. Supp. 546, 558 (E.D. Pa. 1978) (as to notice requirement); Becker v. Toia, 439 F. Supp. 324, 329-33 (S.D.N.Y. 1977) (as to notice and advisory committee requirements).

248. *See* Budnicki v. Beal, 450 F. Supp. 546, 553-54 (E.D. Pa. 1978).

249. *See* 42 C.F.R. § 441.52(b)(2) (1977).

argue that the new regulation cannot be validly enforced with respect to anyone under governing federal standards, or that it should not be adopted as a matter of policy. For example, Medicaid recipients in Pennsylvania sought to show that widespread fraud and abuse in the provision of orthopedic shoes could be remedied by less drastic means than complete elimination of the covered service.[250] In *Benton*, the district court held that the first two types of claims constituted adjudication subject to prior individual notice and hearing and that the third involved the state rulemaking process governed by the requirement that the state agencies consult with recipients and providers on the Medical Care Advisory Committee.

In *Benton* and other federal cases, recipients' need for immediate relief to forestall impending program reduction led litigants to focus their claims around the two federal requirements of hearing and consultation. Since most state agencies had omitted any mention of hearings from their notices and had failed to consult with their advisory committees, either defect (or both) often resulted in a preliminary injunction halting the announced reductions.[251] Judicially imposed delay in turn encouraged more careful consideration of state policy. Budget figures showing the existence of a fiscal "crisis," for example, sometimes turned out on close examination to be substantially erroneous or to be the result of cash flow problems that could be remedied without service reductions. Expanded participation by Medical Care Advisory Committees sometimes led to innovative suggestions on how to reduce program costs or increase revenues without cutbacks in needed services.[252] Even when program reductions were considered necessary, judicial intervention tended to raise the political visibility of the recipients' claims and so increase the incentive for state agencies and legislatures to take the interests of recipients into account.

Although the district court decisions in Ohio and other states granted recipients immediate relief from program cutbacks, their reliance on the federal hearing and advisory committee regulations left them vulnerable to later attack. As discussed above, HEW's position on when state agencies had to provide notice of and opportunity for a pre-reduction hearing for class-wide changes was anything but clear. The district courts' efforts to make sense of the tortured HEW language resulted in decisions that required hearings on individual

250. Budnicki v. Beal, 450 F. Supp. 546, 556 (E.D. Pa. 1978).

251. *See, e.g.*, note 247 *supra* (citing cases); Robinson v. Maher, [1976-1977 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 27,707, at 9053 (D. Conn. Jan. 19, 1976).

252. *See* Robinson v. Maher, [1976-1977 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 27,707, at 9053 (D. Conn. Jan. 19, 1976).

circumstances of fact and law in the context of state rulemaking. The decisions were thus vulnerable to reversal on the basis of the general due process doctrine that prior hearings are not required when governmental agencies act in a "legislative" or policymaking capacity.[253] Similarly, the advisory committee regulation, though cast in mandatory language, rested on such general phrases as "adequate opportunity for meaningful participation."[254] The absence of an articulated theory of recipient participation in state agency decisionmaking created the danger that the district courts' decisions would be dismissed as simply a "misreading" of HEW and congressional intent.

That danger materialized in the Sixth Circuit's decision reversing the district court's injunction in *Benton*.[255] In an opinion remarkable for its summary disposition of the issues and tone of overt hostility to the poor, the appellate court held that "matters of law and policy are not subject to any hearing requirements under the applicable regulations, whether the hearing be pre- or post-reduction."[256] On the issue of consultation with the Medical Care Advisory Committee, the appellate court simply reversed the district court's factual finding and, without discussion of the considerable evidence to the contrary, declared that the committee "was sufficiently apprised of the problems."[257] Finally, the Sixth Circuit did not even address the state's inaccurate description and omission of many of the proposed changes in the notice to Medicaid recipients.[258]

The Sixth Circuit reserved its strongest language for criticism of the district court's requirement of hearings for individual circumstances in the context of state policy changes. "It does seem rather ridiculous that a person, who has not even filed a claim, could object to the reduction of optional benefits because of the possibility that he might

253. *See* Bi-Metallic Inv. Co. v. State Bd. of Equalization, 239 U.S. 441, 444-45 (1915), *discussed at* pp. 300-01 *infra*.

254. *See* 42 C.F.R. § 446.10(a)(3) (1977).

255. No. 76-2177 (6th Cir. Aug. 10, 1978) (reversing, after more than two years, the district court opinion at [1976-1977 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 28,025 (S.D. Ohio May 11, 1976)).

256. *Id.*, slip op. at 5.

257. *Id.*, slip op. at 6. *But see* Brief of Plaintiff-Appellees at 32-33 (Medical Care Advisory Committee first convened to consider proposed cuts four days after notice of change mailed to recipients; Committee only given one-page summary of Medicaid budget, and requests for more information and time to review cutbacks denied).

258. For example, no mention was made of the reduction in the number of allowed physician visits, the possibility of obtaining prior authorization for eliminated services if medically necessary, and the numerous exceptions to the reductions for children that were required by federal law. *See* Brief of Plaintiff-Appellees at 12, Benton v. Rhodes, No. 76-2177 (6th Cir. Aug. 10, 1978). Some of the inaccuracies were noted in the concurring opinion. *See* Benton v. Rhodes, No. 76-2177, slip op. at 8-9 (6th Cir. Aug. 10, 1978) (Keith, J.).

want to have a corn removed from his toe, or might want to go to a dentist to have his teeth cleaned."[259] This is a serious misreading both of the evidence and of the district court's opinion. The injunction had been granted to prevent the state from denying important—even life-sustaining—benefits to persons who were arguably eligible for them under federal law.[260] As the district court implicitly held, for these recipients a state rule reducing benefits has both a legislative and adjudicative effect, because once the rule is enacted, providers begin to terminate benefits automatically. The Sixth Circuit's decision may have effectively denied these recipients their right under *Goldberg* to a prior hearing regarding individual circumstances. A fortiori, the court seemed to hold in its very brief opinion, recipients have no right to present evidence or argument to the agency regarding the necessity of the cutbacks or the possibility of less harmful ways to accomplish legitimate cost-control objectives.

Although the Sixth Circuit failed to support its position with any analysis of legal doctrine or of the Medicaid program, such support can indeed be found. The argument rests on the analogy of agency rulemaking to the legislative process: since the state legislature itself could enact a rule depriving persons of important Medicaid benefits without any notice or opportunity to be heard, the state Medicaid agencies, with authority delegated by the legislature, should have comparable procedural latitude.[261] The usual authority cited is Justice Holmes's opinion in *Bi-Metallic Investment Co. v. State Board of Equalization*,[262] which is said to stand for the proposition that "no hearing at all [is] constitutionally required" prior to agency action "promulgating policy-type rules or standards."[263] In addition to the analogy between rulemaking and legislation, it is generally argued that it is impractical to hold hearings for the large numbers of persons affected by a general rule and that the type of decision involved in making general policy is not illuminated by the testimony regarding particular facts that is characteristic of a hearing.[264]

Bi-Metallic's distinction between rulemaking and adjudication as a matter of constitutional doctrine remains good law, and no coun-

259. *Id.*, slip op. at 6.

260. Benton v. Rhodes, [1976-1977 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 28,025, at 10,142-43 (S.D. Ohio May 11, 1976), *rev'd*, No. 76-2177 (6th Cir. Aug. 10, 1978).

261. *See* Note, *The Judicial Role in Defining Procedural Requirements for Agency Rulemaking*, 87 HARV. L. REV. 782, 787 (1974).

262. 239 U.S. 441 (1915).

263. United States v. Florida E. Coast Ry., 410 U.S. 224, 245 (1973); *see* L. TRIBE, *supra* note 39, at 514; Note, *supra* note 261, at 786-87.

264. *See* Bi-Metallic Inv. Co. v. State Bd. of Equalization, 239 U.S. 441, 445-46 (1915).

ter-doctrine has arisen to challenge it explicitly. But careful examination of how the courts have actually responded to procedural due process issues in agency action of a general character suggests that current doctrine involves a more complex analysis than simply determining whether the agency decision fits into the category of rulemaking or adjudication. In deciding whether and to what extent procedural due process protections apply, the courts have increasingly looked to the nature of the agency's mandate, the type of decisions involved in agency action, the importance of the individual interests at stake, and the contribution that some type of public participation can make to the kind of decision involved.[265] From this perspective, one can make a strong case for the proposition that rulemaking by state Medicaid agencies should be subject to the kinds of procedural requirements that have emerged in the structural due process approach to federal administrative law.

The argument is built on the fact that the federal Medicaid statute does not simply set the state Medicaid agencies at large, but rather requires them to operate the program so as to provide a reasonable range of necessary services to eligible low-income persons. Under the federal statute, the state program must include a significant number of mandatory services, ranging from hospital and physician care to preventive screening, diagnosis, and treatment for children.[266] Although in theory a state might totally eliminate an optional service like prescription drugs or dental care, in practice at least some of these services are usually provided and so must be sufficient in amount, duration, and scope reasonably to achieve their purpose.[267] States are also required to engage in extensive review of provided medical services in order to insure the appropriateness, efficiency, and quality of care.[268] To be sure, cost control is also a congressional goal, but the statute, legislative history, and HEW regulations indicate that it is to be reconciled as far as possible with the program's original goal of providing quality health care for the poor.

The state Medicaid agencies are thus in the difficult position of having to balance the health needs of the poor against budget limitations and to choose among cost-control measures ranging from program reductions to significant reform of the health care system. The

265. *See* Geneva Towers Tenants Organization v. Federated Mortgage Investors, 504 F.2d 483, 489-93 (9th Cir. 1974); Thompson v. Washington, 497 F.2d 626, 634-39 (D.C. Cir. 1973); Burr v. New Rochelle Mun. Hous. Auth., 479 F.2d 1165, 1168-69 (2d Cir. 1973).

266. 42 U.S.C. §§ 1396a(a)(13), 1396d(l)-(5) (1970 & Supp. V 1975).

267. 42 C.F.R. § 449.10(a)(5)(i) (1977).

268. *Id.* § 450.18.

Medicaid statute does not explicitly require that recipients be included in the process of making these choices, but exclusion of recipients is strikingly inconsistent with the general governmental practice of allowing persons to participate, at least in some form, in important decisions affecting their interests. The analogy between administrative and legislative rulemaking authority articulated by Justice Holmes in *Bi-Metallic* has, in a sense, been taken seriously, though with somewhat different results than he anticipated. Requirements that agencies give public notice of proposed rules, permit submission of written comments, and respond to submissions with at least a brief statement, are now seen as the appropriate administrative equivalent of the legislature's public hearings and accessible legislative process.[269]

Although most rulemaking procedures have been developed in the context of the federal APA, they have also been seen as having constitutional sources that would apply to state Medicaid decisionmaking. For example, several courts of appeals have held that tenants of public and subsidized housing have a constitutional right to receive notice of proposed rent increases and "to participate in the process of official consideration of rent increases" through written submissions.[270] The rationale is that the tenants have a legal interest in obtaining decent housing under the National Housing Act and that rent increases threaten "substantial deprivation" triggering constitutional due process protection.[271] The tenants' right to be heard is further grounded on the courts' finding that they can make a "material contribution to the process of fixing rents" by supplying information about their own ability to pay, the operating costs and sources of income of the housing project, and "innovative suggestions for compromising competing interests."[272] The District of Columbia Circuit read *Bi-Metallic* as consistent with this position; the right to notice and opportunity for comment does not depend on the number of affected persons, but rather on "whether tenants can make relevant contribution to the issues presented for decision, notwithstanding the fact that they apply to a potentially large class."[273]

The Supreme Court's recent decision in *Vermont Yankee Nuclear*

269. *See* J. Skelly Wright, *Court of Appeals Review of Federal Regulatory Agency Rulemaking*, 26 AD. L. REV. 199, 211 (1974).

270. Thompson v. Washington, 497 F.2d 626, 628 (D.C. Cir. 1973); *see* note 265 *supra* (citing cases).

271. *See* note 265 *supra* (citing cases).

272. Thompson v. Washington, 497 F.2d 626, 638-39 (D.C. Cir. 1973).

273. *Id.* at 638 n.42.

Power Corp. v. Natural Resources Defense Council, Inc.[274] does not encourage the federal courts to define state rulemaking procedures, but neither does it prohibit such a decision. On the contrary, the Court cited *Bi-Metallic* for the proposition that the Constitution does not require rulemaking procedures *in addition* to those specified in the APA, which implies that the APA notice-and-comment procedures may themselves have constitutional sources.[275] In this context, the focus of the Medicaid cutback litigation on the right to an individual hearing obscures the central issue, which concerns the fact that many state agencies are not allowing even elementary participation through rulemaking procedures.

The history of the 1975-1976 Medicaid cutbacks indicates both the need and the justification for expanding recipient participation in state agency decisionmaking. Like publicly subsidized housing tenants, Medicaid recipients have a federal statutory right to program benefits. These benefits are obviously of great importance; agency action reducing or terminating health care services threatens at least as much of a "substantial deprivation" as rent increases for low-cost housing. In the Medicaid area, moreover, the likelihood of unnecessary, illegal, and erroneous deprivation is high. The state agencies' financial interest in holding down program costs often leads to disregard of recipients' interests and even of applicable federal law, and may also encourage poor administration as a way of rationing scarce resources through error and delay. Finally, as in the housing cases, Medicaid recipients could make (and actually did make) real contributions to agency decisionmaking by pointing out exceptional cases, unresolved administrative problems, and alternative means of saving funds while minimizing reduction of health care services.[276]

Adoption of rulemaking procedures by state Medicaid agencies will not, of course, resolve by itself the serious political and financing problems of the Medicaid program. Agencies will still be subject to strong internal and external pressures to respond to the inflation and waste of the health care system by curtailing services to the poor. At its best, however, a structured process of rulemaking would expose the state agency's data and policy assumptions to public scrutiny and provide the beginnings of a participatory process in which the difficult issues of health care reform could be addressed.

274. 435 U.S. 519 (1978).
275. *Id.* at 542 n.16.
276. *See generally* Dodson v. Parham, 427 F. Supp. 97, 105-07 (N.D. Ga. 1977) (suggesting such a role); Robinson v. Maher, [1976-1977 Transfer Binder] MEDICARE-MEDICAID GUIDE (CCH) ¶ 27,707, at 9053 (D. Conn. Jan. 19, 1976).

IV. Health Planning: The Meaning of Representation

By the early 1970s, Congress was becoming painfully aware of the inadequacy of federal health policy. Despite billions of federal dollars spent under Hill-Burton and other planning programs, the Senate Committee on Labor and Public Welfare echoed in 1974 its predecessor committee of 1945:

> Widespread access and distribution problems exist with respect to medical facilities and services. In many urban areas, hospitals, clinics and other medical care institutions and services are crowded into relatively tiny sectors, while large areas go poorly served or completely unserved. Many rural communities are completely without a physician or any other type of health care service, while adjacent urban areas are oversupplied.[277]

The Committee also noted its "great concern" with the rapid escalation of health care costs,[278] linked in part to unnecessary investment in costly health care technology.[279]

As one major response to these problems,[280] Congress established in 1974 a national system of health planning with ambitious substantive goals: to expand access to primary and preventive care, especially for the poor;[281] to reduce health cost inflation and maldistribution of resources;[282] and to promote innovative forms of organized, efficient, and high quality care.[283] To achieve these goals, Congress largely sidestepped the obvious devices of regulatory standards[284] and

277. S. REP. No. 1285, *supra* note 96, at 7879.

278. *Id.* at 7895.

279. *Id.* at 7879.

280. Congress's other major responses to the problems of cost inflation and unnecessary utilization were: (1) limiting federal funding under Medicare and Medicaid for capital expenditures (*i.e.*, reimbursement for depreciation) to those health facilities that had secured approval for capital expenditures from a designated health planning agency, Social Security Act § 1122, 42 U.S.C. § 1320a-1 (Supp. V 1975), and (2) providing funds for PSROs to determine whether services are medically necessary, meet professionally recognized standards of care, and are delivered at the appropriate institutional level of care for purposes of reimbursement under Medicare and Medicaid, 42 U.S.C. § 1320c (Supp. V 1975).

281. *See* 42 U.S.C. §§ 300k-2(1), (8) (Supp. V 1975).

282. *See id.* §§ 300*l*-2(a)(2) to (4).

283. *See id.* §§ 300k-2(2) to (7), (9), 300*l*-2(a)(2).

284. The Health Planning Act itself does not contain any operational standard for health planning that specifies, *e.g.*, a maximum ratio of hospital beds to population, or the minimum number of anticipated procedures needed to justify investment in particular types of medical technology. Rather, the Act requires the Secretary of HEW to establish, within 18 months of the Act's passage on January 4, 1975, regulatory "guidelines concerning national health planning policy," *id.* § 300k-1(a), that must include "[s]tandards respecting the appropriate supply, distribution, and organization of health resources," as well as a statement of national health planning goals expressed "to the maximum extent

financial incentives,[285] and relied on an exceptionally difficult technique: the redistribution of policymaking power at the state and local levels from physicians, hospital administrators, and government officials to "consumers of health care."[286] This was to be accomplished by the establishment of local "Health Systems Agencies" (HSAs). Health care providers and government officials were expected, of course, to continue to play a very large role in defining and implementing health care policy.[287] But the theory of the National Health Planning and Resources Development Act of 1974 (Health Planning Act)[288] was that the traditional influence of health care providers would be balanced by a strengthened consumer role in selecting health care priorities and in ensuring that health facilities and services were organized to meet them.[289]

A. *Congressional Intent: Strengthening Consumer Representation in Health Care Policy*

In choosing to rely on health planning as an integral part of national health care policy, Congress was engaged in a classic effort to reform an existing but inadequate institution and thus achieve stated public goals. "Health planning" as an organized activity was created by the hospital industry during the Depression to limit the supply of hospital beds in a period of declining revenue.[290] But the efforts

practicable . . . in quantitative terms," *id.* § 300k-1(b). Local health plans (termed "health systems plans," *id.* § 300*l*-2(b)(2)) developed by the Health Systems Agencies (HSAs) must "take into account" and be "consistent with" these national health planning guidelines. *Id.* § 300k-1.

285. Title XVI of the Health Planning Act holds out the possibility of federal grants to upgrade the quality of public hospitals, to increase the number of outpatient facilities serving medically underserved populations, and to stimulate planning and development of high-priority health projects, but there is no assurance (and indeed much doubt) that any more than a fraction of the necessary funds will ever be appropriated. *See id.* §§ 300*l*-2(c)(3), 300p-1(d)(2), 300r, 300t, *discussed in* Schneider & Wing, *The National Health Planning and Resources Development Act of 1974: Implications for the Poor*, 9 CLEARINGHOUSE REV. 683, 687-89 (1976). In the absence of such appropriations, the health planning agencies can only impose negative financial sanctions by blocking federal reimbursement for capital expenditures under § 1122 of the Social Security Act, 42 U.S.C. § 1320a-1 (Supp. V 1975), *discussed in* note 280 *supra*.

286. 42 U.S.C. § 300*l*-1(b)(3)(C)(i) (Supp. V 1975).

287. Providers are to constitute 40% of the governing boards of the local HSAs, *id.* § 300*l*-1(b)(3)(C)(ii), and are to be represented on the Statewide Health Coordinating Councils and on the National Council on Health Planning and Development, *see id.* § 300m-3(b). Government officials must be included on the governing boards of the HSAs, either as consumer or provider members. *Id.* § 300*l*-1(b)(3)(C)(iii)(I); 42 C.F.R. § 122.109 (b)(3)(i) (1977).

288. Pub. L. No. 93-641, 88 Stat. 2225 (1975) (codified at 42 U.S.C. §§ 300k-300t (Supp. V 1975)).

289. *See* S. REP. No. 1285, *supra* note 96, at 7885-86.

290. B. EHRENREICH & J. EHRENREICH, *supra* note 8, at 199-200.

of the urban hospital associations' "hospital survey committees" to regulate the distribution of private philanthropy were generally unsuccessful and, in any event, made no attempt to elicit or include the viewpoints of consumers. Under the Comprehensive Health Planning and Public Health Services Amendments of 1966 (CHP),[291] Congress sought to expand and strengthen the existing voluntary system of health planning by granting federal funds to local and statewide planning agencies that established advisory "planning councils." A majority of the members of these councils had to be "representatives of consumers of health services."[292] The federal law failed, however, to define who a "consumer" was or to differentiate among types of consumer interests. Without federal standards, local agencies were free to define consumer qualifications in such terms as " 'education, leadership ability, a broad sense of civic responsibility, and experience in making decisions affecting the welfare of people and expenditure of large sums of money.' "[293] This approach yielded "an overwhelming representation" on CHP boards of "local business leaders—often hospital trustees in their spare time."[294] Congress understood that consumer "representation" of this sort had contributed to the CHP program's "marginally successful" performance[295] and attempted in the 1974 Health Planning Act to prevent provider domination of health planning by requiring the inclusion of a broader range of consumer interests.

To accomplish this, the Health Planning Act established the HSAs, a national system of local planning agencies. These agencies are generally organized as private, nonprofit corporations,[296] with professional staffs funded by HEW grants and able to implement the detailed priorities developed by the governing board of each HSA. The board, in turn, must be composed of a majority (but not more than sixty

291. Pub. L. No. 89-749, 80 Stat. 1180 (1966) (codified at 42 U.S.C. § 246 (1970 & Supp. V 1975)).

292. 42 U.S.C. §§ 246(a)(2)(B), (b)(2)(A) (1970).

293. B. EHRENREICH & J. EHRENREICH, *supra* note 8, at 211.

294. *Id.; see* O'Connor, *Comprehensive Health Planning: Dreams and Realities*, 52 MILLBANK MEMORIAL FUND Q. 391, 404 (1974) (study of CHP program shows that many consumers on CHP boards are affiliated with provision of medical care in some way and that "views of these consumers are on many issues more in sympathy with the providers on the board than with other consumers").

295. S. REP. No. 1285, *supra* note 96, at 7879.

296. Under the Act, an HSA may be either a "nonprofit private corporation," a "public regional planning body," or a "single unit of general local government." 42 U.S.C. § 300*l*-1(b)(1) (Supp. V 1975). In the latter two cases, however, the jurisdiction of the regional planning body or governmental unit must be identical to the HEW-designated "health service area" served by the HSA, and governance of the unit must be consistent with the requirements applicable to nonprofit private corporations. *Id.* §§ 300*l*-1(b)(1)(B), (1)(C), (3)(A).

percent) of "consumers of health care" who must be "broadly representative of the social, economic, linguistic and racial populations, geographic areas . . . and major purchasers of health care."[297] Although the Act does not define "consumer of health care," it does exclude from the consumer category "providers of health care," who are in turn extensively defined as virtually anyone with a professional, financial, or institutional connection with the delivery of health care services, as well as members of their immediate families.[298]

The powers of the HSAs are limited primarily to gathering information, establishing priorities for new facilities and services, and offering recommendations about the appropriateness of capital investment and the distribution of federal health funds.[299] Nevertheless, Congress clearly intended to encourage substantial consumer influence in health care policymaking to balance the "relatively disproportionate influence" of health care providers, "particularly physicians."[300] As one commentator noted, even the limited powers of the HSAs and of their state-level analogues, the Statewide Health Coordinating Councils, could, if "[a]ggressively pursued . . . begin to change the direction of the health care system."[301]

Between this potential and reality lie political and administrative barriers. The Health Planning Act gave the HSAs legal authority to establish health priorities and to influence resource allocation, but it stopped short of requiring the HSAs to use their authority against the inevitably strong opposition of hospitals and physicians.[302] On the contrary, by announcing only general goals for HSA performance and by failing to create strong financial incentives for the allocation of resources to primary care, the Act provided numerous opportunities for local health leaders to continue defining patient needs in terms of high-technology, professionally prestigious services.[303] The most important check on the continuation of the status quo was the possibility, encouraged by the consumer representation requirements,

297. *Id.* § 300*l*-1(b)(3)(C)(i).
298. *See id.* § 300n(3).
299. *See id.* § 300*l*-2.
300. S. REP. No. 1285, *supra* note 96, at 7885.
301. Sparer, *Health Systems Agencies and Consumers: Will the Congressional Intent Fail?*, HEALTH L. PROJECT LIB. BULL., Oct. 1975, at 2, 4.
302. *See* Dunham & Marmor, *Health Planning: A Comment*, 6 INT. J. HEALTH SERVS. 667 (1976).
303. A comprehensive review of state "certificate of need" programs, which operate similarly to the federal Health Planning Act, found that although the health planning process "did indeed slow the growth in hospital beds, [it] accelerated the growth in intensity per bed [*i.e.*, capital expenditures on equipment and supporting plant] so that capital cost increases (and hospital operating cost increases) remained unaffected." W. MCCLURE, REDUCING EXCESS HOSPITAL CAPACITY 65 (1976).

of a strong consumer health movement pressing for expanded access and patient-oriented forms of care. But here too the Act spoke in somewhat general terms and left crucial issues for administrative implementation.

The major responsibility imposed on HEW was to define the nature of "representation." The statute was silent about the methods by which an HSA governing board was to be selected, and the requirement of "broad representation" could thus be read narrowly to regulate only the descriptive outcome of whatever selection process the founders of an HSA chose to adopt. Under this "descriptive" model, consumer governing board members would represent their constituencies by *resembling* them in some characteristic considered relevant by the statute—race, linguistic group, geographic area, or unspecified "social" and "economic" characteristics—and would together form a kind of cross-sectional "jury" for the purposes of health planning.[304]

The legislative history of the Act, however, recognized that such descriptive representation was inadequate for the complex and somewhat adversarial task of health planning. The goal of the Act was not simply "consumer representation," but representation for the purpose of achieving a difficult substantive goal: the injection of new values and perspectives into health policy and the balancing of well-articulated provider interests with the interests and needs of various types of consumers.[305] The congressional committee report reflected this substantive concern in its reference to what might be termed a "constituency" model of representation.[306] Under this model consumer board members would be selected by, and hence accountable to, "organizations representing the interests of consumers."[307] The House Interstate and Foreign Commerce Committee indicated that HEW should develop an approach along these lines:

304. *See generally* H. PITKIN, THE CONCEPT OF REPRESENTATION (1967) (discussing representation in its "descriptive" sense, and relationship of this sense to other concepts of representation).

305. *See* 42 U.S.C. § 300k(a)(2) (Supp. V 1975) (congressional findings) ("The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources."); H.R. REP. No. 1382, 93d Cong., 2d Sess. 32-35 (1974) (examining strengths and weaknesses of existing health planning efforts and cataloguing need for new values and perspectives); S. REP. No. 1285, *supra* note 96, at 7879-81, 7885 (detailing numerous criticisms of existing health care delivery and stressing need to limit appropriately influence of providers on health planning process).

306. *See* S. REP. No. 1285, *supra* note 96, at 7885.

307. *Id.*

> [I]t is particularly important that [the HSA governing boards] adequately and equitably represent the area's population and health care providers. Thus, it is intended by the Committee that in the regulations for the program, the Department [of HEW] take particular care to assure that the governing bodies [of the HSAs] are *chosen and composed* so as to assure that they are not dominated by any particular part of the area's health industry, that they adequately represent all of the area's population, and that they experience an appropriate turnover in their membership. This can be partially accomplished by requiring the health systems agencies to limit the number of terms which any member . . . may serve, or by requiring them to accept nominations for membership from a wide array of consumer and provider organizations within the area.[308]

The House Report thus envisioned a much broader role for HEW than simply counting the descriptive characteristics (*e.g.*, race and income) of governing board members in order to determine compliance with federal law, and hence eligibility for federal funding. Rather, HEW was also to regulate the methods by which board members were chosen in order to ensure that a descriptively representative board would in fact "adequately and equitably represent the area's population."[309] This is, to be sure, a difficult and controversial task. The consumer health movement is in its infancy, and there is much legitimate debate over which consumer interests deserve representation and over who can appropriately represent them.[310] But even granted the difficulty of the challenge, HEW did not make an adequate effort to meet it. The Department rested on its classic nonenforcement device of failing to develop any operational policy of consumer representation and thereby refusing to intervene in the local political processes out of which the HSA boards emerged. The result was that, without adequate guidance from Washington and despite consumer objections, regional HEW officials granted millions of dollars to organizations the governing boards of which were grossly unrepresentative in descriptive terms[311] and the members of which had been chosen by methods that involved violations of the text and spirit of the Act.[312]

308. H.R. REP. No. 1382, *supra* note 305, at 57 (emphasis supplied).

309. *Id.*

310. *See, e.g.*, Aldamuy v. Pirro, 436 F. Supp. 1005 (N.D.N.Y. 1977), *discussed at* pp. 314-17 *infra* (challenge by minority persons concerned with representativeness of minority members of HSA governing board).

311. *See* note 324 *infra.*

312. For example, HEW's Regional Office in Atlanta funded the Atlanta-based North Central Georgia HSA despite allegations that "of the 37 consumers on the original board, 2 were nominated by the State Nurses Association, one by the District Pharmacy Associa-

The consumers who tended to be underrepresented on, or excluded from, the HSA boards were, as one might expect, from the politically weakest groups: the poor, minorities, women, and the aged.[313] As in the Hill-Burton cases, these consumers argued in the courts that the Act required a different outcome, *i.e.*, greater representation of politically weak consumer interests on the HSA boards. Although consumers, and particularly low-income and minority consumers, were among the chief intended beneficiaries of the Act, the lack of statutory specification made it difficult for the courts to conceive of particular outcomes to enforce. As happened in *Perry v. Greater Southeast Community Hospital Foundation*,[314] the courts simultaneously affirmed that consumers had a "legal interest" in representation on the HSA boards and upheld agency and HSA decisions that appeared to give that interest little if any weight. The way out of this dilemma was not articulated by the courts, but has begun to emerge from agency responses to litigation pressure: consumers have a right, not to a specific representational outcome, but to a process of board selection that takes statutory interests into account and produces membership outcomes that can be justified in terms of the Act's substantive and structural goals.

B. *HEW's Original Interpretation of the Representation Provision*

The enactment of the Health Planning Act required HEW to develop implementing regulations within specified time limits, and in October 1975 the Secretary issued proposed regulations soliciting ap-

tion, 6 by local hospitals, and 24 by local medical societies." *Health Planning Amendments of 1978: Hearings on S. 2410 Before the Subcomm. on Health and Scientific Research of the Senate Comm. on Human Resources*, 95th Cong., 2d Sess. 448 (1978) (statement of Dr. Daniel S. Blumenthal) [hereinafter cited as *1978 Senate Hearings*].

313. The flavor of minority representation on at least some HSA governing boards was captured in Senate testimony. After detailing the excess hospital bed capacity of New Orleans, *see 1978 Senate Hearings, supra* note 312, at 437, and the refusal of 15 of the city's 18 hospitals to serve Blacks in significant numbers, *id.* at 438, Russell Henderson, a consumer board member of the New Orleans Area/Bayou Rivers HSA, pointed out that

> few if any of our 39 consumer members are accountable to anyone. None are selected from or by any low-income persons. To attain board membership, a prospective member must pass the scrutiny of the nominating committee. To date, only a handful of low-income persons or their advocates have passed that scrutiny . . . . My ability to gain board status had nothing to do with my commitment to equal access and cost containment, goals with which the nominating committee was not concerned, but was the consequence of my status as chairperson of the Drug Abuse Advisory Council of New Orleans.

Id. at 439-40.

314. *See* pp. 273-78 *supra*.

plications for HSA designation and funding.[315] The proposed regulation concerning consumer representation, however, merely repeated the statutory language requiring a majority of the board to be residents "who are consumers of health care," who are not providers of health care, and who are "broadly representative" of the statutory categories.[316] During the comment period, HEW received many requests for further specification.[317] In its response in March 1976, the Department noted that the regulation's language was taken verbatim from the Act and "declined to further define or amplify this provision."[318] HEW explained its position as follows:

> Recognizing the variety in designated health service areas, the Department wishes, at this stage, to give as much discretion as legally permissible to health systems agencies. The Department does state that in its view although the term "broadly representative" does not necessitate an equal proportion, it does indicate that the consumer majority should roughly approximate, in its representational aspects, the whole population of the health service area.
>
> The Department will, however, be reviewing the performance of agencies in meeting these criteria to see if, in the future, more specific regulation is warranted.[319]

On its face, HEW's position was not unreasonable. The concept of interest representation in health care is at an early stage of development; as in other programs, there is little consensus on how to identify the relevant interests, assign them weights or proportions, select their representatives, and assure accountability.[320] On a practical level, experience under prior health planning programs had shown that constructing a local planning board was often a matter of intense political conflict.[321] In these circumstances, an argument certainly could be made that HEW should avoid premature hardening

315. Notice of Proposed Rulemaking, 40 Fed. Reg. 48,802 (1975). The Health Planning Act required the Secretary to "enter into agreements . . . for the designation of health systems agencies" within 18 months of the statute's enactment. 42 U.S.C. § 300*l*-4(a) (Supp. V 1975).

316. 40 Fed. Reg. 48,808 (1975) (codified at 42 C.F.R. § 122.109(b)(1) (1977)).

317. *See* 41 Fed. Reg. 12,812, 12,820 (1976) (preface to final regulations).

318. *Id.*

319. *Id.*

320. *See generally* Stewart, *supra* note 12, at 1763-70, 1794.

321. Despite the relative powerlessness of the agencies under the Comprehensive Health Planning Act of 1966, *see* p. 306 *supra*, vigorous struggles took place over membership on their boards. *See* West & Stevens, *Comparative Analysis of Community Health Planning: Transition from CHPs to HSAs*, 1 J. HEALTH, POL., POL'Y & L. 173, 176-77, 190 (1976).

of policy and should experiment with a variety of ways to achieve the congressional goal of broadly representative HSA governing boards.

The strength of this argument depends entirely, however, on the quality of the experimentation carried out in relation to the risks of the experimental period. The risks of HEW's position were substantial, since the formative period of the HSAs is crucial to their future performance. During this period the organization takes its basic shape; its bylaws are written, key staff hired, traditions of working developed, and important political relations formed. If the governing boards established in the initial two-year conditional period excluded or seriously underrepresented significant consumer interests, that distortion would likely take root in the organization and resist subsequent remedy. To guard against such distortions and to provide guidance for experimental approaches, HEW should have developed at least some tentative operational concepts of "representation" to use in designating and funding applicant organizations as HSAs.

C. *Agency Enforcement and the Theory of Consumer Representation*

As was discussed above, the text and legislative history of the Act pointed toward two concepts of representation: descriptive representation, whereby representatives stand for other people by virtue of resembling them in some characteristic considered relevant,[322] and constituency representation, whereby representatives are chosen by, and are accountable to, "organizations representing the interests of consumers."[323] But as HSAs began to establish themselves in 1976 and 1977, it became clear that HEW had failed to translate either the descriptive or the constituency approach to consumer representation into operational policy. From a descriptive perspective, the HSA governing boards were seriously unrepresentative, particularly of low-income consumers.[324] The HSA for Texas Area 5, for example, cover-

322. *See* p. 308 *supra.*

323. *See* p. 308 *supra.*

324. *See* H. Hyman, HSA Governing Body Composition Analysis of Region II (May 1976), *reprinted in 1978 Senate Hearings, supra* note 312, at 317-39 (most of HSA governing boards in HEW Region II (New York, New Jersey, and Puerto Rico) significantly underrepresented women, elderly, and low-income consumers, but did contain adequate quantitative representation of minority consumers) [hereinafter cited as Hyman Report with page references to *1978 Senate Hearings*]. These results were in part confirmed by a second consultant's study for HEW. *See* 1 Orkand Corporation, Assessment of Representation and Parity for HSAs and SHPDAs (May 12, 1977) (mimeographed study, Contract No. HRA-230-76-0210, prepared for the Office of Health Resources Opportunity and the Bureau of Health Planning and Resources Development, Health Resources Administration, Dep't of HEW, Rockville, Md.) [hereinafter cited as Orkand Representation Report]. The Orkand Representation Report found that minorities (defined as Black,

ing nineteen counties in the Dallas-Fort Worth area, had forty-one consumer members on its governing board, but only three with incomes under $10,000 per year. This income group comprised 60.8% of the HSA's population, but only 7.3% of its consumer governing board. In contrast, persons with family incomes over $15,000 per year constituted only 17.1% of the population, but held 80.5% of the consumer seats on the board.[325] Such patterns were typical of the entire nation.[326] The constituency approach to consumer representation was also called into doubt by widespread litigation and administrative complaints in which important consumer groups protested their exclusion from the HSA boards.[327]

Asian, American Indian, and Hispanic) were, as a composite category, overrepresented on HSA governing boards and executive committees, in the sense that their percentage of board membership generally exceeded their percentage in the HSA's population. *See id.* at II-9 (definitions of representativeness and parity); II-123 to -151 (statistical analysis of representation); IV-12 to -13 (summary of parity and other data). This composite figure, however, is subject to qualification; as the summary of findings section points out, overrepresentation was concentrated largely among Blacks, "while relatively few agencies were overrepresented for other minority groups." *Id.* at IV-12. Women, on the other hand, were found to be "grossly underrepresented on HSA Governing Boards," with approximately two-thirds of the boards having percentages of women less than 80% of their percentage in the population. *Id.* at IV-12; *see id.* at IV-13 (reporting even lower representation of women on HSA executive committees). The Orkand Representation Report did not collect data on the incomes of HSA governing board members, but it did present data on their educational levels and occupations, with distinctly unrepresentative results. This data is subject to qualification, though, because of a high number (55%) of members not reporting, and because data for both consumer and provider members was combined. There may be important advantages to having board members with more education than the population as a whole, but the implications of this pattern for the representativeness of the boards deserve consideration.

325. Brief of Plaintiffs-Appellees at 15, Texas ACORN v. Texas Area 5 Health Sys. Agency, Inc., 559 F.2d 1019 (5th Cir. 1977).

326. Lawsuits raising similar representational claims were filed against HEW and all six HSAs for the state of Georgia in Rakestraw v. Califano, No. C77-635 A (N.D. Ga., filed Apr. 22, 1977), *motion to dismiss action against HSAs for lack of subject matter jurisdiction granted, id.*, Order at 5 (Dec. 19, 1977), and against the New Orleans HSA in Louisiana ACORN v. New Orleans Area/Bayou Rivers Health Sys. Agency, No. 77-361 (E.D. La., filed Feb. 24, 1977). *See 1978 Senate Hearings, supra* note 312, at 412-565 (testimony on behalf of legal services clients); HSA Survey Data, *reprinted in id.* at 526-31 (detailing gross disparities in income representation in HSAs for Central Arizona, South Florida, New Mexico, Cleveland Metropolitan Area, Oklahoma, and Utah); Hyman Report, *supra* note 324, at 333-34 (finding lack of representation as to income, sex, and age in most HSAs in HEW Region II (New York, New Jersey, and Puerto Rico)); Checkoway, *Consumer Issues Around HSAs: The Case of the Champaign County Health Care Consumers*, HEALTH L. PROJECT LIB. BULL., Mar. 1978, at 23 (reporting study showing lack of active low-income, minority, and rural representation on sub-area councils of East Central Illinois HSA and lack of HEW response to these findings).

327. *See* note 326 *supra* (citing complaints filed); Aldamuy v. Pirro, 436 F. Supp. 1005 (N.D.N.Y. 1977); Tannen, *Consumer Issues Around HSAs: The Eastern Kentucky HSA*, HEALTH L. PROJECT LIB. BULL., June/July 1977, at 19 (reporting effectiveness of consumer complaints filed with HEW in increasing representation of women, minorities, and workers on Eastern Kentucky HSA).

Aldamuy v. Pirro,[328] the first reported decision on consumer representation in health planning, involved a consumer challenge to an HSA governing board on both descriptive and constituency grounds. Minority individuals and an organization claiming "affiliation with a wide variety of governmental bodies, community health organizations, health-related professions, and minority interests generally"[329] sought to enjoin HEW funding of the Central New York HSA (CNYHSA), centered in Syracuse, New York, on the grounds that its board membership did not adequately represent the area's social, economic, linguistic, and racial groups. Specifically, plaintiffs pointed to the absence of poor persons or of any residents of the inner city on the governing board, and to the designation of government officials as "consumers," as evidence of violation of the Act and also charged that the minority members of the board "do not really represent the minority community."[330]

Judge Port held that federal jurisdiction existed only as to the Secretary of HEW,[331] and characterized the legal issue as whether the Secretary's approval of the CNYHSA board violated the Act or

328. 436 F. Supp. 1005 (N.D.N.Y. 1977).

329. *Id.* at 1008 n.6.

330. *Id.* at 1009.

331. Both Judge Port in *Aldamuy*, and the Fifth Circuit in Texas ACORN v. Texas Area 5 Health Sys. Agency, Inc., 559 F.2d 1019 (5th Cir. 1977), held (1) that plaintiffs had to establish a $10,000 amount in controversy in order to secure federal question jurisdiction over the HSA under 28 U.S.C.A. § 1331 (Supp. 1978); and (2) that the consumer plaintiffs had failed to state facts demonstrating that their representational rights under the Health Planning Act could be valued at more than $10,000. *See id.* at 1023; Aldamuy v. Pirro, 436 F. Supp. 1005, 1011-12 (N.D.N.Y. 1977). Rejecting the theory that the jurisdictional amount was met because the defendant HSAs' budgets greatly exceeded $10,000, both courts required "evidence of potential or direct injury to [plaintiffs] themselves." 559 F.2d at 1023; *accord*, 436 F. Supp. at 1011. Both holdings are open to serious question. First, Congress had amended 28 U.S.C. § 1331 to eliminate the $10,000 requirement for federal question jurisdiction over the United States, its agencies and officers. *See* Act of October 1, 1976, Pub. L. No. 94-574, § 703(2), 90 Stat. 2721 (1976) (codified in 28 U.S.C.A. § 1331(a) (Supp. 1978)). This clearly established federal jurisdiction to hear the consumers' claims against HEW. *See* 559 F.2d at 1022; 436 F. Supp. at 1009-10. By declining to extend pendent jurisdiction over the defendant HSAs, the *Aldamuy* and *Texas ACORN* courts created an anomalous situation in which the federal agency's decision to approve the private party's action was subject to federal suit, but the private party itself (the HSA)—although an integral part of the transaction and of the entire administrative scheme—could not be involuntarily joined. Indeed, the Fifth Circuit in *Texas ACORN* wondered why the HSA was resisting federal jurisdiction, since its own budget was at stake: "Surely the HSA would be seeking to intervene, were the litigation to continue against HEW without it." 559 F.2d at 1024 n.9. Second, even if the *Aldamuy* and *Texas ACORN* courts were correct in holding that the $10,000 requirement applied against the HSAs, it is far from clear that plaintiffs' representational rights were worth less than that amount. *See* 1 MOORE'S FEDERAL PRCATICE ¶ 0.96[3.—1], at 940-41 (2d ed. 1978) (noting that "problem of showing the requisite amount in controversy has proved particularly troublesome . . . in cases seeking injunctive . . . relief where issues of the discretionary power of federal officers are involved," with some courts viewing right to be protected as " 'by definition' " or "indirectly" worth $10,000).

constituted an abuse of discretion. To determine the first question, Judge Port compared the plaintiffs' specific allegations of noncompliance with the text of the Act and found no specific provisions supporting their claim for relief. For example, the court noted that the Act required the board to be broadly representative of the social, economic, and racial populations and geographic areas, but did not specifically require representation of the inner city "geographic or socio-economic area."[332] Similarly, Judge Port noted that the Act required the governing boards to include government officials and did not prohibit such officials from serving as consumer members.[333] The claim that the board did not adequately represent the minority community was answered with the fact that 14% of the consumer board members were nonwhite, as compared with only 3.1% of the area's population; this was held to satisfy a descriptive theory of broad representation.[334] Concerning the plaintiffs' claim that the particular minority individuals selected did not "really represent the minority community," the court chose to "yield to the proper exercise of the Secretary's discretion," which could be overturned only if it were " 'so arbitrary as to be clearly wrong.' "[335]

In granting the Secretary's motion to dismiss for failure to state a claim for relief, Judge Port may have reached the correct result, but he did so on the basis of an erroneous conception of the legal issues. If the plaintiffs indeed were who they said they were—approximately thirty individuals with wide connections to health care activities and minority interests[336]—their complaint of exclusion from the CNYHSA board raised at least a *question* about whether the board was broadly representative of the area's social, economic, and racial groups. The applicable statutory standard is not numerical representation of minorities, but rather, in the words of the House Report, whether the board "adequately and equitably represent[s] the area's population."[337] Determining whether this standard has been met in any particular case is a mixed factual and policy judgment that allows for the Secretary's discretion and is subject to judicial review under the federal APA for abuse of that discretion. But what does "abuse of discretion" mean in this context? It cannot mean that a challenger must show that the Secretary has violated a clear statutory mandate, for in such a case the

332. Aldamuy v. Pirro, 436 F. Supp. 1005, 1010 (N.D.N.Y. 1977).
333. *Id.*
334. *Id.*
335. *Id.* at 1011 (quoting Whelan v. Brinegar, 538 F.2d 924, 927 (2d Cir. 1976)) (citations omitted).
336. *See id.* at 1008 n.6.
337. H.R. REP. No. 1382, *supra* note 305, at 57.

Secretary would be said not to have discretion at all, and would be accountable under the APA for action "unlawfully withheld or unreasonably delayed" or "in excess of statutory . . . authority."[338] Even when the Secretary has acted within the scope of his statutory authority, courts must decide "whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment."[339] The Supreme Court has described this review somewhat ambiguously as a "searching and careful" inquiry into the facts in which, nevertheless, "[t]he court is not empowered to substitute its judgment for that of the agency."[340]

Though obviously deferential, this standard does not mean that courts "must rubber-stamp the agency decision as correct."[341] In particular, a reviewing court must determine whether the agency has considered "the relevant factors" and has exercised what the District of Columbia Circuit has termed " 'a reasoned discretion, with reasons that do not deviate from or ignore the ascertainable legislative intent.' "[342]

As applied to *Aldamuy,* the issue thus becomes whether the Secretary considered the relevant statutory factors in reaching his discretionary judgment that the CNYHSA board adequately represented the area's population and whether he can support that judgment with at least some reasoning relevant to the Health Planning Act. Once the factors have been demonstrably considered, and the agency's reasoning offered, the courts must apply a deferential standard of review and may reverse only if the agency's judgment lacks a rational basis or is otherwise improperly motivated or "clearly wrong." But the only reasons advanced by HEW, and accepted by the court, were that minority board members exceeded the numerical proportion of minorities in the population, and that the Act did not require the Secretary to achieve any of the specific results (*e.g.,* representation of the inner city) urged by the plaintiffs.[343] Such a passive agency pos-

338. 5 U.S.C. § 706(1), (2)(C) (1976).

339. Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 416 (1971).

340. *Id. But see* Ethyl Corp. v. EPA, 541 F.2d 1, 34 n.74 (D.C. Cir.), *cert. denied,* 426 U.S. 941 (1976) ("Court's intent in *Overton Park* somewhat difficult to plumb and its standard even more uncertain of application"; case may "unintentionally prompt" "significantly more intrusive" review than is traditional); Note, *supra* note 40, at 1662-63 (criticizing *Overton Park* opinion as ambiguous and as "permitting an extremely wide-ranging review").

341. Ethyl Corp. v. EPA, 541 F.2d 1, 34 (D.C. Cir.), *cert. denied,* 426 U.S. 941 (1976).

342. Greater Boston Television Corp. v. FCC, 444 F.2d 841, 850 (D.C. Cir. 1970), *cert. denied,* 403 U.S. 923 (1971), *quoted in* Ethyl Corp. v. EPA, 541 F.2d 1, 36 (D.C. Cir.), *cert. denied,* 426 U.S. 941 (1976).

343. *See* p. 315 *supra.*

ture itself is at odds with Congress's intent, expressed in the House Report, that HEW "take particular care to assure that the [HSA] governing bodies are chosen and composed so as . . . adequately [to] represent all of the area's population."[344]

A probing of HEW's actual standards for funding HSAs would have revealed the incoherence of the agency's operations. As the *Aldamuy* case indicated, HEW made no effort to evaluate whether an HSA board adequately represented actual consumer constituencies; to take a gross example, HEW funded the Atlanta-based North Central Georgia HSA with a board whose consumer members had allegedly been nominated largely by provider organizations.[345] But despite its position in *Aldamuy,* HEW also made no serious effort to enforce a numerical or descriptive approach to representation, and it approved HSA funding without even collecting information on the income levels of consumer members or their status as "indirect providers."[346] When challenged in several cases for funding HSAs with large numerical disparities in the representation of low-income consumers, HEW abandoned its *Aldamuy* position and asserted the power to approve HSA applicants virtually without reviewable standards.

The numerical or descriptive approach to consumer representation was the focus of *Texas ACORN v. Texas Area 5 Health Systems Agency, Inc.,*[347] in which low-income consumer plaintiffs challenged what was at least a seven-to-one disparity in the representation of low-income consumers on the governing board of the North Central Texas HSA.[348] HEW opposed the plaintiffs' suit, but offered no alternative theory or facts to the district court to justify the representative character of the HSA. On the contrary, in an answer to plaintiffs' interrogatories, HEW appeared to admit that the only board

344. H.R. REP. No. 1382, *supra* note 305, at 57.

345. *See 1978 Senate Hearings, supra* note 312, at 448 (statement of Dr. Daniel S. Blumenthal).

346. *See id.* at 472-73 (statement of Wayne Pressel).

347. 559 F.2d 1019 (5th Cir. 1977). As discussed in the district court's unreported opinion, the plaintiffs were "low-to-moderate income persons who have family incomes under approximately $10,000" and the Texas Association of Community Organizations for Reform Now (ACORN), "an unincorporated association concerned with the interests of low-to-moderate income persons . . . with approximately 1,500 member families statewide" and particularly concerned with the distribution of health resources to poor and low-to-moderate income persons in the Dallas-Fort Worth area. Texas ACORN v. Texas Area 5 Health Sys. Agency, Inc., No. S-76-102-CA, slip op. at 1 (E.D. Tex. Mar. 1, 1977), *vacated and remanded,* 559 F.2d 1019 (5th Cir. 1977). Members of Texas ACORN had met with HEW regional officials to express their concern with the composition of the HSA governing board and had issued a study of the public hospital in Forth Worth, Texas. *Id.* at 2.

348. *See* 559 F.2d at 1021.

members who were "representative of low income consumers" were the three whose incomes were under $10,000 per year.[349] The defendant HSA, though admitting that it had "no established criteria for defining low and moderate income representatives," argued that twenty-nine of its consumer members actually "represented" low-income persons by virtue of factors other than income, such as membership in an ethnic minority, status as a public official or federal employee, or designation by consumer organizations.[350] Since the HSA offered no specific facts to support these contentions, and since the uncontradicted statistical disparity was so great,[351] Judge Wayne Justice granted the plaintiffs' motion for partial summary judgment to enjoin the HSA's federal funding until the board membership was made roughly approximate to the income distribution of the population as a whole.[352]

In reaching this decision, Judge Justice accepted the plaintiffs' argument that the Health Planning Act created two types of consumer "rights" with respect to HSA board representation. The first was that the statutory consumer categories would be represented by persons who themselves shared the descriptive characteristics of the economic, social, or racial group. The second was that the numerical proportions of low-income and minority representatives would approximate their actual proportions in the area's population. The dramatic consequence of Judge Justice's ruling was the requirement that approximately one-half of the HSA's forty-one consumer board members have incomes under $10,000—an increase from three low-income members to from sixteen to twenty-five.[353]

The impulse of the plaintiffs and the district court to read the statute as creating a clear right to a numerically descriptive board is understandable. By requiring the boards to be *broadly* representative of defined consumer groups, as opposed to merely requiring, as it had in the past, an undefined "consumer representation," Congress undoubtedly did intend the new HSAs to have broader and more accountable consumer representation than existed in the CHP program. HEW's willingness to fund boards that were grossly unrepresentative in descriptive terms, and the apparent unresponsiveness of HEW re-

349. *Id.* at 1025.
350. *See* Texas ACORN v. Texas Area 5 Health Sys. Agency, Inc., No. S-76-102-CA, slip op. at 10 (E.D. Tex. Mar. 1, 1977), *vacated and remanded*, 559 F.2d 1019 (5th Cir. 1977) (quoting defendant HSA's answer to interrogatories).
351. *Id.* at 10, 12.
352. *Id.* at 13.
353. *Id.*

gional offices to consumer complaints of inadequate representation,[354] strongly suggested that only clear numerical guidelines would lead to any sort of regulation of HSA board composition. Finally, HEW itself appeared to be adopting a numerical and descriptive approach to consumer representation. The Department's answer to the plaintiffs' interrogatories in *Texas ACORN*—that the only representatives of low-income persons were those with incomes under $10,000—seemed to rest on a descriptive model that was consistent with the preface to the March 1976 regulations, which stated that "the consumer majority should roughly approximate, in its representational aspects, the whole population of the health service area."[355]

But if numerically descriptive representation was an understandable effort to implement Congress's generally phrased requirement of broad consumer representation, it also was subject to serious legal and practical objections. Since the text of the Act, as well as its legislative history, contained a blend of descriptive and constituency concepts of representation, Congress had evidently considered the descriptive characteristics of consumer members to be an important but not exclusive standard for composition of the HSA boards. Moreover, in addition to practical difficulties of administration (*e.g.*, variations in a member's income over time), it is easy to imagine a descriptive representation approach being administered so as to defeat the substantive goals of the Act. As was alleged in *Aldamuy*, consumer board members could be chosen who met the applicable income or racial standards, but were otherwise not representative of, or accountable to, the groups whose interests they purported to serve. The challenge to HEW posed by the Act was to devise a system that effectively incorporated both descriptive and constituency models of representation into the actual practices of the HSAs.

On appeal, HEW seemed both to recognize and to deny the existence of this challenge and its own failure to meet it. On the one hand, HEW strenuously asserted that Judge Justice had misinterpreted the Act and the Department's own position. The agency expressly disclaimed any reliance on numerical standards of representation and argued that the "appropriate test" applied by the Secretary in evaluating HSA compliance was

> whether the consumer portion of the governing body, looked at as a whole, can reasonably be expected to consider and articulate, in carrying out its health planning functions, the interests of each

354. *See id.* at 8.
355. 41 Fed. Reg. 12,820 (1976).

> segment of the population of its health service area to a degree roughly approximate to its share of the total population.[356]

The Secretary's decision to fund a particular HSA, the argument continued, could be overturned only if the plaintiffs could show that the application of this standard was "arbitrary, capricious, or an abuse of discretion."[357] On the other hand, HEW conceded, in a supplementary appellate brief, that its current regulations gave inadequate guidance to its regional officials in approving HSAs, and moved for a stay of all proceedings pending the development of new regulations.[358]

The Fifth Circuit, influenced in part by a congressional committee report criticizing Judge Justice's decision,[359] reversed the district court and remanded the case for trial on the question of whether the Secretary had abused his discretion in approving the HSA board.[360] Just

356. Brief for the Federal-Defendants-Appellants at 17, Texas ACORN v. Texas Area 5 Health Sys. Agency, Inc., 559 F.2d 1019 (5th Cir. 1977).

357. *Id.* at 21.

358. Reply Brief for the Federal-Defendants-Appellants at 2-5, Texas ACORN v. Texas Area 5 Health Sys. Agency, Inc., 559 F.2d 1019 (5th Cir. 1977).

359. The *Texas ACORN* district court opinion sparked considerable efforts by the losing defendant HSA to obtain congressional support for its legal position, on which its receipt of an annual operating grant from HEW of over $700,000 depended. Having lost in the district court, the Texas Area 5 HSA apparently contacted Congressman Jim Wright, the powerful member from its district, who is majority leader of the House of Representatives. Wright in turn contacted Congressman Paul Rogers, chairman of the Subcommittee on Health and the Environment of the House Interstate and Foreign Commerce Committee that has jurisdiction over health planing legislation. Ten days after Judge Justice's district court opinion in *Texas ACORN*, Rogers wrote to Wright expressing the view that "[i]t appears likely that Judge Justice has given stronger interpretation to our requirement for broad representation than was intended." Letter from Congressman Paul G. Rogers to Congressman Jim Wright, March 11, 1977, *reprinted in* Brief for Defendant-Appellant Texas Area 5 Health Systems Agency, Inc., Exhibit B, Texas ACORN v. Texas Area 5 Health Sys. Agency, Inc., 559 F.2d 1019 (5th Cir. 1977).

In July, 1977, while the *Texas ACORN* case was on appeal from the district court decision, Congressman Rogers' subcommittee issued a conference report on a bill to extend the Health Planning Act that stated:

> The conferees . . . wish to clarify the original intent of the [Health Planning Act with respect to HSA governing boards] . . . . In particular, it was not the intent of the Congress . . . to mandate a quota system requiring the selection of representatives of a particular category strictly proportionate to its representation in the population of the area or to require that representatives of a category be members of the class they represent. Instead, the Congress intended that . . . health systems agencies have the flexibility to adopt selection processes most appropriate to local needs.

H.R. REP. No. 500, *supra* note 55, at 581-82, *quoted in* 559 F.2d at 1025 n.13. Since the bill at issue, H.R. 4975, contained no provisions regarding HSA governing boards, the Conference Committee statement represented the views of a subsequent Congress and could therefore "provide no controlling basis from which to infer the purposes of an earlier Congress." Haynes v. United States, 390 U.S. 85, 87 n.4 (1968); *see* United States v. Wise, 370 U.S. 405, 411 (1962); United States v. Price, 361 U.S. 304, 313 (1960). Nevertheless, the Fifth Circuit in *Texas ACORN* admitted that the Conference Committee Report "buttresses our conclusion" that the district court had misinterpreted the Act. 559 F.2d at 1025 n.13.

360. 559 F.2d at 1026.

what the district court was to decide, however, was left unclear. The Fifth Circuit reversed Judge Justice's ruling that consumer board members had to be descriptively representative of the statutory categories and suggested that HEW, and perhaps a reviewing court, had to engage in a far more complex inquiry regarding "effective expression and advocacy of the interests of all segments of the consumer population."[361] Relying on HEW's Draft Guidelines of October 1976, the Fifth Circuit held that "income level is but one factor, albeit perhaps the most important one, in determining who may best represent a particular consumer group, be it low-income or otherwise."[362] Other factors, such as "demonstrated ability to negotiate and mediate, understanding and appreciation of different perspectives in the community, credibility with community groups, [and] legal training and experience"[363] were relevant to HEW's decision in approving low-income representation on an HSA board. The district court was instructed to give HEW an "adequate opportunity to demonstrate the way in which consumer members who make more than $10,000 per year may be representative of low income consumers," and also to develop facts proving "that the Board was 'broadly representative' of the area population."[364]

The Fifth Circuit seemed simultaneously to require an expanded HEW and judicial inquiry into the "effectiveness" of consumer representation, and yet mandate a more deferential standard of review. Although the court did not approve or even quote the Secretary's "test" for measuring representational compliance, it described the Secretary's task in similar terms as "in effect, an accommodation of policy alternatives" regarding "numerous demographic factors and policy concerns."[365] The district court was to determine whether the Secretary's performance of this task had been "arbitrary, capricious or an abuse of discretion."[366]

The Fifth Circuit's opinion in *Texas ACORN* is thus open to two sharply different interpretations. The appellate court may have approved the Secretary's vague, essentially standardless approach to ascertaining representational compliance and have ordered the district court to accept virtually any facts that HEW could muster in support of its decision. On the other hand, the court's justification for

361. *Id.* at 1025.
362. *Id.*
363. *Id.* at 1024.
364. *Id.* at 1025-26.
365. *Id.* at 1026.
366. *Id.*

reversing Judge Justice's clear-cut descriptive model of consumer representation was HEW's apparent offer of a more sophisticated alternative: an inquiry into whether consumer members could effectively represent the actual range of consumer interests in the community. Such an approach, if taken seriously, would require far more careful monitoring of HSA boards by HEW and far more searching responses by HEW to consumer complaints of the type raised in *Aldamuy* and *Texas ACORN*. The necessity of deciding between these alternatives was temporarily avoided by delaying the trial in *Texas ACORN* until HEW promulgated new regulations. But the same problems of agency responsibility and judicial review are likely to arise again in challenges to board composition under the new regulations.

The two approaches embodied in the Fifth Circuit's opinion reflect the neo-formalist and structural due process traditions of judicial review. For the neo-formalist, the absence of clear legislative rules and the existence of broad agency discretion necessarily imply the absence of applicable law and require judicial ratification of the balancing or bargaining outcomes of the administrative process, whatever they may be. This approach is distinctively *neo*-formalist because it does not deny consumers standing or the form of legal rights, but rather asserts that minimal, deferential judicial review under the "arbitrary and capricious" standard *constitutes* a judicial process and the protection of recognized legal rights. The structural due process approach also accepts the "arbitrary and capricious" standard of review articulated in the APA,[367] but applies it with more force because it defines arbitrariness in relation to substantive and structural statutory norms. From this perspective, HEW's decisions approving the North Central Texas and Central New York HSAs are arbitrary if they cannot be justified in terms of representational standards derived from the Health Planning Act. The crucial step in the structural due process approach is to conceive the agency's complex function of assessing representational adequacy as not simply an argument against a mandatory right, but also as the source of affirmative agency obligation to weigh the relevant statutory factors in its decision and to demonstrate in a record how it has balanced the factors.

The Supreme Court's recent decision in *Vermont Yankee*,[368] casts an uncertain light on the choice between neo-formalism and structural due process. In a unanimous opinion by Justice Rehnquist,[369] the

367. 5 U.S.C. § 706(2)(B) (1976).
368. 435 U.S. 519 (1978).
369. Justices Blackmun and Powell did not participate in the decision. *See id.* at 558.

Court held that the rulemaking procedures explicitly defined in the APA[370] establish "the maximum procedural requirements"[371] and that, absent extraordinary circumstances, the federal courts have no authority to impose additional procedural conditions on agency rulemaking.[372] Since structural due process techniques—public participation, rational decisionmaking, and adequate consideration of statutory values—are all arguably constituent parts of the rulemaking process as defined by the APA,[373] *Vermont Yankee* does not necessarily affect their validity. On the other hand, the tone of the Supreme Court's opinion lends support to the formalist view that judicial authority is sharply distinct from legislative and administrative authority and that courts should be particularly reluctant to infer rights and obligations in agency decisionmaking procedures from general statutory norms.[374]

For several reasons, however, *Vermont Yankee* should not be read as definitively closing the door to further development of structural due process doctrines in administrative law. The Court's holding was directed at one particular model of judicial intervention: the requirement, or at least strong "suggestion,"[375] of specific rulemaking procedures such as "informal conferences between intervenors and staff, document discovery, interrogatories, technical advisory committees

370. Except when a statute requires an agency to make rules "on the record after opportunity for an agency hearing," 5 U.S.C. § 553(c) (1976), agencies may issue rules under the "informal" procedures established by §§ 553(b) and (c). *See* United States v. Florida E. Coast Ry. Co., 410 U.S. 224 (1973); United States v. Allegheny-Ludlum Steel Corp., 406 U.S. 742, 757-58 (1972). These procedures require an agency to publish a general notice of the proposed rulemaking in the Federal Register, including the "terms or substance of the proposed rule or a description of the subjects and issues involved." 5 U.S.C. § 553(b)(3) (1976). The agency must then "give interested persons an opportunity to participate in the rulemaking through submission of written data, views, or arguments with or without opportunity for oral presentation." *Id.* § 553(c). Finally, "[a]fter consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose." *Id.*

371. 435 U.S. at 524.

372. *Id.* at 524, 543-44.

373. *See* National Welfare Rights Organization v. Mathews, 533 F.2d 637, 648-49 (D.C. Cir. 1976); Wright, *supra* note 269, at 205-11.

374. *See* 435 U.S. at 549 (courts must not "stray beyond the judicial province to explore the procedural format or to impose upon the agency its own notion of which procedures are 'best' or most likely to further some vague, undefined public good"). *But see* Natural Resources Defense Council, Inc. v. United States Nuclear Regulatory Comm'n, 547 F.2d 633, 655 (D.C. Cir. 1976), *rev'd sub nom.* Vermont Yankee Nuclear Power Corp. v. National Resources Defense Council, Inc., 435 U.S. 519 (1978) (separate statement of Bazelon, C.J.) (denying existence of "bright line" between rulemaking and adjudicatory proceedings).

375. Justice Rehnquist conceded that whether the majority of the appellate panel actually based its decision on the inadequacy of the agency's *procedures,* as distinct from the inadequacy of the record, "is not entirely free from doubt," but concluded that the majority had struck down the Commission's rule because of procedural inadequacies. 435 U.S. at 539-41.

comprised of outside experts with differing perspectives, limited cross-examination, funding of independent research by intervenors, detailed annotation of technical reports, surveys of existing literature, [and] memoranda explaining methodology."[376] The Court explicitly distinguished this disfavored approach from judicial review of the adequacy of the record in support of an agency's decision[377] and remanded the case to the court of appeals to determine whether the agency's action was "sustainable on the administrative record made" according to "the appropriate standard for review."[378]

The crucial issue left open by *Vermont Yankee* is the level of scrutiny involved in judicial review of the adequacy of an administrative record. On this point the law is in great flux; Professor Davis characterizes the law on this subject as "not only unclear but quite confused."[379] Nevertheless the trend is fairly clear: courts are increasingly engaged in review of "greater intensity, . . . [in] examination of the informal record on which the rulemaking is based, [and in] analysis of the factual basis for rules."[380] As Judge J. Skelly Wright notes, a key element in the courts' "more vigorous attitude"[381] has been the application of the concept of the administrative "record" to informal rulemaking and to other informal action. For purposes of judicial review, a "record" now consists not only of the transcript of a formal hearing, if any, but also of

> virtually all the relevant materials that an administrator has used as a basis for action. . . . Where the empirical or predictive basis for an agency action is strongly contested by [the submissions of interested parties], courts are now bound to take those submissions into account in deciding whether the agency has given sufficient consideration to . . . "the relevant factors."[382]

In a companion case to *Vermont Yankee,* the Supreme Court reversed a different panel of the District of Columbia Circuit for excessive re-

376. Natural Resources Defense Council, Inc. v. United States Nuclear Regulatory Comm'n, 547 F.2d 633, 653 (D.C. Cir. 1976), *rev'd sub nom.* Vermont Yankee Nuclear Power Corp. v. Natural Resources Defense Council, Inc., 435 U.S. 519 (1978).

377. 435 U.S. at 542-43, 549.

378. *Id.* at 549 (quoting Camp v. Pitts, 411 U.S. 138, 143 (1973)).

379. K. DAVIS, *supra* note 44, at 652.

380. *Id.* at 656.

381. Wright, *supra* note 269, at 208.

382. *Id.* at 209 (quoting Citizens to Preserve Overton Park, Inc. v. Volpe, 401 U.S. 402, 416 (1971)). *But see* Auerbach, *Informal Rule Making: A Proposed Relationship Between Administrative Procedures and Judicial Review,* 72 NW. U.L. REV. 15, 24-26 (1977) (arguing that review of informal rulemaking on exclusive basis of agency "record" violates original intent of APA and cuts off proper de novo judicial inquiry into relevant facts).

view of the sufficiency of the record, but did so in terms that seemed to leave intact the central trend toward more vigorous scrutiny.[383]

Aside from the uncertain reach of the APA, the Court's *Vermont Yankee* opinion must be reconciled with other recent cases in which procedural requirements have been inferred not from the APA itself, but from the agency's substantive statute. Particularly in reviewing informal agency action in specific cases in which the APA has few procedural requirements, cases such as *Dunlop v. Bachowski*[384] suggest that courts may fashion a kind of common law administrative procedure consistent with substantive and structural provisions of the agency's governing statute.[385]

Finally, the reach of *Vermont Yankee* is limited by the fact that it arose in the environmental law context in which structural due process techniques have been developed in their most advanced form. The Court summarized in detail the extensive hearings and procedures used in rulemaking and licensing proceedings and suggested that such procedures go far toward assuring a "fully informed and well-considered decision."[386] In the area of health care reform, on the other hand, the pattern of agency decisionmaking is quite different, with federal and state agencies frequently denying that a policy need even exist, much less allowing participation in its development.

Thus, despite *Vermont Yankee,* it seems clear that the HEW decisions approving the governing boards of the North Central Texas and Central New York HSAs should not have been sustained. The

383. *See* 435 U.S. at 549-58 (reversing Aeschliman v. United States Nuclear Regulatory Comm'n, 547 F.2d 622 (D.C. Cir. 1976)). In reversing the appellate court's finding of an insufficient record, the Supreme Court emphasized the intervenors' failure to focus their contentions and the availability of some of the data claimed to have been inadequately presented by the Commission. *Id.* at 553-57. The Court also stressed the "incredibly extensive review" given to the proposed plant. *Id.* at 557. The Court's ruling thus does not necessarily validate administrative records when the challengers' contentions are well focused, when important data in the agency's possession are not available to the public, and when the agency's proceedings have been summary rather than extensive.

384. 421 U.S. 560 (1975); *see* Note, Dunlop v. Bachowski *and the Limits of Judicial Review under Title IV of the LMRDA: A Proposal for Administrative Reform,* 86 YALE L.J. 885 (1977).

385. Support for this position can be found in the Court's treatment in *Vermont Yankee* of the relationship between the APA rulemaking requirements and the procedural requirements of the National Environmental Protection Act (NEPA). In response to the argument that NEPA authorizes a court to require more extensive rulemaking procedures than those specified in § 553 of the APA, the Court stated that NEPA's procedural requirements are limited to its "plain language" and cannot serve as a basis for revising "the carefully constructed procedural specifications of the APA." 435 U.S. at 549. In the case of informal action *other* than rulemaking (such as approval of funding for a particular project or organization), neither the APA nor most substantive statutes provide clear legislative guidelines.

386. *Id.* at 558.

question in each case was not whether HEW was required to enforce a particular proposed standard, but how the agency actually considered the consumers' complaints and justified its decisions. In *Texas ACORN,* for example, neither the HEW regional office nor the Secretary had any established procedures for considering consumer complaints about HSA board composition,[387] nor have any procedures been established since then. When the complaints were made to the appropriate regional official, the HSA was apparently not even asked to explain or justify its underrepresentation of low-income consumers. Such an agency process would not pass muster in decisions to license a power plant,[388] set airline fares,[389] or regulate the importation of tomatoes.[390] The task of consumer litigants in the health planning cases was to convince the courts that their statutory interest in health planning representation deserved comparable procedural protection.

D. *The Impact of Litigation on Agency Policy*

Although the consumer plaintiffs in the health planning cases have not won relief in the federal courts, their litigation efforts have had an impact on agency policy. In June 1977, faced with the district court decision in *Texas ACORN* and similar lawsuits in Atlanta[391] and New Orleans,[392] HEW filed a supplemental brief with the Fifth Circuit announcing a significant change in its approach to consumer representation. The Department stated that *Texas ACORN* and other consumer litigation "have prompted informal analyses of existing HSA governing bodies by program officials," after which "it has become clear . . . that there is a need for additional published guidance to . . . HSAs and to the [regional officials] . . . with regard to the 'broadly representative' issue."[393] Having concluded that more specific regulation was "imperative," HEW announced that "the process of developing such regulations has already begun."[394]

387. Texas ACORN v. Texas Area 5 Health Sys. Agency, Inc., No. S-76-102-CA, slip op. at 8 (E.D. Tex. Mar. 1, 1977), *vacated & remanded,* 559 F.2d 1019 (5th Cir. 1977).

388. *See, e.g.,* Vermont Yankee Nuclear Power Corp. v. Natural Resources Defense Council, Inc., 435 U.S. 519, 556 (1978); Scenic Hudson Preservation Conference v. FPC, 354 F.2d 608 (2d Cir. 1965), *cert. denied,* 384 U.S. 941 (1966).

389. Pillai v. CAB, 485 F.2d 1018, 1030 (D.C. Cir. 1973).

390. Walter Holm & Co. v. Hardin, 449 F.2d 1009 (D.C. Cir. 1971).

391. *See* Complaint, Rakestraw v. Califano, No. C77-635 A (N.D. Ga., filed Apr. 22, 1977), *dismissed as to HSA defendants,* Order at 5 (N.D. Ga. Dec. 19, 1977).

392. *See* Complaint, Louisiana ACORN v. New Orleans Area/Bayou Rivers Health Sys. Agency, Inc., No. 77-361 (E.D. La., filed Feb. 24, 1977).

393. Reply Brief for Federal Defendant-Appellants at 2, Texas ACORN v. Texas Area 5 Health Sys. Agency, Inc., 559 F.2d 1019 (5th Cir. 1977).

394. *Id.* at 4.

In May 1978, almost a full year after the Department's announcement in its *Texas ACORN* brief, HEW published a notice of proposed rulemaking on governing body requirements for HSAs.[395] The proposed regulations in effect conceded the validity of the consumers' claims by adopting much of their position on both descriptive and constituency representation. Under the new standards, the Secretary

> must be satisfied that the percentage of [consumer members] . . . is roughly approximate to the [following groups'] percentage of the entire population of the area[:] . . .
>
> (A) Identifiable racial or linguistic population groups which constitute a significant proportion of the population of the area;
> (B) All economic groups, including poverty and low-income groups;
> (C) Women; and
> (D) Persons over age 65.[396]

Moreover, although an individual "need not necessarily be a member of a particular population group" in order to represent that group, he or she will not be considered a particular group's representative "unless the individual has been selected or nominated for that purpose by an organization composed primarily of members of the group."[397] Finally, HEW for the first time asserted its regulatory role over the selection procedures of governing boards by requiring a majority of the consumer and provider governing board members to be chosen by some process "other than selection by the governing body" or other committee of the HSA itself.[398] To monitor compliance with these provisions, HEW further proposed that the HSAs submit to HEW information on income, racial, and other pertinent characteristics of its governing body and other committees, as well as information on the process by which these bodies were selected.[399]

Although the proposed regulations represent a marked improvement in agency policy, they still contain a number of major deficiencies. First, the effort to regulate the selection process only prohibits one particular form of abuse, *i.e.*, the formally self-perpetuating gov-

395. Notice of Proposed Rulemaking, Governing Body Requirements for Health Systems Agencies, 43 Fed. Reg. 22,858 (1978) (to be codified in 42 C.F.R. § 122).
396. *Id.* at 22,860 (to be codified in 42 C.F.R. § 122.109(b)(1)(i)).
397. *Id.* (to be codified in 42 C.F.R. § 122.109(b)(1)(ii)).
398. *Id.* at 22,861 (to be codified in 42 C.F.R. § 122.109(b)(4)).
399. *Id.* (to be codified in 42 C.F.R. § 122.109(g)). For a discussion of the development of reporting forms to generate data for HEW monitoring of HSA compliance, see Orkand Representation Report, *supra* note 324.

erning board. Numerous other methods exist, such as failure to publicize elections adequately and burdensome requirements for voter and governing board eligibility.[400] Second, the proposed regulations do not require the HSAs to provide appropriate training and staff support to their consumer members or, more generally, to promote effective consumer participation in health care decisionmaking.[401] Third, the requirements of descriptive and constituency representation are not backed by an explicit enforcement system that would require HSAs to respond to, and HEW to review, complaints of consumer exclusion and underrepresentation in the composition and operation of the health planning system.

Despite these deficiencies, the proposed regulations are a significant step in developing an operational policy of consumer representation. The explicit articulation of at least a rough quantitative standard, the insistence on at least some constituency accountability, and the promise of more active HEW review of governing board composition provide levers for consumer influence and participation. These standards can, and undoubtedly will, be interpreted by some HSAs and HEW officials to exclude important consumer groups. But judicial relief in such cases will be much more likely in the context of these more definite standards and so will provide both a corrective for and a deterrent to arbitrary administrative action.

E. *The Need for Broad Consumer Representation*

The history of health planning programs under the earlier Comprehensive Health Planning Act and the subsequent Health Planning Act provides abundant evidence of the capacity of "insiders"—leaders of the hospital industry and medical profession, together with local

400. *See, e.g., 1978 Senate Hearings, supra* note 312, at 483 (statement of Melissa F. Greene) (failure of Southeast Georgia Health Systems Inc. to publicize elections adequately); Letter from Linnis Cook to Jay Halpern, chief of HEW Regional Planning Operations Cluster (June 5, 1978) (student researcher notes that two-thirds of Delaware HSA governing board is chosen by "a self-perpetuating, limited (60) number of people mysteriously designated as having 'manifested an interest in the objectives and purposes of the Delaware Health Council," and remaining one-third by Governor).

401. One suggestion as to how this might be accomplished was the proposal of legal services organizations to amend the Health Planning Act to require HSAs to establish a "consumer resource staff which is selected by and accountable to consumer members of the health systems agency." *See 1978 Senate Hearings, supra* note 312, at 423. The functions of such a staff would include education of consumer members with regard to health care and health planning, facilitation of consumer involvement in HSA functions, technical assistance to consumer members, including review of HSA plans and project reviews, and facilitation and review of the solicitation and election of consumer board members. *Id.*

and state political leaders—to dominate decisions about health care resources. Although some HSAs have undoubtedly attempted to be responsive to a broad range of consumer interests, many others have successfully flouted the text and purpose of the Health Planning Act through a host of exclusionary devices: self-perpetuating boards, closed nominating procedures, unrepresentative policy committees, unpublicized meetings, and the withholding of information on projects being reviewed.[402] Aside from restricting board membership, many HSAs blocked informed participation by the interested public through such devices as "making it hard to obtain committee reports or staff projects analyses," and not seriously considering proposals offered by "outsiders."[403] Low-income consumers and their advocates testified repeatedly in the 1978 Senate and House hearings on HSA failures to make serious efforts to educate either their consumer board members or the public at large on HSA procedures and on the issues involved in health planning.[404] The resulting decisions have frequently contradicted the substantive goals of the entire program by approving duplicative high-technology investment in areas already saturated with sophisticated hospital services[405] and by studiously disregarding racial discrimination and other access barriers to health care for the poor.[406]

The addition of two or three low-income or minority consumers to a thirty- or forty-member governing board is not going to balance the pressure of strong provider interests, particularly when many consumers themselves have no information about alternative health care policies. Full implementation of the "broadly representative" standard would require more than token representation of the low-income and other major groups of health care consumers, and would create the potential for opening up health planning decisions to extensive public participation. In a few instances this potential has been realized. In Savannah, Georgia, for example, an active group of low-income consumers helped generate a widespread dialogue in the press, as well

402. *See id.* at 437-57, 479-85 (statements of Russell Henderson, Dr. Daniel S. Blumenthal, Willie Mitchell, and Melissa F. Greene).

403. *Id.* at 451.

404. *Id.* at 451, 456, 484-85.

405. *Id.* at 442-44.

406. *See id.* at 437-46, 455-57 (statement of Russell Henderson and Willie Mitchell); Administrative Complaint addressed to Harry P. Cain, director, HEW Bureau of Health Planning, and David Tatel, director, HEW Office of Civil Rights, by Memphis Area Legal Services, Inc., the National Health Law Program, and NAACP Legal Defense and Education Fund (Oct. 7, 1977), *reprinted in id.* at 517 (alleging "[d]enial of access to care to blacks and Medicaid recipients in Memphis, Tennessee by Saint Joseph's East and Methodist Central Hospitals").

as in the HSA, over a hospital's proposed relocation from a poor downtown area to a location adjacent to an existing county hospital, and this initiative resulted in the HSA's first decision against excess beds and duplicative services.[407] Extensive public participation in the hospital relocation decision also led to a consumer coalition slate that won half the seats on the governing board.[408] Similar efforts at consumer mobilization have occurred in other states, notably Arkansas and Illinois.[409]

HEW could play an important role in supporting consumer efforts to further the substantive goals of the Act. The federal agency has the primary responsibility for regulating the HSAs and has begun, under consumer pressure, to prohibit some exclusionary practices and require that information be made available to the public. As discussed above, HEW could go further by mandating various types of outreach and publicity measures and by ensuring that HSA consumer members receive adequate staff support to enable them to participate effectively.

The courts also have an important role in reviewing HEW's standards and procedures, regarding consumer representation. Clear articulation and application of the structural due process doctrines would help to prohibit the most egregious exclusionary devices and to preserve the option for more widespread popular involvement. The existing evidence indicates that such involvement is crucial to achievement of the goals of the Health Planning Act, both because strong consumer organizations with knowledge of alternate modes of health care delivery are needed to counteract provider influence, and also because popular understanding and acceptance is essential for major change in a personal service such as health care. To the extent that the techniques of structural due process can help promote agency support for consumer independence and influence, they can increase the range of choice in the development of health care policy.

407. *See 1978 Senate Hearings, supra* note 312, at 482 (statement of Melissa F. Greene).
408. *Id.* at 483-84.
409. *See* Arkansas ACORN, *ACORN Plan Endorsed: An Organizing Success Story*, HEALTH L. PROJECT LIB. BULL., Oct. 1977, at 15-16 (reporting success of Arkansas ACORN, a citizens' organization, in persuading the Central Arkansas HSA to adopt plan making 24-hour, 7-day-a-week clinics "number one priority" of Central Arkansas HSA); Giarizzo & Daley, *A Report on Health Care Consumer Organizing in Illinois—The Association of Health Care Consumers*, HEALTH L. PROJECT LIB. BULL., Dec. 1977, at 18 (success of consumer organizers in Illinois).

V. Conclusion: Participatory Structures of Decisionmaking

The Hill-Burton, Medicaid, and Health Planning Acts were attempts by Congress to deal with serious problems in American health care delivery. In each instance, Congress perceived the issue in both economic and political terms: consumers, particularly those with low incomes, lack the economic means to obtain needed care of adequate quality in the private health care market and the political means to secure effective regulatory and financial measures from state and local government. In each context, lower levels of government, as well as the private sector itself, had responded to a limited extent to consumer needs—with public hospitals and private charitable care in the 1940s, small state and local welfare medicine programs in the 1950s and early 1960s, and predominantly voluntary health planning programs in the middle and late 1960s. Although some of these efforts were worthwhile, they varied enormously in their effects among and within localities and were characterized by standardless decisionmaking about the amount of resources committed and the allocation of those resources among potential beneficiaries. As a result, consumer interests were routinely subordinated to the institutional, budgetary, and professional concerns of the hospitals and welfare agencies, with no public review of the nature and basis of the choices made. Each congressional program was a response to the perceived weaknesses in health care policy resulting from the lack of public standards: uneven geographical distribution of hospitals and inadequate care for low-income patients (Hill-Burton), inadequate government health care benefits for welfare recipients and other low-income persons (Medicaid), and inappropriate, often duplicative, capital investment in health care technology at the expense of essential primary care (health planning).

The congressional response to these problems has not been to abolish or to alter radically the frontline institutions—hospitals, state and local welfare agencies, and health planning programs—but rather to attempt to enlarge their scope and to reform their operations through conditional grants of federal funds. In each case, the Congress tried to change established patterns of standardless decisionmaking into more structured systems of choice in which the interests of politically weak consumers would be taken into account. Thus, in the Hill-Burton program, the traditions of private philanthropy and institutional charity were to be integrated into a "state plan" for adequate hospital care. Similarly, the historically fragmented patterns of state and local wel-

fare medicine were to be rationalized into state Medicaid programs under federal supervision, and federally guided health planning was to create a countervailing force of consumer representatives to bring capital investment and resource allocation into line with defined national and local needs.

Carrying out such statutory schemes, however, has proved to be enormously difficult. The most immediate reason is that the theoretical beneficiaries of the programs—the poor and the general public—have always been much weaker in terms of organization, knowledge, and resources than the hospitals, state agencies, and health planning agencies that comprise the "regulated firms." Moreover, these private and state agencies are integral elements of the programs themselves, with considerable power over day-to-day operations and with strong support in Congress for their financial viability and political autonomy. The federal agencies at the top have thus been in the unenviable position of having to balance the often antagonistic interests of low-income consumers against the interests of powerful health care providers and state and local governments. The administrative agencies have had the task of reducing inequality of resources and power, while simultaneously responding to the pressures of powerful interests to maintain and even strengthen their dominant position.[410]

The response of the federal agencies to this dilemma has been virtually to deny the existence of low-income consumers as program beneficiaries. As a practical matter, this has been accomplished in each of the three programs through nearly identical nonenforcement devices. The federal agencies routinely failed to develop operational standards to guide federal and state officials and private actors. Absent outside pressure, the agencies did not define criteria for determining whether a Hill-Burton hospital was providing a reasonable volume of free care, whether a state was providing an adequate amount, duration, and scope of Medicaid services, or whether an HSA governing board was broadly representative of its area's population. In a related fashion, the agencies repeatedly failed to collect relevant data that might have indicated the need for a more specific policy: the budgets that hospitals themselves claimed they devoted to charitable care, the results of the states' utilization review programs, or the demographic characteristics of the HSA governing boards. Even when the agencies

410. *See generally* R. UNGER, *supra* note 24, at 176 *passim* (discussing such tensions throughout the legal system); Tushnet, *A Marxist Analysis of American Law*, 1 MARXIST PERSPECTIVES 96 (1978) (same).

did collect pertinent information,[411] the "policy" branch of the agency seemed to have no impact on the "operations" branch, so that violations went uncorrected and operational decisions remained unchanged. Finally, even when the statute or regulations contained clear legal norms—such as the National Health Planning Act's requirement that HEW collect compliance data on Hill-Burton hospitals[412] or HEW's requirement that state Medicaid agencies consult their Medical Care Advisory Committees on major policy issues[413]—the agencies took no effective steps to enforce them.

When consumers challenged the legality of these nonenforcement devices, the federal agencies (together with state agencies and providers) responded by invoking neo-formalist modes of statutory interpretation. The core of the neo-formalist argument is that the purpose of the legislative scheme should be inferred from the large scope of discretion granted the federal agencies and from the absence of explicit remedies for consumers. From this perspective, the primary purpose of the statutes is to create an administrative bargaining relationship, rather than a substantive legal one, between the federal funding agency on the one hand, and the grantee hospital, state agency, or health planning program on the other. To be sure, consumers are meant to be beneficiaries of this relationship, but the nature and amount of that benefit is to emerge from bargaining between the federal agency and the grantee institutions.[414] The outcome of this bargaining, expressed in federal regulations, guidelines, and enforcement practices, is to be subject only to very limited judicial review to ensure compliance with clear statutory commands. Thus, neo-formalist analysis makes it a sufficient defense for an agency whose decision is challenged in court to show that it is not *required* by statute to grant a consumer's claim.

Under the structural due process approach, the focus of the judicial inquiry shifts from whether, for example, HEW is required to define health planning representation in the particular way requested by

411. *See* note 324 *supra.*

412. *See* 42 U.S.C. § 300*o*-1 (Supp. V 1975).

413. 42 C.F.R. § 446.10 (1977), *discussed at* p. 299 *supra.*

414. An argument by Hill-Burton grantee hospitals along these lines was made in Cook v. Ochsner Foundation Hosp., 319 F. Supp. 603, 604-05 (E.D. La. 1970). *See* T. Lowi, *supra* note 12, at 144 (legislation increasingly cast in form of instructions to administrators rather than commands to citizens; meaning of these instructions then subject of bargaining among organized interest groups); Cahn & Cahn, *The New Sovereign Immunity*, 81 Harv. L. Rev. 921, 929-57 (1968) (discussing impact of politics and discretion on agency-grantee relationship and lack of due process protections for politically weak grantee institutions as well as for consumer-beneficiaries).

consumers, to whether the agency has in fact exercised its discretion in accordance with the statute's substantive and procedural norms. From this perspective, agency nonenforcement practices involve a double violation of a more broadly conceived statutory purpose. First, the substantive results sought by Congress are pervasively frustrated: low-income patients are excluded from Hill-Burton hospitals because of their race and income, Medicaid recipients are unnecessarily deprived of needed services, and HSAs fail to promote primary care and nonduplicative hospital investment. Second, the process envisioned by Congress to resolve the often complex and difficult value choices does not come into existence: federal and state Hill-Burton agencies do not define standards of community service and free care in relation to hospital resources and community needs, state Medicaid agencies often do not consult with consumers and providers in identifying priorities and inefficiencies, and HSAs often are not broadly representative of the consumers in their communities. The substantive and procedural failures are closely linked. For example, the unrepresentative character of most HSA boards contributes to their frequent incapacity to promote the national health goals of consumer-oriented primary care.

In choosing between these two approaches in deciding claims of agency nonenforcement, the courts must interpret the legislative purpose in relation to the agency's own defense of its policies and procedures. As expressed in the neo-formalist mode, the agency's typical defense is simply that it has discretion—that the statute does not *require* it to accord consumers more participation, more definite standards, more detailed explanations, or more benefits. In every case discussed in this article, the agency's position consisted largely of asserting delegated authority and the absence of specific restraint.[415] In only two cases did the agency attempt to justify its policy with reference to substantive statutory goals.[416] This posture of nonexplanation, blanket discretion, and routine disregard of unorganized consumers is precisely what characterized the state, local, and private sys-

415. *See, e.g.*, Texas ACORN v. Texas Area 5 Health Sys. Agency, Inc., 559 F.2d 1019 (5th Cir. 1977); Saine v. Hospital Auth., 502 F.2d 1033 (5th Cir. 1974); Aldamuy v. Pirro, 436 F. Supp. 1005 (N.D.N.Y. 1977); Cook v. Ochsner Foundation Hosp., 319 F. Supp. 603 (E.D. La. 1970).

416. *See* Dodson v. Parham, 427 F. Supp. 97 (N.D. Ga. 1977) (agency justification of drug formula reduction as meeting standard of medical necessity); Corum v. Beth Israel Medical Center, 373 F. Supp. 550, 554-57 (S.D.N.Y. 1974) (agency justification of limiting free care obligation to "maximum compliance" guidelines for 20 years after Hill-Burton grant).

tems of health care delivery and planning that predated the three statutes and that Congress attempted to reform.

The agency defense that the statutes do not require a particular result may be correct, but it is also beside the point; the legislative purpose is in large part not to specify particular results, but rather to create an agency process that takes into account the interests of the relatively unorganized health-care consumers. The Hill-Burton Act, for example, does not contain a formula defining the balance between a hospital's financial integrity and a consumer's need for free and below-cost care. But it does require grantee hospitals to provide a significant amount of services to low-income consumers and creates a public, administrative process for regulating the amount and nature of the services given.[417] The *minimal* statutory duty of the administering agencies, therefore, is to develop regulations and an enforcement procedure that reflect at least *some* consideration of the applicable values and interests. This may seem like an elementary standard, but the federal and state Hill-Burton agencies have often failed to meet it. The second *Cook* opinion, in which Judge Comiskey ruled that HEW could not permit Hill-Burton hospitals to exclude Medicaid beneficiaries,[418] rests essentially on this ground. The federal agency itself had recognized that the issue was important and was appropriately addressed under the community service regulations, but, for no articulated reason, had persistently failed to issue any policy.[419] In these circumstances, Judge Comiskey was justified in ordering the Secretary of HEW to issue some policy with at least minimal protection for consumer interests.[420]

In the end, however, techniques of structural due process can only inform, but not substitute for, a fundamental judicial choice. Given our legal traditions, courts would obviously feel much more confident and legitimate in enforcing general statutory goals if Congress would

417. *See* pp. 267-68 (discussing community service and nondiscrimination requirements of Hill-Burton Act).

418. Cook v. Ochsner Foundation Hosp., 61 F.R.D. 354, 361 (E.D. La. 1972).

419. *See* Rose, *supra* note 3, at 178-79 (HEW acknowledged that issue of whether refusal of hospital to participate in Medicaid was breach of Hill-Burton obligations related to community service assurances, *see* 37 Fed. Reg. 14,719, 14,720 (1972), but did not formulate regulations on issue until two years later, *see* 39 Fed. Reg. 31,765, 31,767 (1974)).

420. HEW's failure to issue regulations or to take other action in response to well-documented complaints of widespread exclusion of Medicaid patients from Hill-Burton Hospitals in New Orleans, *see* Cook v. Ochsner Foundation Hosp., 61 F.R.D. 354, 361 (E.D. La. 1972), may well have amounted to what the Supreme Court has suggested is the "rare case" of agency abandonment of its enforcement function "that might justify review beyond the confines of the [Secretary's] reasons statement," Dunlop v. Bachowski, 421 U.S. 560, 574 (1975).

provide more definite standards for decision and more explicit remedies for consumer beneficiaries.[421] Since Congress has not done so, its intent is not "clear," and enforcement of statutory goals does not comfortably fit within traditional models of judicial application of legislative rules. On the other hand, Congress continues to articulate general statutory commitments in favor of unorganized interests and spends billions of dollars at least in part in an effort to fulfill them. Commitments of this magnitude cannot be ignored, but neither can they be unreservedly enforced; they are clear, but not clear enough,[422] and so tend to reproduce political ambivalence in the form of remedial incoherence and doctrinal contradiction. The techniques of structural due process cannot honestly be used to solve this dilemma by imagining neutrally applicable rules when none exist. Their value lies rather in enlarging the judicial role to include what seems to be an inevitable part of both legislative and judicial law in an era of major social change: the fashioning of a democratic process in which to continue the debate about basic social values and, indeed, to recognize that the debate is taking place.

421. Indeed, one of the major lessons of the health care reform experience is that Congress should define explicit standards and remedies in future legislation seeking to benefit unorganized interests.

422. *Cf. Form and Substance, supra* note 24, at 1773 n.158 (criteria of justice are sufficiently defined to orient search for relevant facts, but not intelligible enough to constitute formal system of *per se* rules).

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