

THE COMMUNITY SERVICE OBLIGATION OF HILL-BURTON HEALTH FACILITIES†

KENNETH R. WING*

Financial barriers to adequate medical care are no longer a problem faced by only low income Americans. Today, hospital bills sometimes amount to tens of thousands of dollars.¹ Indeed, annual per capita spending on medical care now exceeds \$1,000.² Even for those who can afford it, a typical medical insurance policy provides only limited coverage that ill-fits society's needs.³ As for the welfare recipient, the unemployed, or the working poor — people for whom access to medical care has always been difficult — adequate medical care is literally becoming financially inaccessible.

The problem of access to medical care in the United States, however, is only partially defined in financial terms. People who can afford to pay for medical treatment may find that other barriers to adequate health care exist. Many hospitals require patients to have a personal physician on the hospital's staff. Others demand pre-admission deposits before even emergency services are performed. The consumer with a Medicaid or Medicare card will find that for a variety of economic and non-economic reasons, many institutions are reluctant to provide government-sponsored care and some simply refuse altogether. In addition, discrimination against minorities, the handicapped, welfare recipients, and other "undesirables," continues disguised but unabated in medical care institutions as in other aspects of American life.⁴

Those who are denied medical care for financial reasons, or because of other institutional barriers, nevertheless may be guaranteed access to medical facilities which have received federal funds for construction or modernization. Legislation originally enacted by Congress in 1946⁵ initiated a federal spending program which provided funds for the capital development of a significant portion of the nation's hospitals and other health facilities.⁶ This program, com-

† Copyright © 1982 by Boston College Law School.

* Assistant Professor, School of Law and School of Public Health, University of North Carolina, Chapel Hill; J.D., Harvard Law School, 1971; M.P.H., Harvard School of Public Health, 1972. The author would like to express his thanks for the research assistance of third year law student Robert Strand.

¹ See generally Freeland, Colat, & Schlender, *Projections of National Health Expenditures, 1980, 1985, 1990*, 1 HEALTH CARE FINANCING REV. 1 (1980).

² *Id.* at 12.

³ For an excellent discussion of the nature and extent of private health insurance coverage, see A. SCHNEIDER, AN ADVOCATE'S GUIDE TO HEALTH CARE FINANCING 138-83 (1980).

⁴ See generally Institute of Medicine, National Academy of Sciences, HEALTH CARE IN A CONTEXT OF CIVIL RIGHTS (1981).

⁵ The Hospital Survey and Construction Act, Pub. L. No. 79-725, 60 Stat. 1040 (1946). This Act was the initial authorization for what has popularly been known as the Hill-Burton program. See text at notes 40-55 *infra* for a discussion of later amendments.

⁶ As a financing program, Hill-Burton was remarkably successful. By 1974, over five

monly known as the Hill-Burton program, was not intended only to provide funding for the construction and modernization of medical institutions. As the language of the authorizing legislation, its legislative history, and the overall structure of the program demonstrate, Congress also intended that medical services be provided in areas where they were especially needed and under conditions designed to carry out specified congressional objectives.⁷

Both in its original form and as it was amended in the following three decades, the Hill-Burton program was intended to achieve a number of changes in the allocation and availability of health facility services by conditioning receipt of federal funds on compliance with a variety of legislative conditions.⁸ Among the conditions explicitly included in the authorizing statute for the program was a provision imposing specific obligations on both the state agency administering the program and the recipient facility requiring the facilities to provide: (a) a reasonable volume of uncompensated services and (b) "community service," i.e., service to those who may be denied access to health care for reasons other than lack of financial resources.⁹ These "charity care" obligations, as the two requirements have been frequently labeled, were an integral part of the original legislative scheme, as reflected both in the declaration of purposes and throughout other provisions of the original legislation.¹⁰ Indeed, the language of the original charity care obligations was specifically amended into the original draft of the Hill-Burton legislation, apparently as part of a political compromise to ensure broad-based congressional support for the legislation, as will be explained in more detail below.¹¹ Moreover, as the Hill-Burton program expanded to include new funding mechanisms and additional categories of recipients, Congress continued to re-enact these obligations as pre-conditions to funding.¹² Even when Congress terminated the program in

billion dollars in grants and loans had been spent on the nation's health facilities, assisting over \$14.5 billion worth of construction and modernization projects. Cambridge Research Institute, *TRENDS AFFECTING THE U.S. HEALTH CARE SYSTEM 91-95* (1976) (commissioned by HEW). See also figures cited in S. REP. NO. 1285, 93d Cong., 2d Sess. 14-18 (1974), reprinted in 1974 U.S. CODE CONG. & AD. NEWS 7842-49.

Over 496,000 hospital and long term care facility beds received financial assistance through the Hill-Burton program, roughly equivalent to 40% of the nation's current acute care hospital bed supply. American Hospital Association, *HOSPITAL STATISTICS: 1979* (1980). As a major source of capital funds for hospitals and, to a lesser extent, other facilities, the federal Hill-Burton program played an important role in underwriting the development of the existing health care delivery system during three decades marked by rapid growth and systemic change. See Wing & Craige, *Health Care Regulation: Dilemma of a Partially Developed Public Policy*, 57 N.C. L. REV. 1165, 1169-72 (1979) [hereinafter cited as Wing & Craige].

⁷ See text and notes at notes 34-39 *infra*.

⁸ See text and notes at notes 36-50 *infra*.

⁹ See text at note 60 *infra* for the text of the statute.

¹⁰ See note 85 *infra*.

¹¹ See note 75 *infra*.

¹² The same requirements were imposed on recipients of funds under the expanded program established in 1954. See Public Health Service Act § 653(a), as amended by Pub. L. No. 83-482, § 2, 68 Stat. 461 (1954), later recodified along with preexisting § 633(f) in 1964. See notes 44-46 *infra*. For current codification, see 42 U.S.C. § 291c(e) (1978). The requirements were also

1974 the successor federal program attached virtually identical conditions¹³ on receipt of funds.¹⁴ Congress also explicitly mandated additional federal efforts to insure rigorous enforcement of the charity care obligations imposed by the original Hill-Burton program and the new program.¹⁵

attached to the recipients of assistance under the loan funding authorized in 1964, *see* Public Health Service Act § 610(a), *as amended by* Pub. L. No. 88-443, § 3, 78 Stat. 457 (1964), now *codified at* 42 U.S.C. § 291j(b) (1978); and under the loan, loan guarantee and interest subsidy programs established in 1970, *see* Public Health Service Act § 623(a), *as amended by* Pub. L. No. 91-296, § 201, 84 Stat. 346 (1970), now *codified at* 42 U.S.C. § 291j-3(a) (Supp. II 1978).

¹³ See notes 14 and 163 *infra*.

¹⁴ The National Health Planning and Resources Development Act of 1974 included two provisions that created charity care obligations virtually identical to those included in the original Hill-Burton legislation. Public Health Service Act § 1602(5), § 1604(b)(1)(J), *as amended by* Pub. L. No. 93-641, § 4, 88 Stat. 2259 (1974). There are, however, two differences between the charity care obligations imposed in 1974 and those that existed under Hill-Burton. First, § 1604(b)(1)(J) provides that "an application of any project shall set forth . . . reasonable assurance *that at all times* after such application is approved (i) the facility or portion thereof to be constructed, or modernized, or converted will be made available to all persons residing or employed in the area served by the facility . . ." (emphasis added). The expression "at all times" is not found in the Hill-Burton statutory language establishing the basis for the community service or uncompensated service obligations. Whether "at all times" was intended to have significance is not clear from the legislative history of the 1974 statute. The Department of Health, Education and Welfare (HEW), however, had taken the position that this language requires both charity care obligations to be imposed under the 1974 program for an unlimited duration, while the uncompensated service obligation of Hill-Burton facilities is limited to twenty years' duration. *See* 42 C.F.R. § 124.501(b) (1980).

Second, the definition of community service in § 1604(b)(1)(J) of the 1974 legislation requires availability to all persons "residing or employed" in the area of the facility, rather than merely persons "residing" in the area, as the statutory authorization of the Hill-Burton community service obligation.

Section 1602(5) was subsequently repealed by the 1979 health planning amendments, presumably to eliminate the slight differences between § 1602(5) and § 1604(b)(1)(J). *See* Pub. L. No. 96-79, § 201, 93 Stat. 633 (1979). Section 1604(b)(1)(J) was redesignated § 1621(b)(1)(K) and reauthorized by the same 1979 amendment. *Id.* at § 202. The net effect was that the charity care obligations of recipients under the new program established in 1974 were unchanged by the 1979 amendments and remained virtually identical to those imposed on recipients under the Hill-Burton program:

. . . an application for a medical facilities project . . . shall . . . set forth reasonable assurance that at all times after such application is approved (i) the facility or portion thereof to be constructed, modernized, or converted will be made available to all persons residing or employed in the area served by the facility, and (ii) there will be made available in the facility, or portion thereof to be constructed, modernized, or converted a reasonable volume of services to persons unable to pay therefor and the Secretary, in determining the reasonableness of the volume of services provided, shall take into consideration the extent to which compliance is feasible from a financial viewpoint.

42 U.S.C. § 300s-1(b)(i)(k) (Supp. III 1979).

¹⁵ Under Public Health Service Act § 1602(6), *as amended by* Pub. L. No. 93-641, § 4, 88 Stat. 2258 (1974), HEW was required to issue regulations prescribing the manner in which the assurances under both the Hill-Burton and the new 1974 program would be enforced and to collect data concerning compliance:

§ 160 z. The Secretary shall by regulation

. . . (6) prescribe the general manner in which each entity which receives financial assistance under this title or has received financial assistance title VI shall be

While the uncompensated service obligation has been a subject of controversy among the government, the hospital industry, and various consumer groups for more than a decade, the community service obligation prior to 1979 had been virtually ignored.¹⁶ In May of 1979, however, the Department of Health, Education and Welfare (HEW) issued revised charity care regulations. These regulations demonstrate for the first time that the federal government recognizes the Hill-Burton community service obligation as a distinct substantive obligation that the government is prepared to monitor and enforce in a rigorous way.¹⁷

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.

* * *

An entity subject to the requirements prescribed pursuant to paragraph (6) respecting compliance with assurances made in connection with receipt of financial assistance shall submit periodically to the Secretary data and information which reasonably supports the entity's compliance with such assurances. The Secretary may not waive the requirement of the preceding sentence.

Id. HEW later cited these provisions as a mandate to issue new charity care regulations and to federalize their enforcement in 1979. See notes 153-54 *infra*.

The 1974 legislation also authorized the withholding of payments to any recipients not complying with these assurances. Public Health Service Act § 1612(b), *as amended by* Pub. L. No. 93-641, § 4, 88 Stat. 2263 (1974). In addition, it mandated a greater federal enforcement effort for these assurances, set out a federal administrative procedure for adjudicating consumer complaints of non-compliance with the charity care obligations, and established a private right of action for complainants if action is not commenced by HEW within 60 days. Public Health Service Act § 1612(c), *as amended by* Pub. L. No. 93-641, § 4, 88 Stat. 2264 (1974).

These provisions were renumbered, and modified in the 1979 legislation. See Public Health Service Act § 1627, *as amended by* Pub. L. No. 96-79, § 202, 93 Stat. 634 (1979). The new § 1627, which incorporates the language of the preexisting § 1612(b) and (c) now reads:

Sec. 1627. The Secretary shall investigate and ascertain, on a periodic basis, with respect to each entity which is receiving financial assistance under this title or which has received financial assistance under title VI or this title, the extent of compliance by such entity with the assurances required to be made at the time such assistance was received. If the Secretary finds that such an entity has failed to comply with any such assurance, the Secretary shall report such noncompliance to the health systems agency for the health service area in which such entity is located and the State health planning and development agency of the State in which the entity is located and shall take any action authorized by law (including an action for specific performance brought by the Attorney General upon request of the Secretary) which will effect compliance by the entity with assurances. An action to effectuate compliance with any such assurance may be brought by a person other than the Secretary only if a complaint has been filed by such person with the Secretary and the Secretary has dismissed such complaint or the Attorney General has not brought a civil action for compliance with such assurance within six months after the date on which the complaint was filed with the Secretary.

42 U.S.C. § 300s-6 (Supp. III 1979).

The 1979 health planning amendments also strengthened the administrative tools available to enforce compliance with community service by providing that in making certificate of need decisions, health planning agencies can consider the extent to which "proposed services will be accessible to all residents of the area to be served by such services." See Public Health Service Act § 1532(c)(6), *as amended by* Pub. L. No. 96-79, § 116(f)(6)(E), 93 Stat. 613 (1979), codified at 42 U.S.C. § 300n-1 (Supp. III 1979).

¹⁶ See text at notes 137-52 *infra*.

¹⁷ These regulations were not the first specifically to recognize the community service

The principle underlying the requirement of community service as stated in the new regulations is that a health facility:

. . . shall make the services provided in the facility . . . available to all persons residing . . . in the facility's service area without discrimination on the ground of race, color, national origin, creed, or any other ground unrelated to an individual's need for the service or the availability of the needed service in the facility ¹⁸

As defined by the regulations, the community service obligation is far more than a proscription on discrimination in the usual sense of that term.¹⁹ Under the new regulations a hospital is required to accept virtually without exception anyone who is able to pay for medical services. Thus, people who do not have a physician on the facility's medical staff; people who "probably can pay" but do not have cash, credit, or third party payment available; Medicaid and Medicare recipients; and, at least by implication, the privately insured, would be assured access by the regulations.²⁰ The regulations leave little doubt as to the meaning and intent of the community service requirement since they include a series of illustrative examples of applications of the obligation.²¹ These examples indicate HEW's willingness to assert the community service obligation even in the face of time-honored admission practices.²²

Both the hospital industry and the medical profession have closed ranks in opposition to the enforcement of the community service requirement, and the American Hospital Association has brought suit to challenge the government's authority to issue the 1979 regulations.²³ If the protracted struggle over the

obligation. The significance of the new regulations derives from the fact that they clearly indicated an intent, for the first time, to monitor and enforce compliance. See notes 146-58 *infra*. The underlying substantive principles have been incorporated into the federal regulations at least since 1964. See notes 133-36 *infra*.

¹⁸ 42 C.F.R. § 124.603(a)(1) (1980). See text at notes 158-70 *infra* for further discussion of this principle.

¹⁹ The use of the term "discrimination" disguises the true meaning of these regulations somewhat. Among other things, the new regulations employ an "effects" test for measuring compliance. See 42 C.F.R. § 124.603(d) (1980). For a full discussion of this matter, see text at notes 164-70 *infra*.

²⁰ See note 174 *infra*.

²¹ See notes 173-80 *infra*.

²² 42 C.F.R. § 124.603(d)(1)-(3) (1980), cited in full text at note 172 *infra*. The explanatory material that accompanied the issuance of the regulations also clarified HEW's intent. See note 157 *infra*.

²³ The American Hospital Association (AHA) sought to enjoin enforcement of the 1979 regulations immediately following their enactment, arguing that the regulations exceeded HEW's statutory authority, conflicted with the Medicare conditions of participation, and violated its contractual rights. The district court denied plaintiff AHA a preliminary injunction, holding that it had not shown irreparable harm, that it had not demonstrated a reasonable likelihood of success, and that the balance of hardships favored denial of the injunction. *American Hosp. Ass'n v. Harris*, 477 F. Supp. 665, 668-69 (N.D. Ill. 1979), *aff'd*, 625 F.2d 1328, 1331-32 (7th Cir. 1980). The court of appeals affirmed in a brief opinion, giving little indication of the court's views on the merits. See 625 F.2d 1328, 1331-32 (7th Cir. 1980). Judge Pell in a dissenting opinion, however, exhaustively reviewed the merits of the case and indicated he was in agreement with many of the plaintiff's arguments. See *id.* at 1332-44. On remand, the district court upheld the validity of the 1979 regulations. *American Hosp. Ass'n v. Schweiker*,

Hill-Burton uncompensated service regulations is any indication of the controversy that lies ahead, the pending community service litigation is only the first of many judicial, administrative, and possibly, legislative confrontations between the hospital industry and other medical care providers, consumer groups, and state and federal government officials. Even if the federal government's authority to issue the 1979 community service regulations is upheld, it is unlikely that any single judicial determination can definitively settle the seemingly endless array of jurisdictional,²⁴ procedural,²⁵ and substantive issues that rigorous enforcement of community service will eventually raise.²⁶ If, as is likely, future federal administrations revise the federal posture on the regulations or their enforcement, a reshuffling of strategies and another round of challenges by all affected parties will undoubtedly ensue.²⁷

Although the charity care obligations of Hill-Burton hospitals have been repeatedly examined by judicial and administrative tribunals during the last ten years, such review has tended to focus on the uncompensated service, not the community service, obligation.²⁸ Even those courts which have purported to interpret both obligations have generally viewed community service and uncompensated service as deriving from parallel bases, ignoring or failing to appreciate the distinct statutory basis and administrative history of the community service obligation.²⁹ The legal literature concerning the Hill-Burton charity

No. 78C 2269, N.D. Ill., Jan. 8, 1982.

²⁴ See notes 159 and 163 *infra*.

²⁵ The enforcement procedures and methods for determining compliance have been only generally outlined in the 1979 regulations. Subsequent to the regulations, HEW (later HHS) issued a series of draft policy directives to federal and state agencies and to affected institutions outlining compliance and assessment procedures. Most of these directives have been codified into a looseleaf manual available from regional HHS offices. PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, COMPLIANCE STANDARDS MANUAL: UNCOMPENSATED CARE AND COMMUNITY SERVICE OBLIGATIONS (first published in 1979) (also known as "Provider's Guide").

²⁶ See note 164 *infra*. Even if the regulations or enforcement policies are not changed during the current administration other federal policy shifts could have considerable impact on the meaning of the community service regulations. For example, should the Medicaid program be restructured to represent something less than "reasonable cost" reimbursement, see note 178 *infra*, then the notion that a Medicaid recipient has the ability to pay might require modification.

²⁷ As of this writing, federal administrative officials have announced their intention to continue to enforce the charity care regulations. It is not clear, however, whether the 1979 regulations will be revised. See *Washington Report on Medicine and Health*, January 18, 1982 at 3.

²⁸ This is not to say that there has not been some judicial examination of the community service obligation. See cases cited at note 29 *infra*. But it is clear that the initial round of charity care litigation focused primarily on uncompensated service, see note 141 *infra*, and to the extent that derivative issues were pursued vigorously by the various proponents, it appears that the uncompensated service obligation was the primary focus of all concerned. See, e.g., *Corum v. Beth Israel Medical Center*, 373 F. Supp. 550 (S.D.N.Y. 1974). Obviously this is in part a reflection of the government's enforcement efforts. See text at notes 141-45 *infra*, summarizing the various attempts to establish an "uncompensated service" enforcement program.

²⁹ Only a few federal district courts have directly addressed community service in any detail. See *Cook v. Ochser Found. Hosp.*, 61 F.R.D. 354, 356-58 (E.D. La. 1972); *Perry v. Greater Southeast Wash. Community Hosp. Found.*, No. 721-71, 2-11 (D. D.C. June 28, 1972) (see explanation at note 146 *infra*). See also *American Hosp. Ass'n v. Harris*, 625 F.2d 1328,

care obligations suffers from the same shortcoming. Though there has been substantial debate over the meaning and history of the Hill-Burton charity care obligations, the debate has been almost myopically focused on uncompensated service.³⁰

This article focuses squarely on the community service provision and the regulations promulgated thereunder. The analysis traces the statutory and regulatory history of the community service obligation and examines the scope of the discretion that has been delegated to federal and state agencies to define and enforce this obligation. The discussion begins with a brief history of the original Hill-Burton program and the several amendments and modifications of the program over the last several decades. Next, the legislative history of the community service obligation is examined in an effort to determine the scope of authority created by Congress in establishing the community service obligation. Specifically, this section addresses the questions of whether Congress intended the community service provision to impose an affirmative obligation upon funded facilities, and whether the requirement is one of general availability of medical services or simply a prohibition on racial discrimination. An examination of the regulatory history of the community service obligation follows, including a discussion of the 1979 regulations themselves. This section also addresses the questions of whether the 1979 regulations exceed the scope of authority as defined by previous regulations, and whether enforcement of the 1979 regulations has a retroactive effect which results in an unconstitutional impairment of contract and property rights. It will be submitted that the present community service regulations are indeed authorized by Congress and that retroactive application of the regulations, at least back to 1964, neither exceeds the scope of authority as set out previously by statute or regulation, nor unconstitutionally impairs contract or property rights.

I. BACKGROUND OF THE HILL-BURTON PROGRAM

The Hospital Survey and Construction Act of 1946,³¹ the initial authorization for the Hill-Burton program, was a significant departure from

1342-43 (7th Cir. 1980) (Pell, J., concurring and dissenting).

³⁰ See Rose, *Federal Regulation of Services to the Poor Under the Hill-Burton Act: Realities and Pitfalls*, 70 NW. U.L. REV. 168 (1975) [hereinafter cited as Rose]; Rosenblatt, *Health Care Reform and Administrative Law: A Structural Approach*, 88 YALE L.J. 243, 265-86 (1978) [hereinafter cited as Rosenblatt]; Note, *Due Process for Hill-Burton Assisted Facilities*, 32 VAND. L. REV. 1469 (1979) [hereinafter cited as Vanderbilt Note]; Note, *The Hill-Burton Act, 1946-1980: Asynchrony in the Delivery of Health Care to the Poor*, 39 MD. L. REV. 316 (1979) [hereinafter cited as Maryland Note].

These commentators generally have analyzed the statutory bases for the charity care obligations as if uncompensated service and community service had a single legislative history. They have also addressed the problem as if it were primarily a matter of inferring congressional intent in 1946. As this article will demonstrate, the proper inquiry should view community service as a related but distinct obligation, and the legislative analysis should involve at least two inquiries, one focusing on the 1946 legislation and the other on the 1964 legislation. See text at notes 56-129 *infra*.

³¹ Pub. L. No. 79-725, 60 Stat. 1040 (1946).

previous federal policy and clearly represented the first major federal investment in mainstream medical care.³² In the three decades that followed, it was one of the principal vehicles through which the federal government became actively involved in the development and distribution of health care resources. While mild in comparison to some of the state and federal health financing and regulatory programs which would follow in ensuing decades, the Hill-Burton program laid the groundwork for many of these later efforts and initiated a new and active role for both federal and state government in health care delivery.³³

The original 1946 legislation established a complicated administrative scheme under which federal financial assistance was provided to state governments³⁴ to survey the need for health facility services and to develop a state plan for the construction of hospitals and related facilities.³⁵ Public and non-profit applicants that conformed to the federal and state requirements were

³² Prior to Hill-Burton, the federal government had maintained a limited role in the delivery of medical care, chiefly through programs of direct services to federal dependents, e.g., the merchant marine, Indians, and military service personnel and their dependents. In addition, the federal government had traditionally carried out a variety of federal public health and disease prevention programs. For a good history of these activities, see Chapman & Talmadge, *Historical and Political Background of Federal Health Care Legislation*, 35 L. & CONTEMP. PROB. 334 (1970). See also Wing & Siltan, *Constitutional Authority for Extending Federal Control Over the Delivery of Health Care*, 57 N.C.L. REV. 1423, 1440 n.74 (1979) [hereinafter cited as Wing & Siltan].

Nor did Hill-Burton mark the first time the federal government had subsidized health facility construction. See programs described in Feshback, *What's Inside the Black Box: Allocative Politics in the Hill-Burton Program*, 9 INT. J. HEALTH SERVICES 313, 317 (1979). See also COMMISSION ON HOSPITAL CARE, *HOSPITAL CARE IN THE UNITED STATES* 531 (1947). The significance of the Hill-Burton program was its enormous cost relative to the cost of previous programs and its initiation of direct federal involvement in the delivery of medical care to the public at large. For a discussion of the political implications of this sudden shift in federal policy, see notes 63-64 *infra*.

³³ For an overview of the Hill-Burton program and its role in the emergence of federal and state health care financing and regulatory efforts, see Wing & Craige, *supra* note 6, at 1187; see also A. SOMERS, *HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY* 132-51 (1969) [hereinafter cited as SOMERS].

³⁴ See generally Public Health Service Act §§ 612, 623, as amended by Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946).

The amount of federal funds for direct grants and, later, loans allotted to each state was determined by a complicated formula based on each state's population, financial need (according to per capita income), and the need for facilities. As the program was reauthorized and amended, this formula was revised in several minor ways. For example, in 1970 a "floor" was placed under each state's allotted share. Public Health Service Act § 602(a), as amended by Pub. L. No. 91-296, § 103, 84 Stat. 338 (1970). But throughout the program each state's share was determined primarily on the basis of population, relative income, and need. For current codification, see 42 U.S.C. § 291b (1976). For an analysis of this allocation formula and its impact on the program's results, see Lawrence, Clark, Field & Koontz, *The Impact of Hill-Burton: An Analysis of Hospital Bed and Physician Distribution in the United States, 1950-70*, 18 MEDICAL CARE 532, 541-44 (1980).

³⁵ The original legislation earmarked Hill-Burton funding for hospitals and public health centers. It allowed the funding of projects for other health facilities, but only when operated in connection with a hospital. See Public Health Service Act §§ 622, 631, as amended by Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946). Subsequent amendments allowed funding of other categories of facilities. See notes 42, 49 and 50 *infra*.

eligible for federal construction grants.³⁶ In addition to the federal planning requirements, participating states had to establish programs to maintain the quality and safety of funded projects³⁷ and meet a variety of other federal requirements in the administration of their survey and planning activities.³⁸ Similarly, funded projects had to meet relatively extensive federal requirements relating to standards of construction, operation, maintenance and financial viability, as well as conform to the priorities established by the state plan.³⁹

Although the basic administrative structure remained the same throughout the history of the program, the original authorizing legislation was amended frequently by Congress, adding new categories of funding recipients,⁴⁰ supplementing the grant program with authorization for loans, loan guarantees, and loan interest subsidies, and reflecting a changing — and, apparently, ever growing — list of congressional priorities.⁴¹

In 1954, for example, the program was expanded by authorizing Hill-Burton grants to various categories of health facilities not included in the original legislation, such as nursing homes, rehabilitation facilities, and other

³⁶ Hill-Burton grants did not pay the full cost of approved projects. The original legislation established a program of direct grants, limited to 33 1/3 % of the cost of the project. Public Health Service Act § 625(b), as amended by Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946). In 1949, the federal share was increased to no more than 66 2/3 % or no less than 33 1/3 %. Pub. L. No. 81-380, § 3, 63 Stat. 899 (1949). This share remained essentially unchanged thereafter. However, the 1970 amendments authorized states to pay 90% of certain "high priority" projects. Pub. L. No. 91-296, § 113(b)(4), 84 Stat. 341 (1970). For current codification, see 42 U.S.C. §§ 2910(b)(2), 2910(b)(4) (1978). Note also that subsequent amendments to the Hill-Burton program allowed recipients to receive both a grant and a loan. See note 43 *infra*.

³⁷ States were not specifically required to establish licensing programs for health facilities, but were required to establish licensing programs for health facilities, to "provide minimum standards . . . for the maintenance and operation of hospitals which receive Federal aid. . . ." See Public Health Service Act §§ 623(a)(7), 623(d), as amended by Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946). For current codification, see 42 U.S.C. § 291d(a)(7) (1978). Under this authority, federal regulations were issued interpreting this provision that included 32 pages of detailed standards for construction and equipment for funded health facilities. These regulations were, in effect, de facto federal licensing standards. See 42 C.F.R. § 53, Appendix A (1949). The result was that many states established licensing programs for all hospitals and other health facilities as a result of the original Hill-Burton legislation. See SOMERS, *supra* note 33, at 118-32.

³⁸ Public Health Service Act §§ 612, 622, 623, as amended by Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946). For current codification, see 42 U.S.C. § 291d (1978). For example, states were required to establish merit systems for employees in the administration of their planning and survey activities. 42 C.F.R. § 53.158 (1949 ed., Supp. I).

³⁹ See Public Health Service Act §§ 622, 625, as amended by Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946). For current codification, see 42 U.S.C. § 291d(a)(5)-(7) (1978).

⁴⁰ See notes 42, 49 and 50 *infra*.

⁴¹ In addition to the supplemental financing mechanisms added later to the Hill-Burton program, see note 43 *infra*, and the various shifts in the programs priorities, see notes 45-50 *infra*, funding for a variety of related activities was frequently amended into the authorization for the Hill-Burton program. See, e.g., the various research and demonstration grants authorized in 1949, Pub. L. No. 81-380, § 5, 63 Stat. 900, or those added in 1961, Pub. L. No. 87-395, § 4, 75 Stat. 825.

long-term care facilities.⁴² In 1958, amendments allowed states to make loans as well as grants to health facilities out of their allotted funding.⁴³

The Hospital and Medical Facilities Amendments of 1964⁴⁴ added several substantive changes to the explicit and underlying objectives of the program,⁴⁵

⁴² The 1954 legislation supplemented the hospital construction program by establishing a separate funding program for diagnostic or treatment centers, chronic disease hospitals, rehabilitation facilities, and nursing homes. Public Health Service Act §§ 651-54, *as amended by* Pub. L. No. 83-482, § 2, 68 Stat. 461 (1954). These separate programs were later consolidated in the recodification of the Hill-Burton legislation in 1964. See note 45 *infra*.

The 1970 amendments, described in notes 49-50 *infra*, also expanded the types of projects that could be funded, including projects for new equipment not associated with construction projects, and projects for emergency and related services, and added a "laundry list" of special priorities, e.g., projects which have special significance for the treatment of alcoholism.

Thus, in the span of three decades, the Hill-Burton program evolved from a program of rather narrow statutory focus, funding the construction of new hospitals, to a vehicle for providing federal financial assistance for a variety of capital and other expenditures by health care providers.

⁴³ Amendments to the Hill-Burton program in 1958 authorized states to give loans for the construction of health facilities out of their allotments, but this was apparently intended to apply only in the case of religious-affiliated institutions that had conscientious objections to receiving grants from the federal government. Public Health Service Act §§ 661-664, *as amended by* Pub. L. No. 85-589, 72 Stat. 489 (1958). See S. REP. NO. 1846, 85th Cong., 2d Sess., *reprinted in* 1958 U.S. CODE CONG. & AD. NEWS 3255, 3255.

In 1961, this loan authorization was extended without reference to religious institutions in the legislative history, and the authorization was increased from \$30 million to \$50 million a year. Pub. L. No. 87-395, §§ 6, 8, 75 Stat. 826, 827 (1961). In lieu of a separate authorization for loans, the 1964 amendments allowed states to make loans to applicant facilities out of their allotments for grants, under the same terms and conditions as they make grants. Public Health Service Act § 610, *as amended by* Pub. L. No. 88-443, § 3, 78 Stat. 457 (1964). For current codification, see 42 U.S.C. § 291j (1978).

The 1970 amendments created two separate loan programs. The first program authorized: (1) loan guarantees and interest subsidies for private non-profit applicants and; (2) loan guarantees without interest subsidies for public applicants. This program was for either construction or modernization of projects of any type allowed under the legislation. See *generally* Public Health Services Act §§ 621-626, *as amended by* Pub. L. No. 91-296, § 201, 84 Stat. 344 (1970).

The second loan program created by the 1970 amendments authorized a direct loan program for public applicants for construction or modernization projects of any kind permitted under the legislation. See *generally* Public Health Service Act §§ 631-638, *as amended by* Pub. L. No. 91-296, § 301, 84 Stat. 350 (1970).

Among other essential differences between these programs and earlier authorizations for loans, applicants under the 1970 loan programs could receive Hill-Burton grants and also receive loan guarantees and subsidies for the remaining cost of the project. As noted above, the loan guarantees and direct loan programs established in 1970 significantly expanded the program; \$2.4 billion in loan guarantees and \$750 million in direct loans were authorized, more than double the 1970 authorization for direct Hill-Burton grants. For current codification of these loans programs, see 42 U.S.C. § 291j-1 (1978).

⁴⁴ Pub. L. No. 88-443, 78 Stat. 447 (1964). These amendments reorganized and recodified the statutory authorization of the Hill-Burton program, and made many substantive changes as well. See notes 45-46 *infra*.

⁴⁵ In addition to emphasizing the funding of modernization projects and other major policy changes, see note 46 *infra*, the 1964 amendments gave priority to "facilities serving densely populated areas," adding to the list of program priorities that had previously included rural areas with relative small financial resources. In 1970, however, Congress de-emphasized services to rural areas, making it a priority at the option of the state, and gave highest priority to modernization projects in urban poverty areas. Pub. L. No. 91-296, § 110, 84 Stat. 339 (1970).

The 1964 amendments also authorized for the first time federal funding of areawide

among them a requirement that a substantial portion of the hospital appropriations be spent for modernization projects — a significant shift in the program's policy.⁴⁶ The 1964 amendments also greatly expanded authorization for loans.⁴⁷

In 1970, Congress again revised and expanded the loan program, creating additional programs of direct loans to public applicants as well as a program of loan guarantees and interest subsidies for private non-profit applicants to supplement the grant program.⁴⁸ The 1970 amendments also, for the first time,

health planning agencies, albeit on a modest scale; \$2.5 million for 1965; \$5 million for each of the next four years. Pub. L. No. 88-443, § 2, 78 Stat. 447 (1964). However, this authorization was superceded by the health planning program authorized under the Partnership for Health Amendments of 1967, Pub. L. No. 90-174, 81 Stat. 533 (1967), and was never fully implemented.

⁴⁶ See Public Health Service Act §§ 605, 606, as amended by Pub. L. No. 88-443, § 3, 78 Stat. 454 (1964), now codified as 42 U.S.C. § 291(f) (1976).

While the original legislation theoretically allowed for the funding of both new construction and modernization, that legislation specifically required that priority be given to new construction projects in rural areas and in areas with few financial resources. The initial regulations also implied an administrative preference for "additional capacity" over "replacement." See 42 C.F.R. § 53.43 (1949). As a consequence, most of the funding went to projects for new construction and, generally, new hospital construction. By 1964 the Hill-Burton program had funded 7,306 new construction projects, assisting in the construction of 311,000 inpatient hospital beds in 2,011 health facilities at a cost of \$6.7 billion. See S. REP. NO. 1274, 88th Cong., 2d Sess. 2, reprinted in 1964 U.S. CODE CONG. & AD. NEWS 2800, 2800-01.

However, the 1964 amendments and all subsequent authorizations specifically earmarked a large portion of the program funds for modernization and, in effect, the 1964 legislation shifted the emphasis of the program from new facility construction to modernization. In terms of dollar amounts, the 1964 legislation authorized a total of \$840 million to be appropriated over the following five years for hospitals and public health centers. Of this amount, \$680 million was designated for construction and \$160 million was designated for modernization projects. However, up to \$530 million of the grant funds could be transferred to modernization projects, at the option of each state. States could also transfer up to \$70 million from modernization to new construction. Pub. L. No. 88-443, § 602, 78 Stat. 448 (1964).

In comparison, the 1964 legislation also authorized a total of \$350 million for the construction of long-term care facilities, \$100 million for the construction of diagnostic or treatment centers, and a total of \$50 million for the construction of rehabilitation centers. See S. REP. NO. 1274, 88th Cong. 2d Sess. 1-2, reprinted in 1964 U.S. CODE CONG. & AD. NEWS 2800, 2800-01.

By 1969, only 25% of the program funds were being spent for new construction projects; apparently the states had opted to shift the bulk of their Hill-Burton allotments to modernization. See S. REP. NO. 657, 91st Cong., 2d Sess. 9, reprinted in 1970 U.S. CODE CONG. & AD. NEWS 3332.

When the program was reauthorized in 1970, the need for the modernization of existing hospital and long-term care beds was described as the "nation's gravest health facility problem" and there was estimated to be a need for modernizing or replacing 455,130 acute and long-term beds at a cost of \$1 billion dollars, i.e., an investment nearly equal to the entire expenditures that had been assisted under the grant program prior to 1970. *Id.* at 6, reprinted in 1970 U.S. CODE CONG. & AD. NEWS at 3338.

The 1970 authorizations reflected these findings and the program's growing focus on modernization financing: \$920 million was authorized for construction of hospitals and public health centers, \$515 million for modernization, and \$155 million for construction of other types of health facilities, with slight changes in the options for shifting funds from one category to another. See Public Health Service Act § 601, as amended by Pub. L. No. 91-296, §§ 101-102, 84 Stat. 337 (1970).

⁴⁷ See note 43 *supra*.

⁴⁸ See note 30 *supra* for a description of these programs.

authorized Hill-Burton assistance for freestanding clinics and ambulatory care facilities,⁴⁹ and for the construction or modernization of emergency rooms and related services.⁵⁰

In 1974 appropriations for the Hill-Burton program were discontinued and the program was effectively replaced by the enactment of the National Health Planning and Resources Development Act.⁵¹ The new legislation essentially reorganized several existing federal activities, including the Hill-Burton program, into a single health planning program.⁵² The new program authorized federal funding for the construction of health facilities in a manner similar to the Hill-Burton program, but with a significantly different emphasis and with the authority carried out in conjunction with other related resource planning activities by newly created state health planning programs.⁵³ While Congress continued to authorize federal assistance for the construction of health facilities under the new Act, it has not yet appropriated funding for this part of the program. Given the political realities of the 1980's,⁵⁴ it appears unlikely that the kind of federal support for health facility construction or modernization that had been available under Hill-Burton will be forthcoming in the foreseeable future.⁵⁵

From its beginning, then, the Hill-Burton Act represented the efforts of Congress to use funding incentives to influence the construction and

⁴⁹ Public Health Service Act § 621(a), as amended by Medical Facilities Construction and Modernization Amendments of 1970, Pub. L. No. 91-296, § 201, 84 Stat. 344 (1970).

⁵⁰ 1970 amendments authorized \$20 million for three years for grants for the construction or modernization of emergency rooms, communication networks, or transportation systems. Public Health Service Act § 601, as amended by Pub. L. No. 91-296, 84 Stat. 350 (1970).

⁵¹ Pub. L. No. 93-641, 88 Stat. 2225 (1974), codified at 42 U.S.C. § 300k *et seq.* (Supp. III 1979).

⁵² For an explanation of this legislation and its background, see Wing & Craige, *supra* note 6, at 1190-92.

⁵³ The new legislation authorizes resources development grants and loans, 42 U.S.C. §§ 3000-300t-14 (Supp. III 1979) but the statute outlines a slightly different set of funding priorities, *see* §§ 300q(a)(1), 300r(a) and (b), than those of the original Hill-Burton program. Furthermore, the new scheme consolidates the resource development funding with other regulatory and planning functions performed by newly-created health systems agencies and state health planning programs. *See* 42 U.S.C. § 300s-1(b)(1)(A) (Supp. III 1979).

⁵⁴ Estimates vary, but there is general agreement that an excess of hospital capacity exists in this country, *see* Wing & Craige, *supra* note 6, at 1177-78, an excess created at least in part by the financial incentives of the Hill-Burton program. Thus, there is unlikely to be much political support for the continuation of federal financial assistance for health facility construction. Hospitals and other health facilities have generally turned to other sources for their capital funds. *See* Hilferty, *Capital Financing For Hospitals: The New York Experience*, 57 N.C. L. REV. 1383, 1384-85 (1979).

Ironically, recent congressional amendments to the 1974 planning legislation allow for federal financial assistance to convert or discontinue use of health facility assets, a program which might be labeled a "reverse Hill-Burton program." *See* National Health Planning and Resources Development Act of 1979, Pub. L. No. 96-79, 93 Stat. 634, codified at 42 U.S.C. § 300k *et seq.* (Supp. III 1979).

⁵⁵ For a relevant discussion of the shift in federal health policy which has resulted in this reluctance to provide further federal funding of health facility construction, *see* Wing & Siltan, *supra* note 32, at 1428-35.

maintenance of the nation's health facilities in accordance with congressional objectives. As mentioned above, one of those objectives is the requirement of community service imposed upon funded facilities. To illustrate the substance of that requirement, it is necessary to examine the legislative history of the program.

II. ANALYSIS OF THE LEGISLATIVE HISTORY

In analyzing the legislative history of the statutory language authorizing Hill-Burton community service obligation, two questions of fundamental importance must be addressed: (1) whether Congress intended to impose an affirmative obligation on recipient facilities to provide community service, and (2) whether Congress intended the community service obligation to require general availability of services or only to prohibit racial discrimination. Both of these questions require an analysis of the text and legislative history of the original 1946 enactment, as well as the subsequent amendments to the original authorizing legislation.

A. Did Congress Intend to Authorize Regulations Affirmatively Requiring Recipient Facilities to Provide "Charity Care" Services?

Previous commentary on the legislative and administrative history of charity care — commentary which has focused primarily on the meaning of the uncompensated service obligation⁵⁶ — has stimulated a lively debate over the nature and extent of the government's authority to enforce charity care obligations.⁵⁷ Among other things, critics of rigorous enforcement of charity care in general and of the 1979 regulations in particular have argued that the obligations as originally enacted were not meant to be substantive conditions affirmatively requiring recipient facilities to provide services.⁵⁸ Furthermore, relying

⁵⁶ See note 30 *supra*.

⁵⁷ See articles cited at note 30 *supra*.

⁵⁸ See Vanderbilt Note, *supra* note 30, at 1475-80; see also Maryland Note, *supra* note 30, at 318-25; American Hosp. Ass'n v. Harris, *supra* note 23.

The most extreme position is that taken by the Vanderbilt Note. The Note's analysis of the legislative history urges that the objective of the legislation — and not the means chosen to achieve it — was to finance only facilities, not services. Therefore, it is argued, Congress could not have intended the charity care provision to be interpreted to authorize regulations requiring recipient facilities to either provide uncompensated services or community service. See Vanderbilt Note, *supra* note 30, at 1475-76. See also Maryland Note, *supra* note 30, at 320-21.

This "facilities-not-services" argument is an unconvincing one. Even a cursory reference to the declaration of purposes, see note 85 *infra*, or the statutory provisions outlining requirements for the state plan or allocation of funds, see notes 34-39 *supra*, indicates that the objective of Congress was not to fund facilities per se. Both Notes also seem to ignore the regulatory conditions that accompanied state and recipient facility funding. See note 39 *supra*. Why would there be priorities, allocation formulas, and a requirement of determining need, if Congress was not concerned with services and the populations that needed them?

Further, the "facilities-not-services" argument in the Vanderbilt Note is based almost entirely on remarks made during the 1945 Senate hearings, remarks which preceded the inclusion of the "charity care" language in the statute. See note 73 *infra*. Even assuming the Senate

on the observation that Congress' original intent in establishing the Hill-Burton program was only to finance hospital *construction*, not hospital *services*, some critics have reasoned that the language of the charity care provision could not have been intended to impose substantive obligations on recipient facilities to provide either uncompensated service or community service. As one commentator phrased it, charity care was meant only to be a "spirited promise."⁵⁹

On its face, the text of the original statute authorizing the charity care regulations seems to refute the contention that Congress intended merely to make a "spirited promise." The charity care legislation, containing the language from which both the community service and the uncompensated service obligations are derived, provided, in its original form, that:

Within six months after the enactment of this title, the Surgeon General, with the approval of the Federal Hospital Council and the Administrator, shall by general regulation prescribe —

(f) That the State plan shall provide for adequate hospital facilities for the people residing in a State, without discrimination on account of race, creed, or color, and shall provide for adequate hospital facilities for persons unable to pay therefor. Such regulation may require that before approval of any application for a hospital or addition to a hospital is recommended by a State agency, assurance shall be received by the State from the applicant that (1) *such hospital or addition to a hospital will be made available to all persons residing in the territorial area of the application, without discrimination on account of race, creed, or color*, but an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group; and (2) *there will be made available in each such hospital or addition to a hospital a reasonable volume of hospital services to persons unable to pay therefor*, but an exception shall be made if such a requirement is not feasible from a financial standpoint.⁶⁰

hearing transcript reflected the interpretation that the Notes claim, reliance on these remarks as the basis for determining the congressional intent in an amendment subsequently added is questionable. See notes 75-76 *infra*.

Similarly, it is difficult to understand the confidence with which the Maryland Note claims that "a reading of the transcripts shows" that the Congress did not intend by the charity care provision to impose substantive obligations on Hill-Burton recipients. See Maryland Note, *supra* note 30, at 321. Given the dearth of congressional commentary on the meaning of the statutory language, an overall reading does not provide much guidance as to the congressional intent with regard to charity care, and, in particular, community service.

⁵⁹ See Vanderbilt Note, *supra* note 30, at 1479.

⁶⁰ Public Health Service Act, § 622(f), *as amended* by Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946) (emphasis added).

Note that an exception to the uncompensated care obligation was allowed in the original legislation if implementation was "not feasible from a financial standpoint." Public Health Service Act § 622(f)(2), *as amended* by Pub. L. No. 79-725, 60 Stat. 1041 (1946). This same exception is contained in all subsequent versions of the relevant provisions, even after the revisions in 1964. See note 45 *supra*. See 42 U.S.C. § 291c(e) (1976). Presumably, facilities could be allowed to waive the "community service" obligation if its implementation were not "feasible from a financial standpoint." In practice, however, no grantee has ever been permitted to waive the obligation. See Rose, *supra* note 30, at 170.

The plain meaning of the statutory language, then, foresees regulations requiring funded facilities to be "available to all persons" residing in the community (community service), and to provide a "reasonable volume of hospital services for those unable to pay therefor" (uncompensated services). In short, the legislation authorizes substantive conditions to be imposed upon recipient facilities.

Furthermore if the original legislation and its history are examined closely, and with exclusive concern for the meaning of the "available to all" language which creates the community service obligation, it is clear that critics have vastly oversimplified the statutory scheme and that Congress' intent with regard to community service cannot be so easily inferred. Indeed, despite the inclinations of various critics to find clarity where there is none,⁶¹ the specific meaning of the original "available to all" language may well defy definitive interpretation, however closely the legislative history is read.⁶² Yet it is difficult to read that history and conclude that Congress did not intend to impose an affirmative community service condition on recipient facilities, however it is specifically defined.

In analyzing the legislative history of the charity care provision, it must be noted that the political dimensions of the legislative process which led to the enactment of the original Hill-Burton program are also not easily characterized. Clearly the legislation was a result of the genuine — and apparently universal — concern in Congress that there was a shortage of hospital services in many parts of the country during the Depression and World War II.⁶³ But

⁶¹ See note 58 *supra*.

⁶² See text at notes 82-89 *infra*.

⁶³ Throughout the public health and legal literature, commentators have uniformly and repeatedly described the Hill-Burton program as a response to the shortage and maldistribution of hospitals and other health facilities recognized by Congress following the Depression and World War II. Indeed, a straightforward reading of the legislative history of the original Hill-Burton proposal would certainly indicate that there was general — virtually unanimous — agreement within Congress and in public opinion as to the pressing need for more hospitals.

Both in the congressional committee reports, S. REP. NO. 674, 79th Cong., 1st Sess. (1945); H.R. REP. NO. 2519, 79th Cong., 2d Sess., reprinted in 1946 U.S. CODE CONG. & AD. NEWS 1558, and in the floor debates, see, e.g., 91 CONG. REC. 11,713-17 (1945) (remarks of Sen. Hill); 92 CONG. REC. 10,211 (1945) (remarks of Rep. Whittington), frequent and unchallenged claims were made that many areas of the country had insufficient hospital services and that some areas had no hospital services at all. The committee reports even went so far as to estimate the number of Americans without access to hospital care, see, e.g., S. REP. NO. 674 at 41, and to estimate that if the proposed federal program spent \$75 million a year for five years that only 20% of the hospitals that would be needed would be built. *Id.* at 6.

As the proposal was considered by Congress, no one contested the need for additional hospital services and virtually no one disputed the need for remedial legislation. Despite the range of ideological differences that prevailed during the period, see note 64 *infra*, liberals and conservatives from both parties rallied support for the legislation.

There is no indication of any organized opposition to the proposition that there was a nationwide shortage of hospitals or to the call for remedial legislation. Though some provisions of the bill caused a series of lively skirmishes in committee and on the floor of both houses, they involved largely peripheral issues. There was some opposition from political conservatives who correctly anticipated that the Hill-Burton program would be just the beginning of even broader federal involvement in health care, e.g., 92 CONG. REC. 10,210 (1946) (remarks of Rep.

Hill-Burton was also the result of the interaction of a variety of diverse political forces which, for somewhat different purposes, converged in support of a single proposal. This observation must qualify any attempt to infer congressional intent from the legislation's political history.⁶⁴ On the other hand, while descriptions of the program's politics and their implication can vary, the legislative

Jensen), but these objections were repeatedly answered by the assertion that there was a shortage of hospitals created by World War II and the Depression, and neither private initiative nor local government could underwrite the necessary capital investment. *See, e.g.*, 92 CONG. REC. 10,209 (1946) (remarks of Rep. McCormack), 92 CONG. REC. 10,213 (1946) (remarks of Rep. Savage).

Remarkably unanimous support for the concept of a health facility construction program also came from the private sector. Throughout the legislative process the bill received the active support of the American Hospital Association, but see note 64 *infra*, the American Public Health Association, the American Medical Association (which had traditionally opposed any form of government involvement in medical care, *see* 92 CONG. REC. 10,208 (1946) (remarks of Mr. Bulwinkle)), and a host of other lobbyist and political groups. For a list of organizational sponsors, *see* H.R. REP. NO. 2519 at 3, *reprinted in* 1946 U.S. CODE CONG. & AD. NEWS 1560.

⁶⁴ A program to provide federal financial assistance for hospital construction was part of the legislative strategy of political forces from both ends of the political spectrum during the 1940's. Although once the Hill-Burton legislation had been submitted it moved through Congress with a speed that suggested a firmly-built political consensus, it is also clear that the proposal was the end-product of a long and hard-fought political struggle. In fact, the Hill-Burton program and the ease with which it was enacted may be best described in terms which emphasize that a health facility construction program was the single common ground among many ideological and political perspectives.

Several health care reform programs had been advocated by liberal New Dealers throughout the Roosevelt administration, including a number of proposals for a national health insurance program. *See generally* Falk, *Proposals For National Health Insurance in the USA: Origins and Evolution, and Some Perceptions for the Future*, 55 MILBANK MEMORIAL FUND Q. 161, 167-71 (1977). Throughout the Depression and World War II years, Senator Wagner of New York sponsored a series of health care reform proposals and jointly sponsored the Dingell-Murray-Wagner bill, variations of which were first proposed as early as 1939, *see, e.g.*, S.1620, 76th Cong., 1st Sess., *reprinted in* 84 CONG. REC. 10,983 (1939), which would have established a nationalized health insurance program, funding for the development of prepaid group practices, expansion of federal research and public health programs, and a program of financial assistance for the construction of health facilities.

While opposed to these broader reform measures, some political conservatives, eager to develop an alternative to President Roosevelt's New Deal politics and, later, the proposals of the Truman administration, attempted to forge a series of alternative health initiatives which called for programs which minimized federal involvement and relied more heavily on the private sector for delivery and financing of health care services. As early as 1939, Senator Taft from Ohio, a moderate Republican, proposed in a speech to the Cameron Medical Association the adoption of a federal hospital construction program — very much like the eventual 1946 legislation — arguing that it would be both good policy and a preferred alternative to the national health insurance proposals and other reform schemes proposed by Wagner and other liberals. *See* 84 CONG. REC. A3156 (1939).

The interplay of conservative and liberal ambitions nearly resulted in the establishment of a health facility construction program in 1940, when a program very similar to the eventual Hill-Burton proposal was passed by the Senate but died in the House. The bill was sponsored by Senators George and Wagner and actively supported by Senator Taft, with some objections, and other Senate Republicans. *See Hearings on S.3230 before the Senate Subcommittee of the Committee on Education and Labor*, 76th Cong., 3d Sess. 8-12 (1940). S.3230 was apparently the result of a proposal made earlier that year by President Roosevelt, *see* H.R. DOC. NO. 604, 76th Cong., 2d Sess. 1-3 (1940). Note also that this same section included a community service provision. Curiously, this same "community service" language was not included in the 1945 Hill-Burton proposal, but was amended to that proposal during committee deliberations, possibly at the in-

history of the original proposal,⁶⁵ is surprisingly short and straightforward, particularly with regard to the charity care provision and the portion of that provision which established the statutory basis for the community service obligation.

sistence of Senator Taft. See note 75 *infra*.

A similar proposal was also spawned by hearings held in 1944 before the Senate Subcommittee on Wartime Health and Education, chaired by Senator Pepper, later one of the principal actors in the consideration of the Hill-Burton proposal, which also documented a need for additional hospital services in this country and for remedial federal legislation. *Investigation of the Educational and Physical Fitness of the Civilian Population as Related to National Defense: Hearings on S. 74 before the Subcommittee on Wartime Health and Education of the Committee on Education and Labor*, 78th Cong., 2d Sess. 1873-74 (1944).

Apparently, by the end of World War II, the political debate in Congress centered principally on the scope and form of health reform legislation, not whether legislation in any form was appropriate. During this same period, representatives of the hospital industry, realizing their inability to secure private or local government sources to finance capital expansion, were also actively pursuing federal health legislation to assist health facility construction. In 1942 the American Hospital Association (AHA) sponsored the establishment of a private commission to study the future of the American hospital industry; after two years of study, the commission issued a report purporting to document a shortage of hospital facilities and urging a national survey and planned effort. COMMISSION ON HOSPITAL CARE, *HOSPITAL CARE IN THE UNITED STATES* (1947). Although the final report was not published until after the Hill-Burton program was enacted, the AHA-backed commission apparently worked closely with congressional representatives, see *id.* at 3-7, and it has been reported by several authorities that the commission and the AHA were influential in writing the first draft of the original Hill-Burton proposal. See SOMERS, *supra* note 33, at 133-34; Feshback, *supra* note 32, at 316-18. See note 70 *infra*. The commission and AHA representatives were also actively involved in the public debate over this program and some commentators have credited them with a substantial role in the behind the scenes maneuvering. See Feshback, *supra* note 32, at 319. For a good history and description of the composition of the Commission on Hospital Care, see *id.* at 317-19.

From a broader perspective, some commentators have also argued that the Hill-Burton proposal was only one part of a broader social and economic strategy and essentially a compromise between organized labor, business interests, and the government in an attempt to stabilize the economy and avoid post-war labor unrest. See Feshback, *supra* note 32, at 314-16. See also E.R. BROWN, *ROCKEFELLER MEDICINE MEN* 198-212 (1979).

⁶⁵ As some commentators have argued, the original Hill-Burton program may have been principally a rejection of liberal reform proposals, such as the Dingell-Murray-Wagner bill, see note 64 *supra*, and a victory for those who favored a more conservation approach to the hospital shortage problem. See Vanderbilt Note, *supra* note 30, at 1478. See also Maryland Note, *supra* note 30, at 320.

Conversely, Rosenblatt, *supra* note 30, at 266-68, describes the enactment of Hill-Burton more as a compromise victory for moderate conservatives who made several significant concessions to secure liberal support. Rose, *supra* note 30, at 172, also characterizes the legislative history in these terms.

This latter characterization appears to be more accurate. During the time that the Hill-Burton proposal was working its way through Congress, it is clear that liberals still hoped to secure a more sweeping bill. There were several attempts to attach broader reforms to the Hill-Burton proposal by amendment. See, e.g., 91 CONG. REC. 11,799 (1946). Some Senate liberals made clear that their support for S. 191 came only from a preference for broader but unattainable reforms and that they considered Hill-Burton only a first step in the right direction. See, e.g., S. REP. NO. 674, *supra* note 63, at 21 (minority view of Senator Murray).

When the Senate-passed bill was before the House, the committee deliberations continually involved a comparison of S. 191 to several other health facility construction program proposals, some of which involved maintenance funding, and to the pending National Health Act of 1945, H.B. 4730, the latest version of the Dingell-Murray-Wagner bill. See, e.g., *Hospital Con-*

Following the introduction of the original proposal by Senator Hill,⁶⁶ six days of public hearings were held before the Senate Committee on Education and Labor in February and March of 1945.⁶⁷ During the public hearings, a special subcommittee composed of Senators Hill, Taft, Ellender, Tunnell, and LaFollette held several weeks of closed and undocumented "study sessions" during which Hill's original bill was in large part rewritten.⁶⁸ This revised bill was approved by the committee, reported back to the Senate floor, and, after a relatively short debate, passed by a virtually unanimous vote in December, 1945.⁶⁹

In the House, the Senate bill followed a similar course. The House Committee on Interstate and Foreign Commerce held five days of hearings and reported the Senate bill favorably back to the House floor, but with several apparently controversial amendments concerning the appropriations authorized and the method for allocating funds to each state.⁷⁰ With these amendments and following a lively but short debate, the bill was passed by the House.⁷¹

While the two houses were of like mind with regard to most provisions of the bill, they locked horns over the House amendments. A joint conference negotiated a compromise, but the House rejected the first conference report.⁷² A second report, essentially calling for the Senate to accede to the House

struction Act: Hearings Before A Subcommittee of the Committee on Interstate and Foreign Commerce, 79th Cong., 2d Sess. 163-64 (1946) [hereinafter cited as *1946 House Hearings*].

It is quite obvious that it required a coalition of both liberals and conservatives to sponsor the Hill-Burton program and shepherd the legislation through Congress. The rapidity of the proposal's enactment can only be explained by the near consensus which that coalition represented.

⁶⁶ S. 191, 79th Cong., 2d Sess. (1945), submitted 91 CONG. REC. 158 (1945).

⁶⁷ S. 191 was referred to the Senate Committee on Education and Labor which held public hearings in February and March, 1945. *Hearings on S. 191 Before the Senate Committee on Education and Labor*, 79th Cong., 1st Sess. (1945) [hereinafter cited as *1945 Senate Hearings*]. Concurrently, a subcommittee held closed "study sessions" during which S. 191 was redrafted prior to final action by the whole committee. S. REP. NO. 674, *supra* note 63, at 2.

⁶⁸ *Id.* at 1.

⁶⁹ On the Senate floor, the amended bill received little opposition, *see* note 63 *supra*, and after a relatively short debate and little visible controversy, S. 191 was passed on December 11, 1945. 91 CONG. REC. 11,800 (1945).

⁷⁰ In the House, S. 191 was referred to the House Committee on Interstate and Foreign Commerce, 91 CONG. REC. 11,930 (1945), which also held extensive hearings, *1946 House Hearings*, *supra* note 65, and issued a report closely paralleling the Senate committee report. The bill was reported favorably back to the House floor, 92 CONG. REC. 10,204 (1946), but with several apparently controversial amendments: The House committee (1) recommended reducing the federal reimbursement for state planning program costs from 50%, as in S. 191, to 33%, (2) reduced the \$5,000,000 appropriation for state planning to \$3,000,000, and (3) reduced the amount of federal grant from a range of 75% - 33 1/3 % of the construction project costs to a flat 33 1/3 %. *See* H.R. REP. NO. 2519, 92d Cong., 2d Sess. 2-3, *reprinted in* 1946 U.S. CODE CONG. & AD. NEWS 1558-59.

⁷¹ As in the Senate, after a relatively short debate the amended S. 191 was passed with little dissent. 92 CONG. REC. 10,213 (1946).

⁷² After the Senate refused to accept the amendments, a joint conference committee was appointed, *id.* at 10,241, 10,316, but the first conference report was rejected by the House

amendments, was eventually accepted,⁷³ and the bill was signed into law by President Truman in August of 1946.⁷⁴

Thus, in the span of one session Congress enacted an unprecedented spending program and drastically revised federal health policy. Understandably, the bill provoked a series of lively skirmishes on both floors and in committee. But opposition to the bill was surprisingly short-lived and generally focused on peripheral issues such as the powers of the federal hospital council or the method and amount of appropriations to each state. Congress, it appears, was primed for prompt action. Weighty issues of federal-state relations, trade-offs for other social programs, the over-all impact on the federal budget, and other policy considerations were dispatched with surprising speed and virtual unanimity.

As a consequence, the relatively minor issue of the scope and nature of the conditions that could be imposed on recipient facilities received little attention and infrequent mention throughout the short legislative deliberations. In fact, the entire legislative history of the community service obligation involves a single thread of legislative events to which little coloration can be added. The charity care provision including the "available to all" language was added as one of the revisions made during the closed "study sessions" that coincided with the Senate hearings. It appeared for the first time with many other amendments but without elaboration in the Senate committee report.⁷⁵ Once added to the rewritten bill, the provision remained unchanged through both

and resubmitted. *Id.* at 10,484.

⁷³ *Id.* at 10,619, 10,667.

⁷⁴ *Id.* at 10,741.

⁷⁵ See S. REP. NO. 674, *supra* note 63, at 9. Senate 191 in its original form mentioned neither obligation, but only established the general goal of "furnishing adequate service to all of the people" in the declaration of purposes. S.191, 79th Cong., 1st Sess., § 601 (1945), as cited in Rosenblatt, *supra* note 30, at 266 n.78. More specific standards were to be left to the discretion of the Federal Hospital Council. *Id.* at 266 n.79. The language of the charity care obligations appeared for the first time in the amended S.191 that emerged from the closed executive sessions held by the Senate study committee, during the hearing on S.191 in November, 1945. See note 67 *supra*.

Rose, *supra* note 30, at 167, credits Senator Taft with authorship of the charity care provision during the closed executive session, drawing attention to his earlier remarks during the public hearings indicating that a "free service" requirement might be an appropriate amendment. *Id.* at 168. While his specific authorship of the "community service" language has never been suggested, he did play a major role in the legislation and in the redrafting of the proposal during the closed study session. See S. REP. NO. 674, *supra* note 63, at 2.

The chronology of events and the fact that the bill was rewritten in subcommittee are critical aspects of the legislative history. Some critics have attempted to infer congressional intent from the statements of witnesses and legislators made at the public hearings *prior* to the redrafting and *prior* to the inclusion of the charity care amendments. For example, the Vanderbilt Note, *supra* note 30, at 1474-75, goes into great detail in analyzing the committee deliberations during the public hearing in an effort to determine congressional intent of the subsequent amendment. Oddly, the Note ignores any of the subsequent legislative deliberations, including parallel hearings in the House. At the least, a legislative history should only begin with a reference to the 1945 Senate hearings, but focus on inferring the intent of the subsequent amendments and the

houses and several rounds of committee hearings.⁷⁶ As with many other provisions of the bill, it received little mention or commentary in either the Senate or House deliberations.⁷⁷

To be sure, as several critics have stressed, Congress, by enacting the 1946 legislation or by amending into it the charity care language, did not intend to provide funding for rendered services or to require that all indigents be provided with care.⁷⁸ Congress had rejected broader reform proposals such as national health insurance⁷⁹ and, during consideration of the bill, had rejected

deliberations that followed. See note 58 *supra*.

⁷⁶ There is no general discussion of the meaning of the "charity care" or the "available to all" language in the 1946 House Hearings. There are references to the obligation, however, in statements by several of the witnesses that indicate at least these witnesses considered "available to all" a substantive obligation. See, e.g., statements of Physician's Forum, 1946 House Hearings, *supra* note 70, at 146-47; Congress of Industrial Organizations, *id.* at 162; National Farmer's Union, *id.* at 177; American Osteopathic Association, *id.* at 183; American Optometric Association, *id.* at 202; Independent Citizens' Committee, *id.* at 237. All of these statements called for an amendment to the "available to all" language to prohibit discrimination against physicians seeking staff privileges at Hill-Burton hospitals. This position was also voiced in the Senate floor debate, see note 71 *supra*. Cf. statement by American Public Health Association, *id.* at 142 (claim that the bill needed to be amended to prohibit discrimination against either patients or physicians). There is also a statement by the representative of the Alpha Kappa Alpha applauding the inclusion of language specifically prohibiting racial discrimination. *Id.* at 186.

⁷⁷ The committee reports from both houses make similarly laconic references to the charity care obligations. The House report virtually reiterates the statute:

The State plans would be required by regulations under paragraph (f) to provide for adequate facilities without discrimination on the basis of race, creed, or color, and for adequate facilities for those unable to pay. The regulation may require an applicant for an individual project to give assurance that the hospital facility constructed pursuant to such project *will serve all persons residing in the territorial area of the applicant*. The latter requirement, however, must permit of an exception where separate hospital facilities are provided for separate population groups, but only if the State plan makes equitable provision, on the basis of need, for facilities and services of like quality for each group. The regulations under this paragraph may also require that an applicant give assurance to the State that it will furnish a reasonable volume of services to persons unable to pay therefor, unless such a requirement is not financially feasible.

H.R. REP. NO. 2519, *supra* note 62, at 17, *reprinted in* 1946 U.S. CODE CONG. & AD. NEWS 1564 (emphasis added). The Senate Report used similar language:

(f) The regulations would require that the Senate plan provide for adequate hospital facilities for the people of the State, without discrimination on account of race, creed, or color, and for adequate hospital facilities for persons unable to pay therefor. Regulations may require that an applicant for an individual hospital construction project give assurance to the State that it will serve all persons residing in the territorial area of the applicant, but if the regulations do so prescribe, they must make an exception where separate hospital facilities are provided for separate population groups, if the State construction plan makes equitable provision on the basis of need for facilities and services of like quality for each such group. The regulations may also require that an applicant give assurance to the State that it will furnish a reasonable volume of hospital services to persons unable to pay therefor, unless the hospital is unable to undertake such a commitment.

S. REP. NO. 674, *supra* note 63, at 9.

⁷⁸ See note 58 *supra*. See also Maryland Note, *supra* note 29, at 320-21. Cf. Rosenblatt, *supra* note 30, at 268 ("Congress intended to accomplish a substantial but partial solution to the problem of providing hospital care to lower-income patients.").

⁷⁹ See S. REP. NO. 674, *supra* note 63, at 17 (dissenting view of Senator Murray).

attempts to include additional funding for maintenance of services.⁸⁰ Nonetheless, to conclude, as some critics have, that Congress could not have intended to condition receipt of funds on the provision of either uncompensated service or, in particular, community service, is simply a leap of logic not justified by any reading of the legislative history, however sparse it may be,⁸¹ or by any construction of the statutory language, or the events that led to it.

Similarly, to suggest that the original Hill-Burton program was intended to fund facilities, but not services, may be an adequate shorthand description of the principal means Congress chose to achieve its objectives, but hardly describes the objectives themselves, or, for that matter, the structure of the legislation. In enacting Hill-Burton, Congress was clearly intending to assist health facility construction for the purpose of assuring the availability of hospital services.⁸² Congress was just as clearly trying to do so under certain conditions and within certain established and developed priorities.⁸³ The provision of community service is explicitly required by the "available to all" statutory language. It is also reflected in both the structure⁸⁴ and the stated purposes of the program.⁸⁵ To the extent that the issue of "available to all"

⁸⁰ See note 65 *supra*.

⁸¹ Neither of the floor debates addressed directly the meaning of "available to all." The only relevant remark is the brief discussion by Senator Murray on the lack of a provision protecting access of physicians to medical staff. 91 CONG. REC. 11,719 (1945). See a similar statement by Senator Langer. 91 CONG. REC. 11,799 (1945). While it is hard to infer congressional intent from a single remark, Senator Murray's statement at least indicates that he viewed "available to all" as both a general prohibition on discrimination and a substantive, enforceable obligation. Charity care was not mentioned at all on the House floor.

⁸² See description of the original statutory scheme in text at notes 34-39 *supra*.

⁸³ See notes 37-39 *supra*.

⁸⁴ See generally text at notes 34-39 *supra*. Among other things, a requirement that a funded facility would be "available to all" can be found in the method proscribed for determining "need" and the formula for allotting the funds to various states. The original legislation defined "need" for purposes of determining the priority of projects in terms of beds per thousand in the population. See Public Health Service Act, § 622(a), as amended by Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946). See also § 622(c). This specific bed-population formula was later criticized as inflexible and was revised, but the definition of need still remained a function of need of the population. For current codification, see 42 U.S.C. § 291(c) (1976).

Similarly, the original § 622(d) required states to determine the "priority of projects based on the relative need of different areas lacking adequate hospital facilities, giving special consideration to hospitals serving rural communities and areas with relatively small financial resources." Public Health Service Act, § 622(d), as amended by Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946). This language was amended in 1964, see note 44 *supra*, but the recodification retains similar language. 42 U.S.C. § 291(c)(1) (1978).

The provisions of the Hill-Burton legislation relating to appropriations and their allocation among the various states were amended many times, see notes 34 and 36 *supra*, but the basis for the allocation formula remained the same: funds were allocated on the basis of the states' population and per capita income. See 42 U.S.C. § 291(b) (1974). For the original provision, see Public Health Service Act § 613, as amended by Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946).

Taken together these provisions at the least confirm that Congress' intent was to provide needed services, not simply to fund facilities. These provisions also make clear Congress' primary concern focused on the needs of the population in the area of the facilities funded, and therefore carry at least a strong inference that Congress expected funded facilities to be generally available to that population.

⁸⁵ The declaration of purposes in the original legislation included reference to the

was discussed during the 1945-46 legislative process, it appears to have been assumed that recipient facilities would be generally available without discrimination — that they would accept anyone who had the ability to pay.⁸⁶ In fact,

“available to all” principle incorporated in the charity care provision. As stated in the original legislation:

The purpose of this title is to assist the several states —

(a) to inventory their existing hospitals . . . to survey the need for construction of hospitals, and to develop programs for construction of such public and other non-profit hospitals as well, in conjunction with existing facilities, afford the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to *all their people*; and (b) to construct other nonprofit hospitals in accordance with such programs.

Public Health Service Act § 601, *as amended by* Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946) (emphasis added).

This statement of purposes was later amended and expanded several times to incorporate various changes in the program, but the relevant language has remained the same:

The purpose of this subchapter is —

(a) to assist the several States in the carrying out of their programs for the construction and modernization of such public and other nonprofit community hospitals and other medical facilities as may be necessary, in conjunction with existing facilities, to furnish adequate hospital, clinic, or similar services to *all their people*; (b) to stimulate the development of new or improved types of physical facilities for medical, diagnostic, preventive, treatment, or rehabilitative service; and (c) to promote research, experiment, and demonstrations relating to the effective development and utilization of hospital, clinic, or similar services, facilities, and resources, and to promote the coordination of such research, experiments, and demonstrations and the useful application of their results.

42 U.S.C. § 291 (1976) (emphasis added).

⁸⁶ Many of the participants in the Senate committee discussions appeared to assume that recipient facilities would be available to all people who can pay, the principle underlying community service. *See, e.g.*, remarks of Dr. Donald C. Smelzer, President of the American Hospital Association (one of the principal sponsors of the legislation) *1945 Senate Hearings, supra* note 67, at 10-35. *But see* note 65 *supra*. Dr. Smelzer argued against broadening the bill to include free service for the poor, but for a bill to provide “[an] integrated plan for the distribution of those personal services in such a fashion that they may be available to all people.” *See 1945 Senate Hearings, supra* note 67, at 10-11. *See also* statements of Dr. Smelzer, *id.* at 30-35; the Surgeon General, *id.* at 90; the U.S. Department of Labor, *id.* at 130; and a representative of the American Medical Association, *id.* at 149-50.

In discussing the obligations of recipient facilities under the proposed program, Dr. Fredrick Mott, Chief Medical Officer, Farm Security Administration, Department of Agriculture, said: “. . . there would certainly be an obligation to meet the needs of all the people of that service area, for which the hospital was designed, which, of course would include many indigent and medically indigent.” *Id.* at 190.

While Dr. Mott’s opinion is hardly dispositive of the issue, the discussion immediately following the remark between some of the principal sponsors of both the bill and the subsequent charity care amendments is crucial:

Senator Pepper: . . . [I]n determining the burden which the hospital would be expected to carry, they might not be able to get Federal aid unless they agreed to take a fixed number of indigent patients. . . .

Senator Taft: That is what I mean. I imagine every hospital of a general nature would be lucky if they did not have 20 percent of indigent patients. . . .

Senator Ellender: If people in all localities were able to pay for hospitalization there would be no need for this bill. It seems to me that our primary purpose

without the notion that a recipient health facility was to provide certain services to the public, the program becomes almost ludicrous: a major spending program to finance health facility construction solely to benefit the facility, but not the people in its community.⁸⁷

Whatever the specific meaning of the community service obligation, an issue discussed in more detail below, it appears beyond question that Congress in 1946 intended to require recipient facilities to be "available to all,"⁸⁸ just as they were to comply with a number of other conditions. Indeed, it did so under circumstances that strongly suggest that such a provision was one of the revisions of the original bill necessary to consolidate congressional support for the enactment of the program.⁸⁹ The "facilities not services" argument is based on an overly simplistic view of the Hill-Burton program and Congress' intent and is, at best, good advocacy, but hardly sound scholarship.

It seems reasonable to conclude, therefore, that Congress, in enacting the Hill-Burton program, intended to authorize regulations which affirmatively require recipient facilities to provide charity care services. The express language of the statute supports such a conclusion, and the legislative history is void of any indication to the contrary. Indeed, the single dominant theme pervading the legislative history — a concern for establishing adequate medical facilities throughout the country — indicates Congress was deeply concerned that funding be conditioned only on compliance with the program's objectives, including those reflected in the charity care obligations.

B. Does "Community Service" Require General Availability or Merely Prohibit Racial Discrimination?

The "available to all" language of the original statute authorizing the community service regulations can be interpreted in two ways.⁹⁰ Interpreted in

should be to devise means to take care of those who cannot take care of themselves. My reason for supporting a bill providing for federal aid to build hospitals is to make it easy for the community in which a hospital may be built to give aid to the indigent. . . .

Senator Taft: [T]hese facilities must be made available to the people. . . .
Id. at 190-91. *See also id.* at 193-95.

As in the Senate testimony, virtually every witness at the 1946 House hearings appeared to assume that the purpose of the program was to make services generally available to the public. *See, e.g., 1946 House Hearings, supra* note 70, at 51-52 (testimony of American Hospital Association); Catholic Hospital Association, *id.* at 64; American Protestant Hospital Association, *id.* at 77; and American Public Health Association, *id.* at 141.

⁸⁷ *See Rosenblatt, supra* note 30, at 272-73.

⁸⁸ The case law has consistently stated that an enforceable "available to all" condition was established in 1946. *See, e.g.,* *Lugo v. Simon*, 426 F. Supp. 28, 36 (N.D. Ohio 1976); *Cook v. Ochsner Found. Hosp.*, 319 F. Supp. at 606 (E.D. La. 1970).

⁸⁹ *See* text and notes at notes 63-75 *supra*.

⁹⁰ The relevant language is: "(1) such hospital or addition to a hospital will be made available to all persons residing in the territorial area of the applicant, without discrimination on account of race, creed or color. . . ." Public Health Service Act § 622(f), *as amended by* Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946).

its most narrow sense, the original statute, as at least one court has held,⁹¹ prohibits only discrimination based on race, color, or national origin, except under "separate but equal" conditions.⁹² Under a broader interpretation, the "available to all" language is both a prohibition on discrimination on the basis of race, color, or national origin, and a requirement that facilities be generally available to the community as a whole.

Reference to the original declaration of purposes⁹³ and the structure of the bill,⁹⁴ supports the broader interpretation, or, at least, leaves the statute open to that interpretation. While a review of the sparse legislative history has little interpretive value, it nevertheless does allow some support for the proposition that Congress intended "available to all" to be interpreted in the broader sense, not just as a prohibition on racial discrimination.⁹⁵

Congress no doubt intended to condition Hill-Burton funding at least on a prohibition of racial discrimination, if not on the broader mandate. Unfortunately, in exercising that authority, federal administrative officials did little to clarify its scope.⁹⁶ Following the 1946 legislation, there was no further specification of the administrative interpretation of "available to all" until 1964,⁹⁷ nor was there a history of the provision's enforcement⁹⁸ until the 1970's, when HEW was forced to make serious enforcement efforts.⁹⁹ Consequently, whether the authority created by the 1946 legislation was interpreted by the officials carrying out the program to authorize community service

⁹¹ See *Perry v. Greater Southeast Wash. Community Hosp. Foundation*, No. 725-71 at 5 (D.D.C. June 28, 1972). See note 146 *infra* for further discussion of this case. See also *American Hosp. Ass'n v. Harris*, 625 F.2d 1328, 1336 (7th Cir. 1980) (Pell, J., dissenting).

Oddly, the most severe critics of charity care enforcement have not really addressed this issue. It is not clear how the author of the Maryland Note interprets the "available to all" language in the 1964 legislation. At one point it is observed with apparent approval that the community service obligation was perceived to mean that a facility would not discriminate in allowing access by all persons in its service area. See Maryland Note, *supra* note 30, at 325. Later, that same author refers to the *Perry* decision as determining that community service was a negative prohibition against discrimination, not an affirmative mandate. *Id.* at 330. See also Vanderbilt Note, *supra* 30, at 1479.

⁹² See note 162 *infra*.

⁹³ See full text at note 85 *supra*.

⁹⁴ See discussion of program at notes 56-62 *supra*.

⁹⁵ Again, while the legislative history gives little from which a definitive conclusion can be drawn, the implications are strong that many members of Congress understood that Hill-Burton facilities would be available to all in the broader sense. See notes 75-77 and 86 *supra*.

⁹⁶ See note 131 *infra* for the text of the original regulations.

⁹⁷ See note 131 *infra* for the text of the 1947 regulations. HEW officials have on at least two occasions, however, taken the position that the original statute authorized the broader community service obligation. See 1978 proposed federal regulations, 43 *Fed. Reg.* 49,955 (1979) and see note 132 *infra*.

⁹⁸ While neither HEW nor its predecessor agencies had a charity care enforcement program, there was at least one occasion prior to 1964 when community service obligation was enforced and, on that occasion, "available to all" was given the broader interpretation. See note 132 *infra*.

⁹⁹ See note 147 *infra*.

regulations of the scope and nature of those promulgated in 1979, or only regulations¹⁰⁰ prohibiting racial discrimination, is open to question.¹⁰¹

Ironically, the first meaningful interpretation of the community service obligation came from a federal court decision invalidating a portion of the statutory language which created the charity care obligations. Relying on the language which effectively created a "separate but equal" exception to the prohibition on racial discrimination, the Public Health Service (and later HEW), during the first two decades of the program, had given Hill-Burton grants to a number of facilities despite their open and official policies of racial discrimination.¹⁰² In 1963, the Court of Appeals for the Fourth Circuit in *Simkins v. Moses H. Cone Memorial Hospital*, ruled that the portions of the federal statute and related regulations permitting this practice were unconstitutional.¹⁰³

As a result of this decision, when Congress recodified and expanded the Hill-Burton program in 1964,¹⁰⁴ the provision establishing the charity care obligations was amended, modifying the "available to all" language and omitting the "separate but equal" exception. As a result of this amendment, the statute now provides that:

. . . the Surgeon General . . . shall by general regulations prescribe — . . . That the State plan shall provide for adequate hospitals, and other facilities for which aid under this part is available, for all persons residing in the State, and adequate hospitals (and such other facilities) to furnish needed services for persons unable to pay therefor. Such regulations may also require that before approval of an application for a project is recommended by a State agency to the Surgeon General for approval under this part, assurance shall be received by the State from the applicant that (1) *the facility or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant*; and (2) there will be made available in the facility or portion thereof to be constructed or modernized a reasonable volume of services to persons unable to pay therefor, but an exception shall be made if such a requirement is not feasible from a financial viewpoint.¹⁰⁵

On its face, the portion of the amended provision creating the community serv-

¹⁰⁰ See text at notes 165-69 *infra*.

¹⁰¹ See Rosenblatt, *supra* note 30, at 279-80.

¹⁰² The relevant language is: "[B]ut an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group. . . ." Public Health Service Act § 622(f), *as amended by* Pub. L. No. 79-725, § 2, 60 Stat. 1041 (1946) (revised in 1964, see notes 105-06 *infra*). See Wing, *Title VI and Health Facilities: Forms without Substance*, 30 HASTINGS L.J. 137, 144 (1978).

¹⁰³ 323 F.2d 959, 970 (4th Cir. 1963), *cert. denied*, 376 U.S. 938 (1964). The decision gives no interpretation of the portion of the statute relevant to this article.

¹⁰⁴ The specific references to race, color, or national origin were omitted in the recodification of the statute in 1964. See text at notes 91-100 *supra*.

¹⁰⁵ Public Health Service Act § 603(e), *as amended by* Pub. L. No. 88-443, § 3, 78 Stat. 451 (1964), *codified at* 42 U.S.C. § 291c(e) (1976).

ice obligation leaves little doubt as to Congress' intent to establish a general obligation for the facilities to be "available to all," and not merely to ban racial discrimination, since all references to racial discrimination are omitted. It is not clear, however, whether this amended language is a restatement of the pre-existing community service obligation, modified to conform to the *Simkins* decision, or the creation of what is essentially a new obligation to be applied prospectively to facilities funded after 1964.¹⁰⁶ Regardless of how the specific intent of Congress in 1946 is interpreted, there can be no doubt that when Congress revised and recodified the authorizing legislation for Hill-Burton in 1964¹⁰⁷ it intended the program to impose a general community service requirement on recipient facilities, a requirement broader than a simple ban on racial discrimination. This proposition can best be supported by examining the specific legislative events leading to the enactment of the 1964 amendment.

The original 1964 bill, sponsored by Congressman Harris and Senator Hill, purported to carry out the proposal of the Johnson administration for various policy shifts in the existing Hill-Burton health facility construction program.¹⁰⁸ During deliberations before the House Committee on Interstate and Foreign Commerce, however, the committee differed with the administration on several matters relating to the appropriations and the priorities established by the Hill-Harris proposal and eventually rewrote the bill accordingly.¹⁰⁹ Among other things, the committee disagreed with the administration on the nature of the amendment to the "available to all" language required by the

¹⁰⁶ HEW has consistently taken the position that the community service obligation was created by the 1946 legislation, and the subsequent revision to the statute amended the language but did not alter the underlying obligation established in 1946. See, e.g., 43 Fed. Reg. 49,954 (1978).

¹⁰⁷ For a description of the 1964 amendments, see notes 44-47 *supra*.

¹⁰⁸ On February 10, 1964, President Johnson delivered to Congress his message on health services, outlining his proposals on health insurance for the aged (later to be enacted as Medicare), an extension of the Hill-Burton program, federal financing for health personnel education, and various other health services and public health programs. H.R. DOC. NO. 224, 88th Cong., 2d Sess. (1964), reprinted in 110 CONG. REC. 2695 (1964).

Congressman Harris later described H.R. 10041, the Hill-Harris proposal for a reauthorization of the Hill-Burton program, as an attempt to carry out one portion of Johnson's proposal. *Extension and Revision of Hill-Burton Hospital Construction Program: Hearings on H.R. 10041 before the House Committee on Interstate and Foreign Commerce*, 88th Cong., 2d Sess. 2 (1964) [hereinafter cited as *1964 House Hearings*]. But see note 109 *infra*.

¹⁰⁹ From the outset of the initial congressional hearings, it became clear that significant differences existed between the administration and at least some members of Congress. The hearings were marked by long debates between HEW officials and other representatives of the executive branch and members of the committee on such matters as appropriations, the amount to be spent on modernization, and priorities for spending. See notes 44-46 *supra*. For a summary of these differences, see *1964 House Hearings*, *supra* note 108, at 94-95.

The Committee report, H.R. REP. NO. 1340, 88th Cong., 2d Sess., reprinted in 1964 U.S. CODE CONG. & AD. NEWS 2800, substituted by amendment an entirely rewritten Hill-Harris bill, preserving the main elements of the original H.R. 10041, but adding a number of substantive changes, see *id.* at 2, 1964 U.S. CODE CONG. & AD. NEWS at 2801. Among the changes made was a revision of the amendment to the "community service" language proposed in the administration's bill. See notes 110-11 *infra*.

Simkins ruling. The administration's bill had proposed that the new statutory language omit only the reference to the "separate but equal" exception that had been declared unconstitutional in *Simkins*.¹¹⁰ The committee, over the

¹¹⁰ In an important dialogue between the Secretary of HEW, Mr. Celebrezze, and the committee, Mr. Celebrezze voiced his and the administration's views on the language preferred by committee:

H.R. 10041 proposes to eliminate the "separate but equal" provisions of the Hill-Burton legislation and to require that the State plan shall provide for adequate facilities "for all persons residing in the State." It would authorize a requirement that the "facility or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant." We should much prefer the language of the administration proposal, that is, "without discrimination on account of race, creed, or color," because we feel it more clearly expresses the national policy on this matter.

* * *

Following last week's action by the Supreme Court, I directed that the following additional steps be taken:

(1) That we make permanent the earlier decision to approve no new applications under the "separate but equal" provision of the law;

(2) That we require a nondiscrimination assurance in admittance from those pending projects previously approved on a "separate but equal" basis;

(3) That we seek from all pending projects an assurance that there will be no discrimination on the basis of race, or color in granting staff privileges; and

(4) That the application forms to be used hereafter be amended to require of all applicants whose application has not been finally approved a nondiscrimination assurance covering staff privileges and admissions, and that all portions and services of the facilities be made available without discrimination on account of race, creed, or color.

Finally, Mr. Chairman, consideration is being given to calling a meeting of the leaders in organized medicine, in the hospital and other appropriate health fields, with the view toward implementing a program for voluntary compliance with these policies. I would hope that such a voluntary program would encompass not only Hill-Burton hospital facilities but all hospitals in the United States.

Our urgent responsibility is to assure adequate health care to all Americans. I would think that none would deny that consideration of race or color has no place with regard to the ailing body or the healing hand. I believe we have an opportunity to demonstrate a constructive and positive approach to assuring equal opportunity in this important area of health care that will have wide significance in these changing times.

Mr. Chairman, we urge your favorable consideration of legislation improving and extending the Hill-Burton program, and, in particular, that H.R. 10041 be amended to include the administration's proposals in regard to new construction, modernization, and nondiscrimination in the use of Hill-Burton facilities. I shall be pleased to answer any question submitted by the committee.

The CHAIRMAN. Mr. Secretary, in view of the facts of life which you have just recognized in your statement, and which have been called to the attention of all of the American people by the decision of the Supreme Court in its refusal to accept the case of North Carolina, this business of discrimination is completely moot, isn't it?

Secretary CELEBREZZE. In the laying down of the *Simkins* decision, together with other restrictions, I don't know whether it is a moot question. I think we had to take some action also in assurance, but I think that basically we have no alternative but to follow the decision of the *Simkins* case here.

The CHAIRMAN. In other words, the matter has been settled.

repeated objection of the administration, preferred to remove both the exception *and* all reference to race, color, or national origin.¹¹¹ The language adopted

Secretary CELEBREZZE. The matter has been settled by the courts.

The CHAIRMAN. The law is the law.

Secretary CELEBREZZE. That is right.

The CHAIRMAN. And you had taken action even before the Supreme Court denied certiorari.

Secretary CELEBREZZE. Yes. I had to take action.

The CHAIRMAN. Why should we get into a fuss and argument? Even though I don't agree with the Supreme Court decision and I am not in accord, as you know, with some of the matters regarding the civil rights proposal, nevertheless, that happens to be the law today, isn't it?

Secretary CELEBREZZE. That is right. I merely called it to the committee's attention so that the committee was fully informed of what action the administration has taken.

The CHAIRMAN. However, there is no particular reason for us to get into any dogfight because of controversy over that question here now, is there?

Secretary CELEBREZZE. No. If it is the law of the land it becomes the law and there isn't much we can do about it. The courts have spoken on it.

The CHAIRMAN. Therefore, it seems to me the language in the bill with reference to this particular item should satisfy the situation.

Secretary CELEBREZZE. Except that we feel that the words should be kept in the bill, "without regard to race, creed, or color."

The CHAIRMAN. I know you feel that way, but it doesn't add anything, does it, except your feelings.

Secretary CELEBREZZE. No; I think it makes it more explicit. Did you say my feelings?

The CHAIRMAN. I said it didn't add anything except your feelings. You said you feel that it should be included. I said it doesn't add anything except your feelings.

Secretary CELEBREZZE. When I use the word "feeling" I am using it in a broad sense as a lawyer uses it.

The CHAIRMAN. I use it in that sense, too. The point I am trying to suggest for the record here is that I see no reason, in this sensitive, touchy area, when it has been decided for us, to take a lot of time arguing about a moot question.

Secretary CELEBREZZE. I am fearful, Mr. Chairman, that in the administration of the Harris bill which omits the words, "without regard to race, creed, or color" that we are getting into an area, a much, much broader area, as to the definition of what is meant: Do you mean that the hospitals then should include professional people which they do not include now?

I am talking about osteopaths, or the other professional group. Is that what you mean? When you button discrimination down to the three causes, then we are guided by those three causes — you can't discriminate because of race, creed, or color.

The way it is in the present bill I think it would be rather difficult to draw the line as to what is meant by discrimination and I think that is the reason for defining it and limiting it to the three categories.

1964 *House Hearings*, *supra* note 108, at 52-54.

It is not clear from this cat-and-mouse dialogue whether Secretary Celebrezze favored the broad or narrow interpretation of "available to all," but clearly he understood the difference between the original and the amended language. And, whatever his intent during this dialogue, within weeks after the enactment of the 1964 legislation, his agency published regulations interpreting "available to all" in terms leaving no doubt as to the agency's broad reading of that language. 29 Fed. Reg. 18,447 (1964).

¹¹¹ The discussion in the committee hearings is sparse but clearly indicative of the committee's intent. In addition to Secretary Celebrezze, other witnesses representing the executive

by the committee, as critics repeatedly pointed out, imposed a general non-discrimination requirement on recipient facilities. The bill reported back to the floor included the language: "That the state plan shall provide for adequate hospitals and other facilities . . . for all persons in the state . . . assurance shall be received . . . that (1) the facility or portion thereof to be constructed or modernized will be made available to all persons residing in the territorial area of the applicant. . . ." ¹¹²

In this form, the bill was passed by the House without further discussion or amendment. ¹¹³ Because authorization for the program had expired, the bill was heard in one day before a Senate committee and reported back to the Senate floor with no amendments and virtually no substantive discussion. ¹¹⁴

branch continually pointed out that the committee's "available to all" language would be much more than a prohibition on discrimination on the basis of race, creed, or color unless the administration's original language replaced the broader language added by the committee. See, e.g., testimony of representative of Bureau of the Budget, 1964 House Hearings, *supra* note 108, at 20; testimony of the Department of Justice, *id.* at 23; testimony of the Comptroller General, *id.* at 24.

American Medical Association representatives even went so far as to suggest that the proposed "community service" language would make all recipients de facto public hospitals. *Id.* at 203-05. See also the follow-up letter from same witness in the appendix to the hearing record.

¹¹² H.R. 10041, § 3, as amended by H.R. REP. NO. 1340, 88th Cong., 2d Sess. (1964).

There was only a brief discussion of this language in the House report:

[E]xisting law provides, in relevant part, that facilities must be made available to all persons residing in the territorial area served by the applicant, but 'an exception shall be made in cases where separate hospital facilities are provided for separate populations.'

The language quoted above was held unconstitutional by the U.S. Court of Appeals for the Fourth Circuit in the case of *Simkins et al. v. Moses H. Cone Memorial Hospital*, 323 F.2d 959 (1963) and the Supreme Court denied certiorari in the case. For this reason the bill does not contain the language held unconstitutional or any other language on the subject.

Id. at 10. The only other reference to "available to all" in the body of the report, merely reiterates the statutory language verbatim. *Id.* at 16.

Included in the appendix to the committee report are several letters received by the committee from various government agencies including the Attorney General, the Comptroller General, and the Legislative Reference Service. These letters reiterate the testimony which the agencies gave at the House hearings. Each of these letters points out that the language of the House bill as reported by the House is broader than a simple prohibition on racial discrimination. See *id.* at 33-35.

¹¹³ H.R. 10041 passed the House after one day of debate, May 25, 1964. 110 CONG. REC. 11,803 (1964). In the brief debate, the "available to all" provision is mentioned only once, in comments by Rep. Anderson affirming his interest in amending the statute to conform to the *Simkins* decision. 110 CONG. REC. 11,797-798 (1964).

¹¹⁴ In the Senate the bill was referred to the Committee on Labor and Public Welfare on May 26, 1964. 110 CONG. REC. 12,087 (1964). While the bill was being considered, Senator Hill submitted an alternative bill, S.2531, which was nearly identical to the original administration bill rejected by the House. See *Hospitals and Medical Facilities: Hearings on H.R. 10041, S.2531 and S.894 before the Subcommittee on Health of the Senate Committee on Labor and Public Welfare*, 88th Cong., 2d Sess. (1964) [hereinafter cited as 1964 Senate Hearings].

The Senate subcommittee appeared to prefer S.2531 to H.R. 10041, see, e.g., 1964 Senate Hearings, at 132-44 (presentation on behalf of the Department of Health, Education and Welfare), but since the Hill-Burton authorization was to expire on June 30, 1964, H.R. 10041 was favorably, but reluctantly, reported back to the Senate floor to avoid a funding lapse in the program, see *id.* at 171, and without amendment. S. REP. NO. 1274, 88th Cong., 2d Sess. 1, reprinted in 1964 U.S. CODE CONG. & AD. NEWS 2800. Parenthetically, even though it purported

There was no discussion of the community service language in the committee reports or in the hearings.¹¹⁵ The provision was only briefly mentioned, but not discussed, on the Senate floor before the reauthorizing legislation was finally passed.¹¹⁶

The plain meaning of the amended statute is to impose a general requirement of availability, a requirement which thereafter became known as a "community service" requirement. Again, the legislative history of this language, like that of the 1946 provision, is sparse. Congress was primarily concerned with revisions of the broader substantive provisions of the program and was

to conform to President Johnson's original bill, the Senate bill, S. 2431, incorporated the broader community service language used by the House in H.R. 10041, not the narrow language originally proposed by the administration. See notes 110-11 *supra*.

In the only testimony relevant to the community service issue, the American Medical Association, in a prepared statement, once again asked that the community service language be amended to limit its application only to race, color, or creed. 1964 Senate Hearings, *supra*, at 174. There was no further discussion of this point and no subsequent amendment.

¹¹⁵ The Senate report described the "community service" language, with no further elaboration, in the following manner:

Such regulations shall require that the State plan *provide for adequate hospitals and other medical facilities for all persons residing in the State* and that the State plan provide for adequate hospitals and other medical facilities to furnish needed services for persons unable to pay. Regulations may also require that a State agency, before recommending approval of an application for a project under this title, receive assurance from the applicant that the facility or portion of the facility to be constructed or modernized will be *available to all persons residing in the territorial area of the applicant*.

S. REP. NO. 1274, 88th Cong., 2d Sess. 49-50, reprinted in 1964 U.S. CODE CONG. & AD. NEWS 2800, 2809 (emphasis added).

¹¹⁶ H.R. 10041 was passed by the Senate on August 1, 1964, with virtually no discussion. 110 CONG. REC. 17,713 (1964), and signed into law on August 18, 1964. *Id.* at 20,609. There was only one reference to community service or charity care on the Senate floor. Immediately preceding the vote on H.R. 10041, Senator Javits (Rep. N.Y.) commented on the "community service" language as it had been amended in the House bill:

Early this year the Court of Appeals for the Fourth Circuit held that the provision was unconstitutional in the case of two Hill-Burton hospitals in North Carolina, and the Supreme Court denied certiorari. I then attempted unsuccessfully, to learn from HEW what they proposed to do with their regulations in view of the fourth circuit decision. It has been my position throughout that no further legislation was necessary except to remove the invalid language from the books; even without legislation the executive branch has a clear obligation, in my judgment, to disregard unconstitutional legislative directions and to enforce the law in accordance with constitutional requirements.

In the amended Hill-Burton measure proposed to the Congress by the Executive early this year, the separate-but-equal language was eliminated from what was now section 603(e) of the act. As the measure was passed by the House, and as it is now reported to the Senate by the Labor and Public Welfare Committee, both the separate-but-equal language and the antidiscrimination language which had preceded it are eliminated from the act. What is left is the requirement that a State plan shall provide adequate hospitals and facilities "for all persons residing in the State" and that assurance shall be received by the State from the applicant that the federally aided facility "will be made available to all persons residing in the territorial area of the applicant."

110 CONG. REC. 17,713 (1964). See also *id.* at 4183-85 (exchange of correspondence between Senator Javits and HEW Secretary Celebrezze, recorded earlier in Senate deliberations).

forced to act quickly. Nevertheless, there is no doubt that this particular language in both its broad and narrow interpretations was specifically discussed, albeit briefly. Congress opted for the broader meaning. The prohibition of racial discrimination and conformance to the *Simkins* case was one major concern, but Congress rejected repeated and vocal suggestions to prohibit racial discrimination but not to require general availability.¹¹⁷ A priori, it is clear that both proponents and opponents of the broader language understood that language to impose a substantive condition on recipient facilities.¹¹⁸ Moreover, HEW, after initially asking for the narrower language, immediately issued new interpretive regulations clearly conforming to the broader interpretation and specifying what "available to all" would mean.¹¹⁹

Ironically, the 1974 health planning legislation,¹²⁰ which effectively terminated the Hill-Burton program and may have marked the end of direct federal subsidies for health facilities construction, also gives a clear indication of Congress' intent to impose a broadly defined community service obligation on recipients of Hill-Burton funding and to insure enforcement of that obligation. The 1974 legislation attached a community service obligation to the receipt of funds under the new health facility construction fund program.¹²¹ The legislation also mandated a more rigorous federal enforcement effort for both the new program's obligations and the charity care obligations imposed on recipients of Hill-Burton programs,¹²² and required new federal regulations interpreting those obligations.¹²³ The statute's legislative history demonstrates that Congress intended these provisions to mean what they literally required.¹²⁴ There can be no doubt, therefore, that in 1974, Congress

¹¹⁷ See notes 110-11 *supra*.

¹¹⁸ *Id.*

¹¹⁹ See note 110 *supra*.

¹²⁰ See discussion in text at notes 51-55 *supra*.

¹²¹ See explanation of the new and slightly modified community service obligations imposed on recipients of funds under the new health facility construction program authorized in 1974, at note 14 *supra*.

¹²² See note 5 *supra*.

¹²³ See note 54 *supra*, and notes 153-55 *infra*.

¹²⁴ As with the legislative processes examined above, Congress was obviously concerned with a myriad of issues in 1974 and focused mainly on the primary programs incorporated into the 1974 legislation, not the relatively narrow issue of concern to this article. Further, Congress' consideration of the bill was convoluted by the rush to reauthorize the program before the session expired. Nonetheless, the legislative history leaves a clear picture of congressional intent with regard to community service.

The 1974 legislation began with the introduction in the Senate of S.2994 in February, 1974. The Senate Subcommittee on Health of the Committee on Labor and Public Welfare held two different sets of public hearings on S.2994 and related health planning bills in March and June. See *Hearings on S.2994, S.3139, S.2796*, 93d Cong., 2d Sess. (1974); *Hearings on S.2983, S.3577*, 93d Cong., 2d Sess. (1974).

Both the uncompensated service obligations and the community service obligation and the problems with their enforcement were discussed extensively, leaving no question but that the meaning of the "community service" language and the history of its enforcement were brought to Congress' attention. See, e.g., *Hearings on S.3577, S.2983* at 43 and 49 (statement of Charles D. Edwards, Assistant Secretary of HEW), 89-94 (statement of Harold Graning, Health Resources

understood the community service obligation of Hill-Burton recipients to be a substantive condition requiring funded facilities to be generally available, i.e., to provide what was then known as "community service." Congress felt that the community service requirement was so important that it mandated a

Administration), 135 (statement of representative of the American Hospital Association), and 147-202 (statement of Marilyn G. Rose).

Following the subcommittee hearings, a substitute to S.2994 was offered by amendment, effectively combining elements from the various health planning bills pending before the subcommittee. The amended S.2994 included two references relevant to the community service obligation: (1) projects to be funded were required "to make reasonable assurance that at all times after the facility or portion thereof to be constructed or modernized will be made available to all persons residing or employed in the area served by the facility. . . ." See § 603(b)(10); see also notes 13-14 *supra*; (2) several related provisions requiring the Secretary of HEW to establish an enforcement program and a procedure for processing complaints concerning assurances received under this program and the previous Hill-Burton program. See §§ 620 and 621; for explanation and full text, see note 15 *supra*.

This amended S.2994 was reported to the Senate floor; there was no further mention in the Senate Committee report of the "community service" language. See S. REP. NO. 1285, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. CODE CONG. & AD. NEWS 7842. On the Senate floor, the bill was amended several times, but not with respect to the charity care obligations, and S.2994 was passed on November 25, 1974. 120 CONG. REC. 37,244 (1974). There was no discussion on the floor relevant to the community service obligation or the uncompensated service obligation.

In the House, seven days of public hearings were held before the Subcommittee on Health of the House Interstate and Foreign Commerce Committee. The subcommittee redrafted a number of pending bills into a "clean bill" sponsored jointly by all the members of the subcommittee. This bill, H.R. 16204, was reported favorably by the full committee to the House floor. See H.R. REP. NO. 1382, 93d Cong., 2d Sess. 1 (1974).

The House report explains this "community service" language in H.R. 16204, language that was subsequently adopted into the conference version of the bill and which was eventually enacted, as follows:

This section and the requirement of section 1502(a)(5) respecting the provision of adequate medical facilities for all of a state's residents and the provision of services to poor people are intended by the Committee as extensions of the authority presently found in section 603(e) of the Public Health Service Act and are not intended to change the effect or application of that section to existing projects or to require a different effect or application for projects assisted under Title XV than has been the case for projects assisted under Title VI.

H.R. REP. NO. 1382, 93d Cong., 2d Sess. 94 (1974).

In the House, S.2994 prompted a complicated and somewhat laborious debate. Eventually S.2994 was passed on December 13, 1974, but only after being amended to replace the entire body of the bill with H.R. 16204, the House version of the bill with some amendments. See 120 CONG. REC. 39,598-635 (1974). Understandably, there was no mention in the floor debate of the charity care obligations or any discussion relevant to community service.

In the waning hours of the congressional term, the competing versions of S.2994 were submitted to a joint conference committee. 120 CONG. REC. 40,117, 40,846 (1974). The conference managers somehow managed to broker an agreement on the 50-plus page bill. See CONF. REP. NO. 1640, 93d Cong., 2d Sess., *reprinted in* 1974 U.S. CODE CONG. & AD. NEWS 7971. The compromise bill was then passed in the Senate on December 19, 1974. 120 CONG. REC. 41,175 (1974), and in the House, 120 CONG. REC. 41,855 (1974). Again, there was no discussion of either of the charity care obligations in the floor debates incident to the enactment of the conference bill.

The conference report, while not providing a textual account of the interplay over the community service obligation, does establish that the various provisions from the two competing bills relating to charity care and charity care enforcement reflected substantial differences. The final version of the bill adopted the House language in § 1602(b), but the Senate language (with slight modification) in §§ 1604 and 1612. See CONFERENCE REP. NO. 1640 at 24-26, *reprinted in* 1974 U.S. CODE CONG. & AD. NEWS 7995-98. For full text of this language in its final form, see notes 14-15 *supra*.

renewed federal enforcement effort and called for additional interpretive regulations even at a time when the original Hill-Burton program was being dismantled.¹²⁵ Similarly, in 1979¹²⁶ Congress again expressed its continuing recognition of the community service requirement of Hill-Burton recipients and the need for its enforcement by reauthorizing the relevant provisions cited above,¹²⁷ again leaving a clear legislative history of its intent.¹²⁸ Congress also provided further administrative tools to secure compliance by empowering certificate of need programs to consider community service in making decisions on certificate of need applications.¹²⁹

¹²⁵ In one of the more creative attempts to dismiss the implications of the 1974 legislation, one critic of charity care enforcement described Congress as reacting "emotionally" in 1974 and attempting to use the Hill-Burton program charity care obligation as a sub rosa means for extending Medicaid and Medicare coverage. See Maryland Note, *supra* note 30, at 345. Emotional or not, the intent of Congress is quite clearly stated in the legislative history, whatever political interpretation the note's author prefers to divine from between the lines: Congress was attempting to provide for the enforcement of what it viewed as a pre-existing obligation.

¹²⁶ Health Planning and Resource Development Amendments of 1979, Pub. L. No. 96-79, 93 Stat. 592 (1979), reauthorizing and revising the 1974 health planning legislation.

¹²⁷ The 1979 health planning amendment recodified the pre-existing charity care provisions, continuing these obligations as a condition on recipients of health facility development funds. See note 14 *supra*. Significantly, the 1979 legislation also recodified and strengthened the provisions providing for enforcement of both the Hill-Burton charity care obligations and the parallel obligations created under the new facility construction program. See note 15 *supra*.

¹²⁸ The significance of various references to community service must be viewed in their specific context of the congressional deliberations. The 1979 health planning amendments were first submitted in the Senate in February, 1979. S. 544, 96th Cong., 1st Sess. (1979). Lengthy hearings were held and S. 544 was reported to the Senate floor on April 26, 1979. 125 CONG. REC. S.4811 (daily ed. April 26, 1979). S. 544 as reported included the language reauthorizing community service and related provisions providing for its enforcement as described in notes 14-15 *supra*, and made explicit reference to community service and the committee's concern that compliance be secured. S. REP. NO. 96, 96th Cong., 1st Sess. 91, reprinted in 1979 U.S. CODE CONG. & AD. NEWS 1278, 1396. The Senate report also noted the importance of the newly-created authority of certificate of need programs to consider community service. See note 129 *infra*. The Senate acted quickly on S. 544, leaving the provisions described above intact with no discussion relating to community service. 125 CONG. REC. S5113-25 (daily ed. May 1, 1979).

In the House, S. 544 was referred to the House Committee on Interstate and Foreign Commerce. 125 CONG. REC. H2721 (daily ed. May 4, 1979). That committee, however, reported back its own bill, H.R. 3917, which was similar in many regards to S. 544. 125 CONG. REC. H6213 (daily ed. Jul. 19, 1979). H.R. 3917 included the same provisions described in notes 14-15 *supra* relating to community service enforcement, as well as those relating to consideration of community service compliance by certificate of need programs, as described in note 129 *infra*. See H.R. REP. NO. 190, 96th Cong., 1st Sess. 73, 95 (1979). Significantly, the House report specifically criticized HEW for not moving more quickly to enforce community service and to issue new regulations as mandated in 1974. *Id.* at 95.

On the House floor, H.R. 3917 was amended in various ways not relevant to the issue discussed herein, and was passed; then S. 544 was amended to delete all of it and add the body of H.R. 3917. 125 CONG. REC. H6248 (daily ed. Jul. 19, 1979). The debate on the amendments was unrelated to community service. Likewise, the joint conference that followed and related procedures on the floor had no discussion of community service or any impact on the provisions discussed above. See 125 CONG. REC. H8233 (daily ed. Sept. 20, 1979); 125 CONG. REC. S13130 (daily ed. Sept. 21, 1979).

In short, the final bill included the various provisions relating to community service cited above as they were reported and discussed in the committee reports. That discussion, however brief, is quite clear as to Congress' intent.

¹²⁹ The 1979 amendments also empowered state certificate of need programs to consider community service compliance by applicant facilities in making certificate of need decisions. See

It remains unclear, then, whether the community service provision required general availability of medical services or merely prohibited racial discrimination before its amendment in 1964. Both the original declaration of purpose and structure of the bill, however, support the broader interpretation. In any event, the 1964 amendments, which consciously omitted any reference to race, creed, or national origin, clearly envisioned a broad, general availability requirement. The reaffirmation of congressional support for rigorous enforcement of the community service obligation in 1974 and 1979 further buttresses such an interpretation.

III. THE VALIDITY OF THE "COMMUNITY SERVICE" REGULATIONS

The analysis presented thus far has attempted to demonstrate that the Hill-Burton program imposes an affirmative obligation upon funded facilities to engage in community service, and requires general availability of medical services to the community as a whole. For the 1979 community service regulations to be upheld, however, it must also be proven that the regulations are a proper exercise of authority granted by the statute. The 1979 regulations are vulnerable to two lines of attack: first, that the present interpretation of the community service obligation is beyond the scope of the authority created by the statutory delegation; and second, that the present regulations cannot be applied retroactively to recipient facilities without impairing the contract or property rights created at the time funding was originally received.¹³⁰

This section will trace briefly the development of the community service regulations and the history of their enforcement culminating in the 1979 regulations. Once the events, beginning in 1947, which lead to the promulgation of the 1979 community service regulations have been put in perspective, it will be shown that the 1979 regulations are valid interpretations of the statutory obligation and not the retroactive establishment of new obligations.

A. *The Regulatory History*

The original regulations issued in 1947 exercised the permissive "may require" language of the original authorizing statute, thus making the community service obligation mandatory on recipient facilities.¹³¹ The regulations mere-

Public Health Service Act, § 1532(c)(6) *as amended by* Pub. L. No. 96-79, § 116(f)(6)(E), 93 Stat. 613 (1979). The language states only that an agency can consider the extent to which "proposed services will be accessible to all residents of the area to be served." See note 15 *supra*. The committee reports indicate that this is specifically intended to provide certificate of need agencies with a means by which to secure compliance by applicants with their Hill-Burton community service obligations. See H.R. REP. NO. 190, 96th Cong., 1st Sess. 73 (1979). See also S. REP. NO. 96, 96th Cong., 1st Sess. 69, *reprinted in* 1979 U.S. CODE CONG. & AD. NEWS 1374. See explanation relating to the House bill and Senate bill in note 128 *supra*.

¹³⁰ If a regulation effectively creates new responsibilities for funded facilities that were not part of the original agreement at the time of the funding, then the retroactive application of such a regulation could be challenged on both constitutional and contractual principles. See Vanderbilt Note, *supra* note 30, at 1480-94. See also discussion and cases cited in American Hosp. Ass'n v. Harris, 625 F.2d 1328, 1341-42 (7th Cir. 1980).

¹³¹ The original Hill-Burton regulations, defining the charity care obligations, read as follows:

ly reiterated verbatim the statutory language, however, giving no indication of how "available to all" would be defined, and, perhaps more significantly, giving no indication of how either of the charity care obligations would be monitored or enforced.¹³²

In 1964, after the amendment to the statutory language required by the *Simkins* ruling, HEW issued new regulations.¹³³ These regulations provided the

§ 53.6 General. The State plan shall provide for adequate hospital facilities for the people residing in a State without discrimination on account of race, creed, or color and shall provide for adequate hospital facilities for persons unable to pay therefor.

§ 53.6 Non-discrimination. Before a construction application is recommended by a State Agency for approval, the State Agency shall obtain assurance from the applicant that the facilities to be built with aid under the act *will be made available without discrimination on account of race, creed, or color to all persons residing in the area to be served by that hospital*. However, in any area where separate hospital facilities are provided for separate population groups, the State Agency may waive the requirement of assurance from the construction applicant if (a) it finds that the plan otherwise makes equitable provision on the basis of need for facilities and services of like quality for each such population group in the area, and (b) such finding is subsequently approved by the Surgeon General. Facilities provided under the Federal Act will be considered as making equitable provision for separate population groups when the facilities to be built for the group less well provided for heretofore are equal to the proportion of such group in the total population of the area, except that the State plan shall not program facilities for a separate population group for construction beyond the level of adequacy for such group.

§ 53.63 Hospital services for persons unable to pay therefor. Before a construction application is recommended by a State Agency for approval, the State Agency shall obtain assurance that the applicant will furnish a reasonable volume of free patient care. As used in this section, "free patient care" means hospital service offered below cost or free to persons unable to pay therefor, including under "persons unable to pay therefor," both the legally indigent and persons who are otherwise self-supporting but are unable to pay the full cost of needed hospital care. Such care may be paid for wholly or partly out of public funds or contributions of individuals and private and charitable organizations such as community chests or may be contributed at the expense of the hospital itself. In determining what constitutes a reasonable volume of free patient care, there shall be considered conditions in the area to be served by the applicant, including the amount of free care that may be available otherwise than through the applicant. The requirement of assurance from the applicant may be waived if the applicant demonstrates to the satisfaction of the State Agency, subject to subsequent approval by the Surgeon General, that furnishing such free patient care is not feasible financially.

42 C.F.R. § 53.62-63 (1949) (emphasis added). Sections 53.61-63 were recodified without substantial amendment into two sections, § 53.111-112, in 1956. 21 Fed. Reg. 9841 (1956).

¹³² There were a few instances in which HEW took action to enforce community service in its broader sense even prior to the 1964 statutory amendments and subsequent regulations. Apparently in 1963 HEW took the position that Group Health Cooperative of Puget Sound (a "closed" prepaid group practice) could not receive Hill-Burton funds because it was not open to everyone. See *Cook v. Ochsner Found. Hosp.*, 61 F.R.D. 354, 363 (E.D. La. 1970). Thus, on at least one occasion prior to 1964 HEW indicated its willingness to interpret "available to all" in its broader sense.

¹³³ It should be noted that while the statutory authorization for the community service regulations is permissive, the issuance of regulations immediately following the 1946 legislation and again following the 1964 amendments made the obligation, however vaguely defined, man-

first specific interpretation of the community service obligation.¹³⁴ In order to comply with the statute, funded facilities were required to refrain from discriminating on the basis of race, creed, color, or national origin, and to furnish community service.¹³⁵ "Community service," as defined by the 1964

datory on receipt facilities. See note 131 *supra*.

¹³⁴ The former §§ 53.111-112 were expanded into three sections following the *Simkins* decision, see note 103 *supra*, and the amendments to the Hill-Burton statute. 29 Fed. Reg. 18,447 (1964). Although the charity care obligations as interpreted by earlier regulations were reorganized, the only major substantive change was a reinterpretation of the "available to all" language, including, for the first time, the use of the term "community service." As amended, the charity care regulations read:

§ 53.111 Community service; services for persons unable to pay; nondiscrimination on account of creed. Before an application for the construction of a hospital or medical facility is recommended by a State agency for approval, the State agency shall obtain assurance from the applicant that:

(a) The facility will furnish a community service;

(b) The facility will furnish below cost or without charge a reasonable volume of services to persons unable to pay therefor. As used in this paragraph, "persons unable to pay therefor" includes persons who otherwise are self-supporting but are unable to pay the full cost of needed services. Such services may be paid for wholly or partly out of public funds or contributions of individuals and private and charitable organizations such as community chest or may be contributed at the expense of the facility as itself. In determining what constitutes a reasonable volume of services to persons unable to pay therefor, there shall be considered conditions in the area to be served by the applicant, including the amount of such services that may be available otherwise than through the applicant. The requirements of assurance from the applicant may be waived if the applicant demonstrates to the satisfaction of the State agency, subject to subsequent approval by the Surgeon General, that to furnish such services is not feasible financially; and

(c) All portions and services of the entire facility for the construction of which, or in connection with which, aid under the Federal Act is sought, will be made available without discrimination on account of creed; and no professionally qualified person will be discriminated against on account of creed with respect to the privilege of professional practice in the facility.

§ 53.112 Nondiscrimination on account of race, color, or national origin. Attention is called to the requirements of Title VI of the Civil Rights Act of 1964 (78 Stat. 242; P.L. 88-352) which provides that no person in the United States shall, on the ground of race, color, or national origin be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving Federal financial assistance (sec. 601). A regulation implementing such Title VI, applicable to grants for construction and modernization of hospitals and medical facilities, has been issued by the Secretary of Health, Education, and Welfare with the approval of the President (45 CFR Part 80). This regulation, published in the Federal Register of December 4, 1964 (29 F.R. 16298-16305), will become effective on the 30th day after such publication.

§ 53.113 Nondiscrimination in construction contracts. Each construction contract is subject to the condition that the grantee shall comply with the requirements of, and give the assurances required in Executive Order 11114, June 22, 1963 (28 F.R. 6485), and the applicable rules, regulations and procedures prescribed pursuant thereto by the President's Committee on Equal Employment Opportunity (28 F.R. 9812).

Note that the reference to community service in § 53.111(a) is further defined by § 53.1(p). See note 136 *infra*.

¹³⁵ See note 134 *supra*.

regulations, meant "that (1) the services furnished are available to the general public or (2) admission is limited only on the basis of age, medical indigency, or type or kind of mental or medical disability."¹³⁶ HEW also adopted the view that the essential obligation remained unchanged by the statutory amendment, except for the elimination of the "separate-but-equal" exception. Thus, the agency considered the new regulations applicable to all recipient facilities, including those that received funding prior to 1964.¹³⁷ As with earlier charity care regulations, however, the 1964 regulations made no provision for monitoring or enforcing compliance with the charity care obligations.

The regulations as amended in 1964 remained unchanged and, undoubtedly, unenforced, for nearly ten years.¹³⁸ In fact, for the first 25 years of the program, none of the federal or state Hill-Burton agencies took action to interpret the meaning of these obligations, nor is there any evidence of government efforts to monitor or enforce compliance.¹³⁹ Until 1972, the federal regulations implementing the Hill-Burton program did little more than restate the charity care provision of the statute, and similar language was appended into state Hill-Burton plans and individual grants without further elaboration.¹⁴⁰

In the early 1970's, however, a series of privately-initiated lawsuits forced HEW to give more than pro forma recognition to the charity care obligations.¹⁴¹ As a result, HEW reluctantly issued interpretive regulations in 1972 specifying the meaning of the obligation to provide uncompensated service. More critically, the 1972 regulations outlined a program for monitoring compliance by Hill-Burton facilities, relying heavily on state agencies for its implementation.¹⁴² HEW specifically declined the opportunity to amend or to

¹³⁶ 42 C.F.R. § 53.1(p), as added by 29 Fed. Reg. 18,449 (1964) defined "community service" to mean:

... the (1) services furnished are available to the general public or (2) admission is limited only on the basis of age, medical indigency, or the type or kind of medical or mental disability, or (3) the facility constitutes a medical or nursing care unit of a home or other institution which home or other institution is available in accordance with subparagraph (1) or (2) of this paragraph.

Id.

¹³⁷ See explanation given later by HEW. 43 Fed. Reg. 49,954 (1978).

¹³⁸ See *Cook v. Ochsner Found. Hosp.*, 61 F.R.D. 354, 361-62 (E.D. La. 1972). Among other things, the court found that during the preceding 25 years there had not been any federal personnel assigned to investigate or enforce the charity care assurances and there had not been any federal process for handling individual complaints or issuing interpretations with regard to individual facilities. See also *Newsom v. Vanderbilt Univ.*, 453 F. Supp. 401, 409 (M.D. Tenn. 1978).

¹³⁹ See *Rose*, *supra* note 30, at 169. See also *Newsom v. Vanderbilt Univ.*, 453 F. Supp. at 409.

¹⁴⁰ See 42 C.F.R. § 53 (1947). See also 42 C.F.R. § 53 (1971).

¹⁴¹ See, e.g., *Cook v. Ochsner Found. Hosp.*, 559 F.2d 968 (5th Cir. 1977) (note two earlier decisions: 319 F. Supp. 603 (E.D. La. 1970) and 61 F.R.D. 354 (E.D. La. 1972)); *Euresti v. Stenner*, 458 F.2d 1115 (10th Cir. 1972); *Organized Migrants in Community Action v. James Archer Smith Hosp.*, 325 F. Supp. 268 (S.D. Fla. 1971); *Perry v. Greater Southeast Wash. Hosp. Found.*, No. 721-71 (D.C. June 28, 1972). See also *Saine v. Hospital Auth. of Hall County*, 502 F.2d 1033 (5th Cir. 1974).

¹⁴² These charity care regulations were first issued in interim form, 37 Fed. Reg. 14,179

specify the meaning of community service, however.¹⁴³ Subsequent litigation by private consumer groups again attacked the adequacy of the government's efforts,¹⁴⁴ resulting in further amendments to the uncompensated service regulations in 1975.¹⁴⁵

It was not until 1974 — and again under court order¹⁴⁶ — that HEW

(1972). The final version (with slight changes) was issued in 1973. 38 Fed. Reg. 16,353 (1973). For a discussion of the circumstances leading to their initial issuance, see Rose, *supra* note 30, at 174-76; Rosenblatt, *supra* note 30, at 270-77.

¹⁴³ 37 Fed. Reg. 14,720 (1972). See Rose, *supra* note 30, at 178. The 1972 regulation (actually finalized in 1973, see Rose, *supra* note 30, at 177 n.57) did recodify the references to community service and the prohibitions on discrimination on the basis of race, color, or national origin, in effect, renumbering § 53.111-113. However, there were no substantive changes in the community service provisions in 1972, other than in the substantive requirements regarding the "free care" obligation.

¹⁴⁴ See *Corum v. Beth Israel Medical Center*, 373 F. Supp. 550 (S.D.N.Y. 1974), and related decisions, *Corum v. Beth Israel Medical Center*, 373 F. Supp. 558 (S.D.N.Y. 1974), *Corum v. Beth Israel Medical Center*, 359 F. Supp. 909 (S.D.N.Y. 1973). See also Rose, *supra* note 30, at 194-201.

¹⁴⁵ 40 Fed. Reg. 46,203 (1975), amending provisions relating to billing patients prior to uncompensated service determinations.

¹⁴⁶ *Cook v. Ochsner Found. Hosp.*, 61 F.R.D. 354 (E.D. La. 1972). The findings of the court read in part:

The defendant Secretary, who is the Federal government official responsible for implementing the Hill-Burton program, has failed to insure that Hill-Burton hospitals meet their obligations to treat all persons in the territorial area in providing a community service. The defendant Secretary has not issued any rulings, regulations, standards, or taken any specific action with respect to these hospitals, nor to this Court's knowledge, as to any other hospital, to see to it that they terminate their practices and/or policies of excluding substantially all Medicaid beneficiaries. The failure of the Secretary of Health, Education, and Welfare to "prescribe regulations" which would prohibit such discriminatory admission practices by the defendant hospitals is in disregard of the provisions and intent of the Hill-Burton Act.

Id. at 361.

In a related case, *Perry v. Greater Southeast Wash. Community Found.*, No. 725-71 (D.D.C. June 28, 1972), the federal district court for the District of Columbia came to a similar conclusion with regard to the adequacy of the existing federal regulations, holding that the inadequacy of the federal community service regulations prevented a determination of whether or not the defendant hospital was in compliance with its community service obligation. While holding that the interpretation of "community service" was properly a matter for the federal administrative agency, the court did make several relevant observations. First, the court was of the opinion that the "available to all" language in the statute prior to 1964 was only a proscription of discrimination on the basis of race, creed, or color; not an affirmative obligation to provide something called "community service." *Id.* at 5-6. The court recognized, however, that the 1964 amendments and the regulations to follow did impose such an affirmative obligation on recipient facilities, albeit an obligation that the federal agency would have to specify in order to enforce. *Id.* at 6. In the language of the court:

There are not 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.

Id.

Thus, the district court did not rule that the broader interpretation of "community service" could not be imposed on facilities funded after 1964, only that without specification the enforcement could not be pursued by private litigants through the courts. For further discussion, see Rosenblatt, *supra* note 30, at 274-75.

finally issued regulations further interpreting the community service obligation.¹⁴⁷ The major substantive revision added by the 1974 regulations was to specify that community service included the requirements that recipient facilities must participate in Medicaid and Medicare, and must take "such steps as necessary" to insure that Medicaid and Medicare patients were admitted without discrimination.¹⁴⁸ But while the 1974 regulations clarified the meaning implied in the community service provisions of the 1964 regulations, they stopped short of imposing explicit standards for assessing compliance with the substantive requirements.¹⁴⁹ In addition, monitoring and enforcement pro-

¹⁴⁷ 39 Fed. Reg. 31,767 (1974).

¹⁴⁸ 42 C.F.R. § 53.113(d), as added by 39 Fed. Reg. 31,767 (1974), read in part:

In order to comply with its community service assurance an applicant must:

- (1) (i) Make the services it furnished available to general public, or
- (ii) Limit the availability of such services only on the basis of age, medical indigency, or type or kind of medical or mental disability, or
- (iii) If the facility constitutes a medical or nursing care unit of a home or other institution, make such home or other institution available in accordance with paragraph (d)(1)(i) or (ii) of this section; and

(2) (i) Make arrangements, if eligible to do so, for reimbursement for services with: (A) Those principal State and local governmental third-party payors which provide reimbursement for services that is not less than the actual cost of such services as determined in accordance with accepted cost accounting principles; and (B) Those Federal governmental third-party programs, such as Medicare and Medicaid, to the extent that the applicant is entitled to reimbursement at reasonable cost under a formula established in accordance with applicable Federal law.

(ii) Take such additional steps as may be necessary to ensure that admission to and services of the facility will be available to beneficiaries of the governmental programs specified in paragraph (2)(i) without discrimination (or preference) on account of their being such beneficiaries.

As noted earlier, see note 146 *supra*, the federal district court in *Cook v. Ochsner* mandated this substantive amendment. The court declined, however, to rule on plaintiff's argument that as a matter of law a policy to accept only patients who had a private physician on the facility's medical staff violated the obligation as well, holding that the issue would have to be tried and would be dependent on individual circumstances. 61 F.R.D. at 359-60. This issue is resolved in the 1979 community service regulations. See 42 C.F.R. § 125.603(d)(1) (1980), set forth at note 172 *infra*.

It is also worth noting that the nine hospital defendants (in addition to HEW) in the *Cook* litigation agreed to take various steps to accept Medicaid patients under a stipulated settlement entered into prior to trial on the community service issue. 61 F.R.D. at 354-55. Apparently, they acceded to an interpretation of "community service" that included an obligation to provide services to Medicaid patients prior to the issuance of the 1974 regulations. For a discussion of this interpretation of "community service," see Rosenblatt, *supra* note 30, at 279.

¹⁴⁹ In many respects, it appears that HEW was trying to imply standards and specify meaning without explicitly doing so. For example, the regulations in proposed form would have required recipients to make arrangements with private third party payors, but the specific requirement was dropped in the final regulations as both "infeasible and unnecessary." According to the explanatory material that accompanied the final regulations, HEW felt it could not develop specific regulatory language which would not disrupt the reimbursement relationship between providers and most private insurers. 39 Fed. Reg. 31,766 (1974). However, that same explanation claims that HEW felt such a provision, in any event, was unnecessary, since arrangements with private third party payors would be compelled under the general language of § 53.113(d)(1). *Id.*

As another example of HEW's lack of specificity, the term "without discrimination"

cedures were only generally referred to in the 1974 regulations, and almost total discretion was given to the state Hill-Burton agencies to develop methods for evaluation and enforcement of this obligation.¹⁵⁰ The 1974 regulations also limited the duration of the community service obligation to 20 years.¹⁵¹ This provision, however, was invalidated by a federal district court in 1977 and HEW has acceded to that position ever since.¹⁵²

In 1978, HEW proposed new charity care regulations, ostensibly under the mandate of the 1974 health planning legislation¹⁵³ but clearly prodded as well by the continuing efforts of private consumer groups.¹⁵⁴ The new regulations were intended to give more specific meaning to the terms of the uncompensated and community service obligations,¹⁵⁵ and to federalize the en-

was used, but no clear guidelines for measuring discrimination were included. See 42 C.F.R. § 53.113(e) (1975). The explanatory language in the introductory material of the federal regulations added some indication of what was intended but still stopped short of specific meaning:

Beneficiaries of the covered programs must thus be considered for admission to and treatment in each facility on an equal basis with persons who pay their charges through other means, in accordance with the policies which are generally applicable to patients of the facility. Steps designed to ensure this result might include, for example, notification to physicians on the facility's staff that beneficiaries of the covered programs are eligible for admission in accordance with the institution's normal admission procedures.

39 Fed. Reg. 31,767 (1974). See notes 163-74 *infra* for a comparison of similar provisions in the 1979 regulations.

¹⁵⁰ See 42 C.F.R. § 53.113(e)-113(g) (1975). Until 1978 HEW and its predecessors had taken the position that enforcement of the charity care obligations was primarily a matter for state Hill-Burton agencies, as were most other administrative aspects of the program. See *Cook v. Ochsner Found. Hosp.*, 61 F.R.D. 354, 364 (E.D. La. 1972), *Lugo v. Simon*, 426 F. Supp. 28, 31 (N.D. Ohio 1976). While that position seems consistent with the general scheme contemplated by the statute, it hardly explains the virtual silence of the regulations on matters such as methods for determining compliance, or enforcement activities, or even data collection. Moreover, the state agencies, apparently taking the lead from their federal counterparts, did not in any meaningful way carry out their responsibility for charity care enforcement. Testimony given at the 1978 hearings almost uniformly describes the state enforcement activities as non-existent, almost to the point that strains credulity. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE, TRANSCRIPT OF PROCEEDINGS: PUBLIC HEARINGS ON PROPOSED HILL-BURTON REGULATIONS December 5-6 (1979) (two volumes). See, e.g., testimony of Edward Tetelman, Vol. II at 115; Dolores Bullert, Vol. II at 191; Tony Whitson, Vol. II at 228. See also *Rose*, *supra* note 30, at 186-94.

¹⁵¹ 42 C.F.R. § 53.113(a) (1975).

¹⁵² *Lugo v. Simon*, 426 F. Supp. 28, 36 (N.D. Ohio 1976). See 43 Fed. Reg. 49,955 (1978). Section 53.113(e) was amended accordingly. 42 Fed. Reg. 16,780 (1977). A similar limitation was imposed on the free care obligation by the 1972 amendments to the charity care regulations, but it has been held to be valid by both the *Cook* and *Lugo* courts. See 42 C.F.R. § 53.111(a) (1975).

¹⁵³ See note 15 *supra*.

¹⁵⁴ 43 Fed. Reg. 49,954-56 (1978). Both *Newsom v. Vanderbilt*, 653 F.2d 1100, 1105 (6th Cir. 1981) and *Lugo v. Simon*, 453 F. Supp. 677, 686 (N.D. Ohio 1978) interpreted the 1974 legislation to require new charity care regulations. Both parties in *Lugo* agreed to a stipulation settlement under which HEW would develop new regulations and under which the 1979 regulations were issued. See *Fiori, Bureau of Health Facilities Increasing Responsibilities in Assuring Medical Care for the Needy and Services Without Discrimination*, 95 PUBLIC HEALTH REPORTS 164, 167 (1980).

¹⁵⁵ The explanatory materials that accompanied the proposed and final regulations em-

forcement and monitoring responsibilities.¹⁵⁶ Indeed the language of the proposed and final regulations and the voluminous explanatory material that accompanied the regulations¹⁵⁷ reflected an unusual frankness by HEW both in describing the inadequate enforcement efforts of the past and in affirming the agency's intent to come to grips with these controversial obligations and establish meaningful enforcement procedures.¹⁵⁸

In their broadest outlines, the new regulations added nothing to the substantive definition of community service, at least as it has been defined since 1964. Recipients¹⁵⁹ of Hill-Burton assistance from both the Hill-Burton program and the new program established in 1974¹⁶⁰ are essentially required to make their services available to all residents of the area they serve,¹⁶¹ without discrimination on the basis of race, color, creed, national origin¹⁶² or on any

phasized that the new regulations were attempts to clarify the existing obligations, rather than adopt new substantive standards. *See* 44 Fed. Reg. 29,397-99 (1979). For example, the specific requirements of § 124.603(a) are described as making explicit what was implied in pre-existing § 53.113(d)(1). *Id.* at 29,397.

¹⁵⁶ The shift of the primary responsibility for monitoring and enforcement activities from the state agencies to the federal agency may well be one of the most significant aspects of these regulations from a practical point of view. Both the proposed regulations, 43 Fed. Reg. 49,956 (1978), and the final regulations, 44 Fed. Reg. 29,372 (1979), make specific reference to congressional concern over the lax enforcement practices of many states. HEW strongly implied that the 1974 health planning legislation mandated that these new regulations be issued and administered by the federal agency, citing Public Health Service Act § 1612(c), *as amended by* Pub. L. No. 93-641, § 4, 88 Stat. 2264 (1974). *See* note 15 *supra* for subsequent recodification of § 1612(c).

States have not, however, been totally precluded from enforcement or monitoring activities under the 1979 regulations. Both the free service and community service regulations allow the federal government to delegate responsibilities to state agencies under some circumstances. *See* 42 C.F.R. § 124.607 (1980).

¹⁵⁷ The final issuance of federal regulations required 38 pages of the Federal Register, including a 17-page summary of public comments and 11 pages of economic analysis. There were also nine pages of explanation incident to the proposed regulations. These explanatory materials include many specific interpretations of the regulations and such things as HEW's analysis of its own legal authority. Ironically, the economic analysis, required by executive order as an incident to issued regulations, analyzes only the cost of uncompensated services and makes no mention of community service. *See* 44 Fed. Reg. 29,399-401 (1979).

¹⁵⁸ *See, e.g.,* 43 Fed. Reg. 49,955 (1978).

¹⁵⁹ While there is no definition of "federal assistance" for purposes of the community service obligation, "federal assistance" is defined for purposes of the free service regulations as including grants, loan guarantees, and interest subsidies. *See* 42 C.F.R. § 124.502 (1980). Presumably, the same definition applies to community service.

¹⁶⁰ The community service obligation of future recipients under the 1974 health planning legislation is slightly different. *See* note 14 *supra*.

¹⁶¹ "Service area" is defined for purposes of community service as the area defined in the most recent state Hill-Burton plan. 42 C.F.R. § 124.602 (1980). This definition will lead to controversy in some areas. Most of these plans have not been revised since Hill-Burton was effectively repealed in 1974, and some may not be available at all. Apparently, HEW could not find a more satisfactory definition of this potentially controversial issue. *See* 44 Fed. Reg. 29,397 (1979).

"Resident" for purposes of these regulations, is defined to include anyone living permanently or indefinitely in the service area, or living in the area for purposes of employment or living with a resident family member. 42 C.F.R. § 124.603(a)(2) (1980). For an interpretation of this definition as applied to migrants and other groups, *see* 44 Fed. Reg. 29,399 (1979).

¹⁶² The original charity care regulations, 42 C.F.R. § 53.61-63, later renumbered §§

other basis except narrowly prescribed factors.¹⁶³ The critical definition under the new regulations reads:

In order to comply with its community service assurance, a facility shall make the services provided in the facility or portion thereof constructed, modernized, or converted with Federal assistance under Title VI or XVI of the Act available to all persons residing (and, in the case of facilities assisted under Title XVI of the Act, employed) in the facility's service area without discrimination on the ground of race, color, national origin, creed, or any other ground unrelated to an individual's need or the service or the availability of the needed service in the facility. Subject to paragraph (b) (concerning emergency services) a facility may deny services

53.111-112, see note 131 *supra*, specifically prohibited discrimination on the basis of race, color, or creed, although it allowed a "separate-but-equal" exception, reiterating the language of the original statute. After the statutory amendments in 1964, as well as the enactment of the Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241, these regulations were amended, see note 134 *supra*, and the reference to discrimination on the basis of race, color, or creed, was replaced by a new § 53.112 drawing attention to the 1964 civil rights legislation prohibiting discrimination on the basis of race, color, or national origin (but not creed).

It was at that time that the first reference to community service was made, as part of a new § 53.111. This new § 53.111 also prohibited discrimination on the basis of creed. When the revised free service regulations were issued in 1972, the separate provisions referring to discrimination and community service were consolidated into a single § 53.112.

In 1974, a new § 53.113 was created for the expanded definition of community service. Thus the race discrimination provisions which had originally been the central, and perhaps only, focus of the regulations implemented under the statutory language "available to all," and then partially considered as one aspect of community service, became, in effect, a third obligation, i.e., Hill-Burton facilities must provide free service, a community service, and not discriminate on the basis of race, color, national origin, or creed. The regulations proposed in 1978 purport to amend § 53.111 and § 53.113, but not § 53.112. See 43 Fed. Reg. 59,954 (1978). But note that the obligation of § 53.112 is incorporated into the new regulations as part of the community service obligation, and the same language is used in the final community service regulation. See 42 C.F.R. § 124.603(a)(1) (1979).

To add to the confusion, HEW justified this language in the 1979 regulations, not on the basis of the Civil Rights Act of 1964, but on the ground that discrimination on the basis of race, creed, color, or national origin was implied in the earlier definition of community service in § 53.113(d)(1) (1977). Consistent with this reasoning, this same explanation also claims that the reference to racial discrimination was dropped from the statute in 1964 "apparently as redundant." See 43 Fed. Reg. 49,962 (1978).

In any event, discrimination on the basis of race, color, or national origin, but not creed is also prohibited by Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000(d) (1976), and would apply to all Hill-Burton recipients as recipients of federal funds. Consequently, the regulations anticipate some overlap in enforcement responsibilities. See 43 Fed. Reg. 49,962 (1978).

¹⁶³ As in previous community service regulations, see notes 151-52 *supra*, there is no durational limitation on the community service obligation as defined in the 1979 regulations. Interestingly, in the material accompanying the issuance of the regulations HEW contended that because of prior judicial decisions there is no limit on the community service obligation of Title VI (Hill-Burton) facilities. See 44 Fed. Reg. 29,397 (1979). But HEW imposed no limit on the community service obligation of Title XVI facilities (the new program established in 1974) because of the "at all times" language of the 1974 legislation. See note 14 *supra*. It must be noted that the regulation failed to clarify how this unlimited duration will be treated in the event of a closure or a conversion of a facility more than twenty years after the receipt of federal assistance. The explanatory material in the federal regulations purported to answer the question, but failed to do so. See 44 Fed. Reg. 29,399 (1979).

to persons who are unable to pay for them unless those persons are required to be provided uncompensated services under the provisions of Subpart F.

* * *

A facility is out of compliance with its community service assurance if it uses an admission policy that has the effect of excluding persons on any ground other than those permitted under paragraph (a) of this section

... 164

The principal substantive difference between these community service regulations and prior interpretive efforts lies in their level of specification. At least since 1964, Hill-Burton facilities have been specifically prohibited from discriminating against people who can pay for their services.¹⁶⁵ And, since 1946, facilities have been required by both regulation and statute to "be available to all."¹⁶⁶ The prior regulations, however, gave little indication of how these principles would be applied in practice.¹⁶⁷ Even had there been a governmental interest in enforcing the earlier regulations, which quite plainly there was not, there would have been no regulatory standard by which state or federal agencies could measure compliance with community service.¹⁶⁸ For that matter, the prior regulations appear purposefully to avoid addressing some critical — and obvious — issues.¹⁶⁹

¹⁶⁴ 42 C.F.R. § 124.603(a)-(d) (1980), *as amended by* 44 Fed. Reg. 29,380 (1979). The use of the term "effect" and the expression of the standard of compliance in these terms has particular significance, since the substantive obligation is defined as a proscription on "discrimination" against any resident. By explicitly defining an "effect" test for compliance, the regulation avoids any implication that a recipient facility must also show some kind of intent or a specific purpose as a basis for use of an exclusionary practice, an interpretation surely to be challenged should these regulations be enforced.

¹⁶⁵ See description of the 1964 community service regulations in text at note 136 *supra*. Note that the 1964 regulations outlined a slightly different list of factors upon which admission could be limited, but did impose ostensibly the same substantive requirements on recipient facilities, i.e., recipient facilities were prohibited from discriminating against anyone except under specified circumstances.

¹⁶⁶ The regulations issued in 1947 merely reiterated the "available to all" language of the original statute, see note 131 *supra*, but they did make the permissive language of the statute mandatory and thus impose an "available to all" requirement on all subsequent recipients of program funds.

¹⁶⁷ There is no record that any further formal or informal interpretative materials were ever produced, at least prior to 1972.

¹⁶⁸ Even the 1974 community service regulations which purported to specify the meaning of "community service" gave little or no indication of how compliance would be measured or whether an "intent" or an "effects" test would be employed. For that matter, the 1974 regulations were virtually silent as to the method or procedures of enforcement. See notes 148-50 *supra*.

¹⁶⁹ For example, the 1974 regulations require facilities to make arrangements with "federal governmental third party programs, such as Medicare and Medicaid, to the extent that the applicant is entitled to reimbursement at reasonable cost under a formula established in accordance with applicable Federal law." 42 C.F.R. § 53.113(d)(2)(i) (1975).

Given that Medicaid and Medicare had been in effect for at least eight years and that a large portion of the American population relied on these federal programs to pay for hospital care, it is difficult to understand how the federal agency responsible for enforcing these regulations could fail to decide whether Medicaid and Medicare were, for purposes of enforcement, "reimbursement at a reasonable cost . . . in accordance with applicable Federal law." For other examples of obvious omissions from prior interpretive regulations, see note 149 *supra*.

The new community service regulations, however, leave no doubt as to their intent or their application to critical circumstances. By defining "available to all" in terms of discrimination and measuring discrimination in terms of an "effect test," the regulations quite explicitly preclude the exclusion of anyone who is in need of the services offered by the facility¹⁷⁰ and is able to make some manner of payment.¹⁷¹ This substantive standard is buttressed by a series of illustrative examples¹⁷² which clarify the application of the standard in

¹⁷⁰ 42 C.F.R. § 124.603(a) (1980). A facility is also precluded from excluding any resident who requires emergency services even without an ability to pay. 42 C.F.R. § 124.603(b) (1980) reads:

(1) A facility may not deny emergency services to any person who resides (or, in the case of facilities assisted under Title XVI of the Act, is employed) in the facility's service area on the ground that the person is unable to pay for those services.

(2) A facility may discharge a person that has received emergency services, or may transfer the person to another facility able to provide necessary services, when the appropriate medical personnel determine that discharge or transfer will not subject the person to a substantial risk of deterioration in medical condition.

In addition, under these regulations, a recipient facility cannot deny services to people who cannot pay if the facility has not satisfied its concomitant uncompensated service obligation. 42 C.F.R. § 124.603(a)(1) (1980).

¹⁷¹ According to the 1979 regulations, non-compliance could be demonstrated either on the basis of an individual complaint, 42 C.F.R. § 124.606 (1980), or based on statistical inferences derived by a comparison of the characteristics of the patients admitted to a facility to the characteristics of the population of the area served by the facility. See 42 C.F.R. § 124.605 (1980). For a full explanation of how HHS proposes to conduct such investigations, see PUBLIC HEALTH SERVICE, DEPARTMENT OF HEALTH AND HUMAN SERVICES, COMPLIANCE STANDARDS MANUAL: UNCOMPENSATED CARE AND COMMUNITY SERVICE OBLIGATIONS (first published in 1979).

¹⁷² The regulations list three illustrative examples:

(1) A facility has a policy or practice of admitting only those patients who are referred by physicians with staff privileges at the facility. If this policy or practice has the effect of excluding persons who reside (or for Title XVI facilities, are employed) in the community from the facility because they do not have a private family doctor with staff privileges at the facility, the facility would not be in compliance with its assurance. The facility is not required to abolish its staff physician admissions policy as a usual method for admission. However, to be in compliance with its community service assurance it must make alternative arrangements to assist area residents who would otherwise be unable to gain admission to obtain services available in the facility.

* * *

(2) A facility, as required, is a qualified provider under the Title XIX Medicaid program, but few or none of the physicians with staff privileges at the facility or in a particular department or sub-department of the facility will treat Medicaid patients. If the effect is that some Medicaid patients are excluded from the facility or from any service provided in the facility, the facility is not in compliance with its community service assurance. To be in compliance a facility does not have to require all of its staff physicians to accept Medicaid. However, it must take steps to ensure that Medicaid beneficiaries have full access to all of its available services.

* * *

(3) A facility requires advance deposits (pre-admission or pre-service deposits) before admitting or serving patients. If the effect of this practice is that some persons are denied admission or service or face substantial delays in gaining admission or service solely because they do not have the necessary cash on hand, this would constitute a violation of the community service assurance. While the facility is not required to forego the use of a deposit policy in all situations, it is required to make alternative arrangements to ensure that persons who probably can pay for

several regards, anticipating important, controversial questions which will undoubtedly arise in any rigorous enforcement effort.¹⁷³

First, unlike earlier regulations, the 1979 regulations explicitly clarify the obligations of Hill-Burton recipients with regard to people who rely on Medicaid or Medicare for their payment,¹⁷⁴ an issue adroitly muddled by earlier regulations.¹⁷⁵ Though virtually all hospitals take Medicaid and Medicare patients, and many rely heavily on these public programs for a large part of their revenues,¹⁷⁶ some hospitals take very few Medicare and, particularly, Medicaid patients;¹⁷⁷ all do so with increasing reluctance.¹⁷⁸

the services are not denied them simply because they do not have the available cash at the time services are requested. For example, many employed persons and persons with other collateral do not have savings, but can pay hospital bills on an installment basis, or can pay a small deposit. Such persons may not be excluded from admission or denied services because of their inability to pay a deposit.

42 C.F.R. § 124.603(d)(1)-(3) (1980).

Following these illustrations are examples of "alternative arrangements" that a facility might, but is not necessarily required to, undertake, including hiring additional physicians, requiring physicians to take Medicaid or other patients, and other alterations of day-to-day hospital practices.

¹⁷³ See 44 Fed. Reg. 29,397-99 (1979) (explanatory material accompanying the regulations).

¹⁷⁴ 42 C.F.R. § 124.603(c) (1980) requires facilities to be certified as Medicaid and Medicare providers. The illustrations that follow require further that all Medicaid and Medicare recipients seeking treatment must be accepted. 42 C.F.R. § 124.603(d)(2) (1980).

Although it is not specifically required by the regulations, the explanatory materials that accompany the regulations indicated that facilities must also make arrangements with private reimbursers such as Blue Cross and Blue Shield. 44 Fed. Reg. 29,374 (1979). But there is no specific reference to private third party payors in the text of the regulations. Such a requirement is implied, however, by the general requirement to accept all residents who are able to pay. See 42 C.F.R. § 124.603(c) (1980). Note also that HEW earlier had taken the position that arrangements with private third party payors were part of a facility's community service implied but not stated in the federal regulations issued in 1974. See notes 145 and 169 *supra*.

¹⁷⁵ See note 149 *supra*.

¹⁷⁶ The American Hospital Association counted 6,293 hospitals in their national survey in 1979. AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS: 1979, 191 (1980). Not all of these hospitals are acute care facilities. See *id.* at xii. The latest government figures indicate that 6,128 acute care hospitals were certified for participation in Medicare in 1979. *Id.* at 2. Hence, virtually all acute care hospitals participate. More importantly, Medicare paid for over 26% of all hospital care in 1979. Gibson, *National Health Expenditures, 1979*, 2 HEALTH CARE FINANCING REVIEW 1, 6 (1980).

Figures for the participation of hospitals in Medicaid are generally not available, except from each individual state agency. In aggregate amount, however, Medicaid paid for nearly 10% of the services provided in the nation's acute care hospitals. *Id.*

¹⁷⁷ See Rosenblatt, *supra* note 30, at 280-81.

¹⁷⁸ There are a number of reasons for this reluctance. Both programs allegedly impose burdensome paperwork on providers seeking reimbursement. In particular, Medicaid reimbursement payments are delayed for many months in some states. Both programs also reimburse hospitals on the basis of a complicated assessment of "reasonable costs." The result is that facilities often receive for their services an amount somewhat less than the rate they charge to some private-pay patients for the same services.

The impact of Medicaid and Medicare reimbursement on a facility's willingness to take these patients is complicated by the fact that reimbursement of physicians for services rendered to patients in hospitals is separate from reimbursement to the hospital and, particularly under Medicaid, often far less than the physician's customary charges. See Rosenblatt, *supra* note 30, at 280-81. For a good analysis of this problem, see D. ROWLAND, PHYSICIAN PAYMENT: ASSURING

The definition of ability to pay as illustrated in the regulations also severely limits the use of pre-admission cash deposits. While not prohibited by the regulations, deposits cannot be used where the effect is to exclude people who do not have cash but who could pay on an installment basis, or people from whom some other form of payment "probably" could be collected.¹⁷⁹ In addition, if a facility admits only those patients who are referred by members of the hospital's medical staff — a practice employed by virtually all non-teaching hospitals — the facility must provide an alternative means for admitting people who are otherwise admissible under the regulations but who do not have a personal physician on the facility's staff.¹⁸⁰

As the foregoing examination of the development of the community service regulations indicates, the community service regulations of 1979 impose conditions on recipient facilities which are far more concrete than the vague conditions imposed by the 1947 regulations. The critical issue is whether such regulations are a valid exercise of administrative authority.

B. *Challenges to the 1979 Regulations*

Critics of the present charity care regulations have argued that the regulations are invalid because they exceed the scope of authority allowed by the statute. In addition, they argue, the regulations cannot be applied retroactively without impairing the contract or property rights of recipient facilities.

The question of whether the 1947 regulations exceed the scope of the statute depends upon an interpretation of the 1946 legislation. If the original statute allows a broad interpretation, as this article contends,¹⁸¹ then so would the reiterated language in the 1947 regulations. Accordingly, there is no legal principle¹⁸² or compelling argument in equity¹⁸³ which would prevent an agency, through rule-making or adjudication, from defining a vague statutory con-

ACCESS AND CONTAINING COST (published by the Legal Services Corporation, March, 1980).

¹⁷⁹ The regulations do not prohibit "cash only" or "pre-admission cash" policies, as was considered by HEW at the time the regulations were imposed, but instead attempt to limit the use of such policies when they tend to exclude some people who arguably can pay, but not in cash. See 42 C.F.R. § 124.603(d)(3) (1980), cited in full at note 172 *supra*. The critical term "probably can pay" is unquestionably vague but does indicate the intent of the regulation, if not its exact meaning. It is certain, therefore, to be the focus of enforcement problems. See 44 Fed. Reg. 29,399 (1979).

¹⁸⁰ 42 C.F.R. § 124.603(d)(1) (1980).

¹⁸¹ See text at notes 91-100 *supra*.

¹⁸² Whether dealing with an interpretation embodied in a subsequent interpretive regulation, or an interpretation incident to an individual enforcement action, an administrative agency has broad discretion to interpret the substantive standards incorporated in prior regulations, limited only by the usual requirement that an interpretation be reasonable and within the scope of the statute that created the administrative authority. See *United States v. Larionoff*, 431 U.S. 864, 869-73 (1977); *Udall v. Tallman*, 380 U.S. 1, 16-17 (1965). Indeed, "extra weight may be given to an interpretive rule because of such factors as agency specialization, statutory reenactment, contemporary construction, and longstanding effectiveness." K. DAVIS, *ADMINISTRATIVE LAW OF THE SEVENTIES* § 5.05, 162 (1976). These factors arguably apply to the present inquiry.

¹⁸³ See text at notes 187-88 *infra*.

dition.¹⁸⁴ If it were determined, however, that the original statute allows only a narrow interpretation, then expansive definitions of statutory terms, such as the 1979 regulations, might be invalid as applied to facilities that received funds while the 1947 regulations were in effect.

A similar analysis must be applied to determine whether the 1979 regulations impair the contract or property rights of Hill-Burton recipients prior to 1964 by imposing retroactive conditions upon them.¹⁸⁵ The essence of the critic's argument is that subsequent administrative action established a new condition that was not part of the original transaction that created vested interests on the part of Hill-Burton recipients. If, rather than creating a new condition, however, the 1979 regulations merely delineated a vague, existing statutory condition, then the administrative action should withstand judicial scrutiny on constitutional or equitable grounds.¹⁸⁶

Both inquiries, therefore, principally turn on the characterization of the "available to all" language which appears in the original statute and in the 1947 regulations. If this language is viewed as a vague condition allowing subsequent interpretation, the broad interpretation of the statute and of the original regulation may be upheld as an act within the scope of the agency's authority. Consequently, the subsequent specification of conditions created by the provision would also be upheld. Yet if the statutory language is viewed narrowly, any subsequent regulation or administrative interpretation defining community service in its broader sense would be tantamount to the creation of a new obligation. Whether phrased in constitutional terms or simply in terms of equity, the creation of what is viewed by the courts as a new condition, and

¹⁸⁴ See note 130 *supra*.

¹⁸⁵ If a subsequent administrative action to enforce a new condition is applied after the receipt of funds and is viewed as impairing established property or contract rights, constitutional principles may require that the administrative action be judicially examined, perhaps even closely scrutinized. There is substantial authority that suggests that a subsequent interpretation of a statute or regulation that is in effect a retroactive change in a previous interpretation *may* be invalid, particularly under circumstances where individuals affected by the change can claim detrimental reliance on the initial interpretation. See *Automobile Club of Mich. v. Commissioner of Internal Revenue*, 353 U.S. 180, 183 (1957); *Helvering v. Griffiths*, 318 U.S. 371, 403 (1943); *Manhattan Gen. Equip. Co. v. Commissioner*, 297 U.S. 129, 134 (1936). See also *NLRB v. Pease Oil Co.*, 279 F.2d 135, 139 (2d Cir. 1960). See *Vanderbilt Note*, *supra* note 30, at 1480-94. But note that the reasoning of these cases applies to interpretations that are both retroactive in their application and alterations of previous interpretations, not further specifications of a vague or unsettled rule. See K. DAVIS, *ADMINISTRATIVE LAW TEXT* § 5.09 (1959).

A subsequent interpretation of the 1947 community service regulation to clarify its meaning would not be a change in a previously stated rule but a clarification of a vaguely termed requirement. It might not even be retroactive in effect, depending upon such factors as the circumstances of the subsequent interpretation, and the terms of remedial measures required for non-complying facilities. Similarly, and more importantly, as discussed in the text at notes 205-25 *infra*, the 1979 regulations interpreting the 1964 community service regulations were intended only to clarify further, not alter retroactively, previously established rules. For that matter, since the general thrust of the enforcement provisions incorporated in the 1979 community service regulations is to require remedial steps to facilitate future compliance — there is no deficit "makeup" or punitive sanction authority — the new regulations may be viewed as prospective in their actual impact.

¹⁸⁶ See note 182 *supra*.

its retroactive application to previous recipients of funds is unlikely to withstand judicial scrutiny.¹⁸⁷

Turning to an analysis of the Hill-Burton legislation itself, it would be difficult for a court to conclude that the regulations issued in 1947 allow the enforcement of a community service obligation as subsequently specified in 1979 — at least as applied to facilities that received funding after 1946 but before 1964.¹⁸⁸ A court possibly could find that by enacting the original “available to all” language, Congress created statutory language with the intent of allowing subsequent administration discretion to dictate the scope of its meaning; it would be more difficult to find that the administrative agency in 1947 had a similar intent in issuing the “available to all” regulations, particularly when viewed after three decades of inaction.

None of these criticisms apply, however, to the validity of administrative attempts to establish a broadly defined community service obligation or, more particularly, to the validity of the 1979 regulations when considered in light of the 1964 amendments¹⁸⁹ to the “available to all” statutory language or the regulations issued thereafter.¹⁹⁰ The amended “available to all” provision included in the 1964 legislation and the legislative history of that amended language offer a clear picture of congressional intent to authorize a broadly interpreted “available to all” requirement.¹⁹¹ Significantly, that authority was exercised immediately following the enactment of the 1964 amendment, and in a manner that left no doubt as to HEW’s interpretation of Congress’ intent.¹⁹² As summarized earlier, under the regulations issued in 1964 following the statutory amendment, recipient facilities were prohibited from discrimination on the basis of race, creed, color, or national origin,¹⁹³ and required to provide

¹⁸⁷ This is only assuming that the new interpretations would be applied retroactively, i.e., to facilities that had received Hill-Burton assistance before the issuance of a new interpretation. Had the federal agency subsequent to 1947 (and prior to 1964) issued new community service regulations to be applied to future applicants, strong arguments could be made that this was in accordance with the discretion created in the 1946 statute. See note 178 *supra*. This would have eliminated the basis for a constitutional or equitable objection to community service enforcement, since all future applicants would be aware of the interpretation of the condition at the time of receipt of funds. See text at note 185 *supra*.

¹⁸⁸ Virtually all courts that have considered the validity of a community service obligation as derived from the 1946 statute or 1947 regulations have come to this conclusion. See *American Hosp. Ass’n v. Harris*, 625 F.2d 1328, 1342-43 (7th Cir. 1980) (Pell, J., concurring and dissenting); *Perry v. Greater Southeast Wash. Community Hosp. Found.*, No. 721-71 at 5 (D.D.C. June 28, 1972).

¹⁸⁹ See text at notes 44-47 and 104-06 *supra*.

¹⁹⁰ It must be noted that the 1964 amendments, by explicit provision of that legislation, apply only to recipients of funds after 1964. See Pub. L. No. 88-443, § 3(b), 78 Stat. 462 (1964). Thus, facilities that received funds prior to 1964 could only be held to whatever obligation was created by the statute and regulations that existed prior to that date.

Notwithstanding, there were a substantial number of hospitals and other health facilities that received Hill-Burton assistance after 1964. According to HEW estimates, 1742 projects were funded from 1966 through 1971, at a cost of nearly \$944 million. DHEW, HILL-BURTON PROJECT REPORT 29 (1972).

¹⁹¹ See text at notes 107-18 *supra*.

¹⁹² See *Cook v. Ochsner Found. Hosp.*, 61 F.R.D. 354, 360 (E.D. La. 1972).

¹⁹³ More correctly, the 1964 regulations prohibited discrimination based on creed, and

community service, explicitly defined in the text of the regulations as making "services . . . available to the general public, or . . . limited only on the basis of age, medical indigency or type or kind of medical or mental disability."¹⁹⁴ Without further administrative interpretation the 1964 regulations may have been insufficiently specific to allow for independent judicial enforcement, absent agency action.¹⁹⁵ For that matter, the definition of community service includes some perplexing language.¹⁹⁶ Yet the substantive parameters of the obligation created are clearly defined: after 1964 recipient facilities were to provide their services to any member of the public, except for people who are excepted under the community service definition. This definition included among those excepted from the community service definition the medically indigent, meaning, presumably, people who cannot pay their medical bills.¹⁹⁷

There can be little room to argue that these regulations were beyond the scope of the discretion created by the 1964 legislation or that the general meaning of these regulations is unclear.¹⁹⁸ Therefore, at the very least, facilities that received funds after the 1964 regulations were issued should be bound to comply with any reasonable administrative application of these substantive standards.¹⁹⁹ Any subsequent regulations or administrative action interpreting the

drew attention to the Civil Rights Act of 1964 which prohibited discrimination based on race, color, or national origin. See notes 77-79 *supra* and explanation at note 158 *supra*.

¹⁹⁴ For the full text, see notes 134 and 136 *supra*.

¹⁹⁵ See note 146 *supra* and note 199 *infra*. From the viewpoint of administrative enforcement, the 1964 regulations obviously had major problems, most particularly the failure to specify the procedures by which these requirements would be applied and enforced. Presumably, state Hill-Burton agencies were expected to monitor compliance as they monitored compliance with the other requirements imposed on recipient facilities. Subsequent experience indicated, however, that the states were either unwilling or unable to do so, see note 150 *supra*, justifying later amendments to these regulations in 1974 and 1979. See notes 202 and 208-17 *infra*. While the failure to specify the method of application of these requirements may well have been a political signal to recipients that the federal government had a lax attitude towards enforcement, it is hardly a basis for the creation of a judicially enforceable expectation of nonenforcement. For that matter, without further amendment to the regulations or specific delineation of enforcement procedures, HEW could have undertaken to enforce these regulations, or asked states to do so, using general administrative procedures and standards developed on a case-by-case basis.

¹⁹⁶ For example, it is not clear what is meant by allowing limitation of services based on age. See note 136 *supra*. In recent years "age discrimination" has come to mean primarily discrimination against older people. Was this intended by the 1964 regulation? Or at the other extreme, was this an exception merely to allow such institutions as children's hospitals to receive Hill-Burton assistance without violating the community service obligation? There is nothing in the administrative or legislative history further specifying the meaning of this exception, or indicating what was intended by this language.

¹⁹⁷ It is important in this context to note that community service was one of two charity care obligations; the other, the requirement of uncompensated service, defines the amount of service recipient facilities must provide free or below cost; uncompensated service is a separate and distinct obligation, but one which must be read together with community service. For a lengthy discussion, see Rose, *supra* note 30.

¹⁹⁸ See text at notes 167-75 *supra*.

¹⁹⁹ *Cook v. Ochsner Found. Hosp.*, 61 F.R.D. at 360. The court in *Perry*, though critical of the enforceability of the community service regulations by judicial process, nonetheless recognized the validity of the obligation created by the 1964 statute and subsequent regulations.

conditions created by the 1964 regulations would be valid as applied retroactively to 1964 in monitoring or enforcing compliance by post-1964 recipients of assistance. Therefore, if subsequent regulations are a reasonable administrative application of the substantive standards outlined in the 1964 legislation and regulations, they are neither an invalid exercise of administrative authority, nor a retroactive application of a new condition.

Turning to the 1974 community service regulations,²⁰⁰ the validity of which went unchallenged by the hospital industry, it seems clear that they are valid extensions of the 1964 amendments and regulations. In requiring recipient facilities to participate in Medicaid and Medicare and to take "such steps as necessary" to insure that Medicaid and Medicare recipients were admitted without discrimination, the 1974 regulations did not create a new obligation.²⁰¹ Rather, they were an interpretation by HEW of the substantive obligation created by statute in 1964 with specific reference to one form of payment which experience had indicated presented a substantial enforcement problem.²⁰² In fact, HEW was making such a specification under a court order to issue further interpretative regulations providing for the enforcement of the obligation created in 1964 and specifying that the obligation required facilities to be available to Medicaid or Medicare recipients.²⁰³

The 1974 regulations are vulnerable to criticism for failing to incorporate into the substantive interpretation of "available to all" a clear statement of how compliance with the obligation would be monitored and enforced.²⁰⁴ For

See Perry v. Greater Southeast Wash. Hosp. Found., No. 721-71 at 6 (D.D.C. June 28, 1979). In fact, after noting that the 1964 community service regulations were lacking in enforceable standards — meaning standards that would allow judicial enforcement of the obligation absent agency action — the court strongly urged HEW to issue clarifying regulations. *Id.* at 7. This strongly implies the court's belief in the validity of the 1964 statute and regulations and the need for further specification of enforcement standards and procedures.

Similarly Judge Pell's dissent in *Harris*, while quite critical of HEW's interpretation of uncompensated service, limits his criticism of the community service as interpreted in 1979 to the narrow issue of the adequacy of the methods of enforcement. *American Hosp. Ass'n v. Harris*, 625 F.2d at 1342-43. See note 217 *infra*. Unfortunately, some critics have failed to consider the impact of the 1964 regulations. For example, the elaborate chart of Hill-Burton regulations found in the Vanderbilt Note, *supra* note 30, at 1057, omits any reference to the 1964 regulations. Such consideration is necessary for an accurate assessment of the validity of later regulations.

²⁰⁰ See text at notes 146-49 *supra*.

²⁰¹ HEW explicitly stated in the introduction to the 1974 regulations that the new regulations were only intended to make previously established requirements of community service more explicit. 39 Fed. Reg. 31,766 (1974).

²⁰² HEW had substantial basis for issuing further regulations. Experience had indicated that further specification of "available to all" was necessary to deal with the type of circumstances that would likely be presented in compliance review. See examples cited in Rosenblatt, *supra* note 30, at 270-71 n.104-06. The need for further specification of the obligation was also noted by many witnesses testifying on the uncompensated service regulations issued in 1972-73. See 37 Fed. Reg. 14,719 (1973).

²⁰³ In *Cook v. Ochsner Found. Hosp.*, 61 F.R.D. 354 (E.D. La. 1972), HEW was ordered to issue new interpretive regulations allowing for the enforcement of community service and specifically required to indicate whether community service included service to Medicaid and Medicare recipients. *Id.* at 360-61. See also cases cited in note 146 *supra*.

²⁰⁴ As mentioned before, the original regulations can also be criticized for failing to provide methods for monitoring compliance other than delegating compliance responsibility to state agencies *in toto*, without any specification or delineation of this responsibility. See text at notes

example, while it was made explicit in 1974 that Medicaid recipients are within the broad category of people for whom Hill-Burton facilities must be made available, the 1974 regulations are conspicuously silent concerning the methods by which this availability would be measured. It is not clear under the 1974 regulations if a facility must merely show it had no policy or intent to discriminate against Medicaid recipients or whether it must prove Medicaid recipients were in fact provided services in order to comply with the community service requirement.

The same issues can be raised with regard to any group or individual within the broad protection apparently secured by the community service obligation. Without further specification, it is not clear whether the agency interpreted the obligation to be merely a negative injunction on "classical" discrimination, or an affirmative obligation to provide service to certain groups. Consequently, compliance with the community service obligation could be realistically determined only on an *ad hoc*, case-by-case basis, if at all, and not by reference to any administrative interpretation of the standard of compliance. Such a situation is hardly beneficial either to the public or to any Hill-Burton recipient that sought to make a good faith effort to comply with their obligations.

By further specifying the substantive standards enunciated in 1964, the 1979 regulations respond to the fundamental criticisms of the 1974 regulations,²⁰⁵ and increase the likelihood for more uniform and realistic community service enforcement activities. The essential substantive²⁰⁶ elements of the new regulations, as outlined earlier,²⁰⁷ define the principle of "available to all" in terms far more detailed than the perplexing explication of the 1964 regulations, or the 1974 amendments, and describe quite specifically how those substantive standards should be applied and enforced particularly with regard to certain circumstances.

Most importantly, the 1979 regulations clarify the general prohibition on discrimination²⁰⁸ against people who have the ability to pay. As discussed earlier the regulations adopted an "effects" test for determining compliance

133-38 and note 195 *supra*.

²⁰⁵ See citation to HEW's explanation of the need for further regulations at notes 155-58 *supra*. HEW was also responding to criticism Congress leveled during consideration of the 1974 legislation, see note 153 *supra*, and to various issues raised by consumer lawsuits, see note 154 *supra*.

²⁰⁶ The essential procedural element in the 1979 regulations, of course, is the "federalization" of the enforcement activities. See notes 156 and 195 *supra*. The 1974 regulations had delegated virtually all responsibility for enforcement and monitoring and enforcing compliance to the state Hill-Burton agencies, without any specification of the means or procedures to be followed. Presumably, no one challenges the authority of the federal administrative agency to amend the community service obligation in this manner, particularly after the 1974 and 1979 legislative mandates to HEW to do so. See notes 14-15 and 121-29 *supra*. Nonetheless, the impact of this change in the regulations could be as substantial as any other aspect of the 1979 regulations.

²⁰⁷ See notes 159-80 *supra*.

²⁰⁸ As noted earlier, the regulations also add a final note of clarity to the prohibition on discrimination against Medicaid and Medicare as stated in the 1974 regulations. See notes 169 and 174 *supra*.

with the substantive obligation of community service,²⁰⁹ and illustrate both applications of that test and remedial steps that would be sought if a facility were not in compliance.²¹⁰

For example, the regulations make it clear that if a decision or practice by a member of the recipient facility's medical staff has the effect of excluding anyone from the facility who is a Medicaid or Medicare recipient, or who has any other ability to pay, then the facility must take some measure to provide for the admission of that person by alternative means.²¹¹ This approach avoids the difficulty of divining an overt policy or specific intent from the complexity of relationships inherent in the modern health facility — a concession to administrative convenience — while also avoiding the hardship of holding the recipient facility necessarily responsible for the actions of any one individual physician, or even a group of physicians.²¹² It does, however, require a facility to take steps to insure compliance²¹³ where those actions result in a measurable effect on the total services provided by the institution as a whole. Thus, the regulations clarify the application of community service in such a way as to both anticipate and allow voluntary compliance and facilitate realistic enforcement activities.

For similar reasons, the 1979 regulations address the issue of access to recipient facilities by people who have the ability to pay for services but do not have a personal physician on the facility's medical staff. Such individuals are often effectively denied admission by the traditional practice in most non-teaching hospitals of admitting patients only on the order of a member of the facility's medical staff. The 1979 regulations again rely on the pragmatic "effects" test. The regulations do not go so far as to prohibit the traditional practice, but only require that a Hill-Burton facility make alternative arrangements for the admission of any person otherwise admissible but without a personal physician.²¹⁴

²⁰⁹ 42 C.F.R. 124.603(a)-(d) (1980). See note 164 *supra*.

²¹⁰ See text at notes 172-80 *supra*.

²¹¹ See text of 42 C.F.R. § 124.603(d)(2) (1980) and note 172 *supra*.

²¹² It must be noted that the 1979 regulations, for the first time, directly refer to the problem of medical staff physicians. Given the virtually complete control physicians exercise over admissions in most hospitals, it is hard to believe that earlier federal or state regulations could have avoided addressing how the actions or policies of physicians would be considered in determining compliance of the facilities in which they practice. The text of the 1979 regulations and the explanatory material that accompanied the issuance of the regulations explain both the legal basis for this new and, finally, realistic interpretation of "community service" and the policies behind it. See 44 Fed. Reg. 29,399 (1979).

While neither the hospital industry nor the medical profession may be comfortable with the specific reference to this sensitive issue, this approach seems on its face to be both a reasonable and a practical approach to community service enforcement, making some concession to administrative convenience but also avoiding the harsher implications of holding a facility responsible for any physician's conduct per se. In any event, it is a vast improvement over previous regulations which, somehow, chose to ignore this critical issue.

²¹³ See notes 172-73 *supra*.

²¹⁴ 42 C.F.R. § 124.603(d)(1) (1980). A similar approach is also taken to the issue of pre-admission or "cash only" deposits. The practice is not prohibited per se, but where the prac-

The specification of the standards by which the community service obligation would be measured, and the illustrations of its application, are buttressed by the delineation — again for the first time in the federal regulations — of remedial steps that may be required of a facility that fails to provide community service.²¹⁵ While broaching sensitive issues, the regulations again come to grips with an issue that without specification would make individual compliance or enforcement extremely unlikely. Furthermore, the specified remedies are stated in such a manner as to make considerable concession to the practical problems that a facility may encounter in gaining the cooperation of its medical staff.²¹⁶ Non-complying facilities are not required to alter administration of their facility or to require compliance with the requirements of community service by their medical staff in any particular way. In keeping with the “effects” test, Hill-Burton facilities are only required to make alternative arrangements that will result in admission of those people who are protected by community service, but who are excluded by the practices or policies of the institution or its medical staff; recipient facilities are not given a list of exclusive remedies that they must adopt, but are given specific examples of the kind of remedial steps which could be taken or that could be required if the facility fails to develop an acceptable alternative.²¹⁷

The 1979 regulations may have been written with unprecedented specificity and therefore have served as an invitation to controversy, but they were also necessary prerequisites to the enforcement of the obligation. This is hardly a matter of speculation, given the experience of the last several decades. Nor is it even a matter exclusively for the judgment of the federal administrative agency. Repeated judicial, administrative, and legislative inquiries into the meaning of community service and state and federal enforcement of that obligation have come to the same conclusion: additional interpretive regulations and additional specification of the procedures by which the obligation would be monitored and enforced were clearly required. Indeed, further regulations were mandated by the courts and by Congress.

tice has the effect of excluding people who “probably” can pay, alternative arrangements must be made. 42 C.F.R. § 124.603(d)(3) (1980). See note 179 *supra*.

²¹⁵ See 42 C.F.R. § 124.603(d)(1)(i-v) and § 124.603(d)(2)(i-v) (1980).

²¹⁶ This may be especially important for facilities that have considerable trouble gaining the cooperation of medical staff physicians, particularly in regions of the country where the shortage of physicians gives the facility little choice but to offer privileges to non-cooperating physicians.

²¹⁷ Surprisingly, the dissent in *American Hosp. Ass'n v. Harris*, criticizes this aspect of the new “community service” regulations. Indeed, this is apparently the only fault Judge Pell found with the community service regulations promulgated in 1979. He had a number of objections to the uncompensated service regulations. 625 F.2d at 1343. Judge Pell found the enumeration of examples of compliance as tantamount to requiring those exemplified activities as the only proper form of remedy. HEW’s explanation of the regulations that accompanied the issuance of the regulations effectively rebuts this assertion, and lays out a rationale for this approach. See 44 Fed. Reg. 29,398 (1979). Essentially, the agency was trying to avoid tying the hands of facilities while attempting to clarify remedial steps—a legitimate concern given that any community service enforcement would be unprecedented by administrative experience.

The statutory basis created in 1964, and exercised by regulation shortly thereafter, without looking further, seems to have created sufficient authority for these regulations.²¹⁸ In addition, Congress in 1974²¹⁹ and again in 1979²²⁰ specifically applauded — and virtually required — efforts to issue further interpretive community services regulations. Significantly, none of those authorities questioned the statutory authority of HEW to issue further interpretive regulations, nor did they note any constitutional barriers to their promulgation.²²¹

Moreover, the circumstances which allow the argument that administrative agencies are prohibited from retroactively imposing obligations or altering those previously established are not presented,²²² at least on the face of the regulations as enacted in 1979. That is, HEW attempted only to specify the obligations created in 1964 and provide for monitoring and enforcement of compliance. Thus, the agency did not create new conditions for post-1964 recipients.

In short, if the 1979 regulations interpreting community service were anything less than they are, that is, if the critical issues of compliance standards and remedies had not been addressed in specific terms, it would be hard to imagine any realistic federal monitoring or enforcement activities. Without these regulations, community service would mean little more than what each facility would choose it to mean. Moreover, in issuing the 1979 regulations, HEW supported the exercise of discretion with considerable documentation,²²³ particularly with regard to the need for further specification of the standards of compliance and the procedures for enforcement.²²⁴ As argued earlier, HEW was entitled to wide discretion in adding further specifications to the 1964 and 1974 regulations for the purpose of clarifying the meaning of community service as applied to specific circumstances and to facilitate an enforcement program.²²⁵ Viewed as such, the new regulations did not create new obligations or alter previously established policies.

Given the nature of these regulations federal officials could hardly be surprised by the controversy they have spawned. These regulations create, for the

²¹⁸ See notes 107-18 *supra*.

²¹⁹ See notes 120-25 *supra*.

²²⁰ See notes 126-29 *supra*.

²²¹ The Maryland Note, *supra* note 30, at 337-69, seems to argue that HEW, then the courts, and finally the Congress misinterpreted the federal statute. In particular the author accused Congress as falling prey to "emotional" arguments in 1974 and attempting to enact *sub rosa* a form of national health insurance by twisting the meaning of the charity care obligation. Whatever merit this undocumented and somewhat novel political analysis may have, it hardly suffices as a method of statutory interpretation. Presumably even when reading a legislative enactment of an "emotional" Congress, one is still attempting to determine what Congress, emotional or otherwise, intended to enact.

²²² See text at notes 185-86 *supra*.

²²³ See note 157 *supra*.

²²⁴ Note, however, that the issue of statutory authority presents a more formidable barrier to enforcement if applied to facilities that received funds prior to 1964. See notes 182-87 *supra*.

²²⁵ See discussion of agency discretion at note 182 *supra*.

first time, the prospect for realistic enforcement of the assurance of community service given by recipient facilities for at least a decade. Unlike earlier efforts, these regulations establish that enforcement will require far more than pro forma assurances or paper compliance. Community service will require, if enforced in the spirit in which the new regulations were written, that facilities provide their services to everyone in their communities without discrimination.

Admittedly there is some element of inequity present. The vague statement of the obligation and the obvious omission of reference to compliance standards in earlier regulations may have created the unstated expectation that compliance with community service would not be closely monitored. This inequity, however, must be weighed against the benefits that will be created by community service enforcement, benefits that have been recognized and supported in law but unenforced for at least two decades. It is the consumer public that can make the far greater case of inequity: the continued failure of state and federal government to make any attempt to monitor or enforce the legally recognized right to community service. Should the federal government retreat from its apparent willingness to pursue community service enforcement, the controversy sparked by the objections of recipient facilities would only be replaced by a re-initiation of the consumer efforts that originally prodded the federal government to enforce community service.²²⁶

CONCLUSION

The Hill-Burton program marked the beginning of federal involvement in mainstream medical care. By conditioning the receipt of facility construction funds on compliance with certain statutory requirements, Congress hoped to increase the availability of institutionally-based health care in areas where services had been shown to be lacking. Among those requirements were so-called "charity care" provisions, requiring funded facilities to engage in a reasonable volume of uncompensated health care and to provide community service. Despite a congressional mandate in 1964 that re-affirmed congressional support for the community service obligation, both federal and state administrative agencies largely ignored Congress' intent. Regulations issued in 1964 did little to facilitate enforcement of this obligation; nor did 1974 regulations. Finally, in 1979, the most comprehensive explanation of the "communi-

²²⁶ It should be noted that enforcement of the assurances given as conditions to Hill-Burton grants and loans is only one of several ways that this obligation could be recognized. A similar "community service" obligation is also imposed on all non-profit health facilities as part of the quid pro quo for receipt of tax-exempt status. Indeed, a government effort to enforce this obligation would affect more health facilities than enforcement of the assurances of Hill-Burton facilities.

It is also conceivable that a community service obligation could be made a condition of licensure, at least in jurisdictions where the enabling legislation created sufficient authority in the licensing agency. See *New Jersey Assoc. of Health Facilities v. Finley*, 83 N.J. 67, 415 A.2d 1147 (1980), *cert. denied, sub. nom. Wayne Haven Nursing Home, et al. v. Finley*, 449 U.S. 944 (1980).

ty service'' obligation of the Hill-Burton program and its successor program was issued by HEW. The regulations, through their specific instructions, made enforcement of the statutory and regulatory requirements a practical possibility for the first time. These regulations, critical to the implementation of the Hill-Burton program's legislative and regulatory framework, are clearly within the discretionary authority granted to federal agencies to implement federal programs. The regulations are not an embodiment of new conditions to be imposed retroactively on funded facilities, but rather stand as the first serious attempt to implement a congressional directive first issued over three decades ago. To deny their validity would not be just to ignore a congressionally-mandated program — it would be to subvert it.