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CONSTITUTIONAL AUTHORITY FOR EXTENDING FEDERAL CONTROL OVER THE DELIVERY OF HEALTH CARE

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When Jimmy Carter took office in January 1977, he promised the nation that he would establish a number of programs to cure its economic ills, including a program of comprehensive national health insurance.¹ His promises were not unexpected: by the mid-1970s, inflation in general, and the inflating cost of health care in particular, had become major political issues in national elections.² Two years

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¹. See, e.g., Presidents Remarks and Question-and-Answer Session with Employees of the Dep't of Health, Education and Welfare, 13 WEEKLY COMP. OF PRES. DOC. 200, 202-03 (Feb. 16, 1977) for an early statement on the economy and health.

². Various polls have indicated the rising political importance of the health care costs inflation issue. A recent survey indicated that the general public found hospital care and doctors' fees to be the first and third most inflationary items in the typical household budget. LOUIS HARRIS & ASSOCs. INC., HOSPITAL CARE IN AMERICA 66 (1978). The same two items were considered the most overpriced by the public and by those members of Congress who serve on health-related committees. Id. Although doctors recognized the dramatic rise of hospital costs, only 27% felt that those costs were overpriced, and only 5% thought their own fees were overpriced. Id.

The need for comprehensive health care reform has been discussed and proposed in a myriad of forms over the past thirty years. The last two Republican Administrations felt the pressures of rising health care costs, and both announced their support for some form of health care reform. In his first Administration, President Nixon sent a strong message to Congress on health care reform, which included an endorsement for prepaid health insurance payments and national health insurance. Special Message to Congress Proposing National Health Strategy, PUB. PAPERS: PRESIDENT NIXON 170 (1971). After more than two years of study, Caspar Weinberger, Secretary of HEW, finally unveiled the Nixon Administration's limited version of national health insurance. Remarks of HEW Secretary Caspar W. Weinberger at News Conference, 9 WEEKLY COMP. OF PRES. DOC. 1451 (Dec. 10, 1973).

President Ford also expressed his support for national health insurance. See Address to a Joint Session of Congress, PUB. PAPERS: PRESIDENT FORD 6, 10 (1974). As the federal budget expanded and inflation increased, however, President Ford indicated that he could no longer support a national health insurance proposal. See State of the Union Address by Gerald Ford to a Joint Session of Congress, 12 WEEKLY COMP. OF PRES. DOC. 43, 48 (Jan. 19, 1976). See also President Carter's Remarks at the Clinton Town Meeting, 13 WEEKLY COMP. OF PRES. DOC. 358,
later, however, President Carter's promise to enact national health insurance had to be revised in the face of political reality and in light of the recognition that an extension of governmentally financed health insurance would require a significant and unpopular increase in federal government spending, which would most likely increase the rate of inflation rather than mitigate its impact.\(^3\) The Administration is still offi-

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President Carter has repeatedly avowed his support for comprehensive national health insurance during his presidency; see note 1 supra. As the Carter Administration has developed various reform proposals in other policy areas, however, the Administration's formal introduction of national health insurance has been repeatedly delayed. See President Carter's Remarks at the United Auto Works Convention in Los Angeles, Cal., 13 WEEKLY COMP. OF PRES. DOC. 724, 730-31 (May 17, 1977) (delayed to early 1978); Question-and-Answer Session with President Carter in Yazoo, Miss., 13 WEEKLY COMP. OF PRES. DOC. 1070, 1081 (July 21, 1977) (delayed to early 1978); Question-and-Answer Session with President Carter in Bangor, Maine, WEEKLY COMP. OF PRES. DOC. 344, 347-348 (Feb. 17, 1978) (delayed to late 1978); The President's News Conference, 14 WEEKLY COMP. OF PRES. DOC. 1322, 1325 (July 20, 1978) (delayed to 1979). Furthermore, as other economic issues and budgetary constraints came to dominate the President's agenda, his original vision of national health insurance became more limited. See Question-and-Answer Session with President Carter in Spokane, Wash., 14 WEEKLY COMP. OF PRES. DOC. 860, 876-877 (May 5, 1978); Question-and-Answer Session with President Carter in Fort Worth, Texas, 14 WEEKLY COMP. OF PRES. DOC. 1157, 1160-1161 (June 23, 1978).

See note 4 and accompanying text infra for the latest national health insurance proposal, and notes 5 & 6 infra for reactions to the proposal.

3. Lead Agency Memorandum on A National Health Program, from the United States Department of Health, Education and Welfare to the President of the United States (Apr. 3, 1978) [hereinafter cited as Lead Agency Memo]. The initial proposals by HEW contained four options from which the administration could choose its plan for national health insurance. The options varied in scope, coverage, role given to government, and cost—giving the President choices ranging from a truly nationalized, comprehensive plan to limited options that were obviously intended to be far less expensive and controversial. Indeed, by proposing a series of options, the HEW proposal effectively delayed the Administration's final choice of a health insurance strategy while the alternatives were being considered. See note 4 infra for Carter's final decision.

The following is a brief discussion of each option:

(1) The Consumer Choice Health Plan is "essentially a plan for federal funding of a privately administered health care financing and delivery system regulated by market forces and competition." Lead Agency Memo, supra, at 13-14. The government would provide vouchers (for the poor) or tax credits for the purchase of federally approved prepaid group plans, which would compete with existing private insurance plans. The consumer would choose whether to use his federal support to join a prepaid plan or purchase private insurance. Id. at 13-16, Tab A at 1-7.

(2) The Target Plan aims at creating programs that would (i) reformulate and improve on Medicare and Medicaid, (ii) establish catastrophic insurance for all citizens, (iii) improve preventive and health maintenance services for children and (iv) establish standards for private insurers, who would continue to provide a majority of insurance coverage. In short, the Target Plan attempts to fill in the gaps in our present system of health care financing. Id. at 17-21, Tab B at 1-6.

(3) The Quasi-Public Corporation would be created to administer national health insurance by replacing private insurance for any services covered by the program. The Corporation would receive federal funds and private premium payments to pay approved providers for services received by any resident. Id. at 21-24, Tab C at 1-6.

(4) Publicly Guaranteed Health Protection would be a universal, public sector national health insurance plan, which would allow employers and individuals to opt out by purchasing insurance from federally approved private companies. The plan would be funded by premiums and taxes. Id. at 24-27, Tab D at 1-6.
cially committed to the enactment of some form of national health insurance, but Carter's latest proposal\(^4\) envisions a program that would be something far less than comprehensive insurance and that would be implemented gradually over the next decade.\(^5\) Even this proposal faces substantial political opposition from the provider community\(^6\) and a cost-conscious Congress.\(^7\)

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4. The President finally announced his principles for national health insurance on July 29, 1978; the principles were a severe disappointment to political liberals, but clearly did not satisfy traditional opponents of national health insurance. While the President continued to assert the need for a comprehensive program, he did not set forth any specifics. He opted instead to gradually phase in the program as economic conditions warranted. The ten principles are as follows:

1. The plan must be comprehensive.
2. The plan must provide quality care.
3. The plan must provide freedom of choice in selecting medical care.
4. The plan must include strong methods of cost containment.
5. The plan should attempt to offset its costs through improved efficiency.
6. The plan should be phased in gradually.
7. The plan should be funded through multiple sources.
8. The plan should include a significant role for the insurance industry.
9. The plan should promote reforms in health care delivery.
10. The plan should include consumer representation.


5. Senator Edward Kennedy and other liberals favor a strong and comprehensive national health insurance plan with immediate and unconditional implementation. See note 233 infra.

6. While the American Medical Association (AMA) has traditionally been opposed to any form of publicly-financed health insurance (for example, the AMA actively opposed Medicare legislation), in recent years the AMA has endorsed the concept of a national health insurance plan and has focused its opposition toward aspects of proposals that involve government control over the services financed. See, e.g., Statement of James H. Sammons, AMA Executive Vice President, AMERICAN MEDICAL NEWS, March 23, 1979, at 4. According to a 1979 poll, for the first time a majority of physicians (54%) see a need for some kind of national health insurance—but only in a limited, rather than a comprehensive, form. AMERICAN MEDICAL NEWS, March 2, 1979, at 9.

7. For example, in June 1979, in response to Carter's proposal, Representative Al Ullman, Chairman of the House Ways and Means Committee, announced his own NHI proposal. Ullman's plan would require no additional federal spending, encourage enrollment in health maintenance organizations, limit federal tax deductions for medical expenses and require employers to offer a choice of insurance plans. HOSPITAL WEEK, June 15, 1979, at 2.
The overall health care policy that is now being formulated by the Carter Administration has a significantly different emphasis as well. President Carter's legislative program for the Ninety-Fifth Congress included several programs intended to control the costs of Medicaid and Medicare, revisions in existing health planning legislation, recommendations to increase the regulatory authority of health planning agencies, and a proposal for direct hospital cost containment. Carter introduced several proposals that would increase federal spending for health services, but these were decidedly minor in nature. More significantly, in November 1978, the Administration announced that the proposed budget for fiscal year 1980 would include substantial cuts in many existing health programs. At the same time, under existing statutory authorization, the Administration has become much more cost...

8. The President's agenda for health care centered on the economic issues, with limited attention paid to new health care programs. Aside from his long-term goal of national health insurance, the President enumerated a number of short-term goals, including the establishment of community mental health centers, the creation of an immunization program, administrative creation of the Health Care Finance Administration, a program attacking fraud and abuse in Medicare and Medicaid programs, the creation of incentives for additional rural health care under Medicare and Medicaid, passage of hospital cost containment legislation and passage of the Child Health Assessment Program. State of the Union Annual Message to the Congress, 14 WEEKLY COMP. OF PRES. Doc. 98, 103 (Jan. 19, 1978).


9. See, for example, S. 1392, 95th Cong., 1st Sess., 123 CONG. REC. S6408 (daily ed. April 26, 1977) for the Child Health Assessment Program (CHAP), a program designed to replace Medicaid's Early and Periodic Screening, Diagnosis and Treatment Program, 42 U.S.C. § 1396d(a)(4)(B) (1976), by extending $1.8 billion in aid to encourage an improved effort to provide health care for poor children.

10. In the fall of 1978, President Carter had indicated that his proposed budget for fiscal year 1980 would substantially cut back the federal health spending. See WASHINGTON REP. ON MED. & HEALTH, December 4, 1978, at 1. His final proposed budget was more moderate but generally held spending at current levels with modest increases in a few programs. For a summary of the proposed federal health budget, see HEALTH SYSTEMS REP., January 26, 1979, at 1-12.
conscious in its Medicaid and Medicare reimbursement determinations and its administration of related regulatory programs. In summary, the Administration’s short-term strategy is emerging: limited and perhaps reduced federal spending for health care, increased efforts

11. Two areas in which HEW has attempted to be more cost conscious are the capital recapture regulations, 42 C.F.R. § 405.415(d)(3) (1977), and the multiple source drug regulations (MAC), 45 id. § 19.1–6 (1977). The recapture regulations recoup excessive amounts of depreciation taken by providers that withdraw from Medicare and Medicaid or have a substantial decline in their patient mix. The MAC regulations attempt to limit federal reimbursement for multiple-source prescription drugs. For cases upholding the recapture regulations, see Summit Nursing Home, Inc. v. United States, 572 F.2d 737 (Ct. Cl. 1978); Adams Nursing Home, Inc. v. Mathews, 548 F.2d 1077 (1st Cir. 1977); Springdale Convalescent Center v. Mathews, 545 F.2d 943 (5th Cir. 1977); Hazelwood Chronic & Convalescent Hosp. Inc. v. Weinberger, 543 F.2d 703 (9th Cir. 1976), vacated 430 U.S. 952 (1977). The MAC regulations were upheld in American Medical Ass’n v. Mathews, 429 F. Supp. 1179 (N.D. Ill. 1977).


The first set of proposed guidelines, which were published September 23, 1977, 42 Fed. Reg. 48,502 (1977), dealt with the availability and utilization of some inpatient hospital services. After receiving over 10,000 comments, HEW republished its proposed rules utilizing less stringent standards while permitting greater discretion to the health systems agencies (HSAs). 43 Fed. Reg. 3056 (1978) (codified in 42 C.F.R. § 121.1 through .211 (1978)). Both sets of proposed guidelines established standards for inpatient hospital bed supply, hospital occupancy rates, obstetrical services, pediatric inpatient services and occupancy, neonatal intensive care, open heart surgery, cardiac catheterization, radiation therapy, computed tomographic (CT) scanners and end-stage renal diseases.

The weakening of the standards can be illustrated by the radiation therapy and CT scanner standards. The proposed radiation therapy standards mandated that each unit in an HSA should serve a population of 150,000 persons or 450 new cancer patients per year, and that no new facility should be authorized unless each existing unit performed 7,500 treatments per year. 42 Fed. Reg. 48,505 (1977). The revised guidelines retained the 150,000 persons population requirement, but softened the second requirement by reducing the number of cancer patients per unit to 300 and removing the requirement that they be new cancer patients. Furthermore, the standard for the authorization of a new radiology unit was dropped to 6,000 procedures per year per unit with a downward adjustment if significant portions of the relevant population have substantial travel time. 43 Fed. Reg. 3068 (1978) (codified in 42 C.F.R. § 121.209 (1978)).

The CT scanner standards originally prescribed a minimum of 2,500 procedures per year per unit, coupled with the requirement that no new unit be authorized unless all the units in an HSA were performing more than 4,000 procedures per year per unit. In addition, the original guidelines attempted to set cost standards that would have required that charges for each unit be set as if it were performing a minimum of 2,500 procedures per year. 42 Fed. Reg. 48,505 (1977). While the minimum standard of 2,500 procedures per year per unit was maintained, the standard for authorizing new units was reduced to 2,500 procedures per year per unit, and the cost standards were dropped altogether. 43 Fed. Reg. 3067 (1978) (codified in 42 C.F.R. § 121.210 (1978)).

Perhaps the largest overall weakening effect will be felt as a result of the establishment of an adjustment procedure under which HSAs can adjust any federal standard to meet special needs or conditions, and still comply with the guidelines. 43 Fed. Reg. 3064 (1978) (codified in 42 C.F.R. § 121.6 (1978)).
at controlling inflation, including several regulatory programs of an unprecedented nature, and deemphasis of national health insurance.

I. THE DEVELOPMENT OF FEDERAL CONTROLS

The Carter Administration's regulatory strategy is a continuation of the cost-conscious approach that began under prior administrations in the early 1970s. The preceding decade had witnessed an explosive expansion of federal health care spending, providing for direct financial support for health care to the poor,\textsuperscript{13} the elderly,\textsuperscript{14} and other special and high risk populations,\textsuperscript{15} and underwriting a variety of new programs and institutions affecting virtually every aspect of health care delivery.\textsuperscript{16} The general thrust of these federal efforts was directed toward the identified, but unmet, health needs of many Americans.\textsuperscript{17} The approach was designed to "prime the pump" with federal dollars while minimizing governmental interference with health care providers.\textsuperscript{18} Planning programs had been encouraged and, in some cases, required\textsuperscript{19} as a prerequisite for participation in various federal programs. These programs were largely experimental, however, and arguably were never intended to have a direct regulatory impact.\textsuperscript{20} Similarly, cost controls were built into the reimbursement methodology\textsuperscript{21} and

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15. The number of categorical programs is much too large to list. For a general guide to such programs, see \textit{Office of Management and Budget, Catalog of Federal Domestic Assistance} 150-224 (1978); \textit{Office of Management and Budget, Update to the Catalog of Federal Domestic Assistance} at E-15 through E-34 (1978). \textit{See also} 42 C.F.R. §§ 166-523 (1978) (compilation of grants under Public Health Service Act and other legislation).
17. For the legislative purposes of Medicare, see 42 U.S.C. § 1395 (1976) (no federal interference in the practice of medicine), § 1395a (free choice of beneficiaries to select among participating providers), § 1395b (option of beneficiaries to select other insurance protection), § 1395c (establishment of hospital insurance for the aged). For the legislative purposes of Medicaid, see 42 U.S.C. § 1396 (enabling states to establish medical assistance for the poor) (1976). \textit{See also} 42 U.S.C. § 1396a (1976) (describing guidelines for state plans).
18. \textit{See} Wing & Craige, this Symposium, at text accompanying notes 148-54.
19. \textit{See id.} this Symposium, at text accompanying notes 159-64.

The reasonable cost of any services shall be determined in accordance with regulations establishing the method or methods to be used, and the items to be included, in determining such costs for various types or classes of institutions, agencies, and services.
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conditions for participation in Medicare and Medicaid, but these controls were virtually titular in both form and practice, and had little effect on curbing the impact of inflation that characterized both the Medicare and Medicaid programs.

By the 1970s, this era of expanding federal spending had ended. The problem of health care that was drawing Congress' attention was not that of unmet needs for services, but the costs of health care services, particularly the costs of those services associated with existing federal programs. In 1972, Congress amended the Social Security Act to institute a number of cost controlling conditions on provider participation in Medicare and Medicaid and to add several programs intended to regulate directly the costs of those federal programs. Section 221 of the amendments authorized a federal "certificate of need" program, allowing the Department of Health, Education and Welfare (HEW) to limit reimbursement under federal programs for un-

... Such regulations may provide for determination of the costs of services on a per diem, per unit, per capita, or other basis, may provide for using different methods in different circumstances, may provide for the use of estimates of costs of particular items or services, ... Such regulations shall (A) take into account both direct and indirect costs of providers of services in order that, under the methods of determining costs, the costs with respect to individuals covered by the insurance programs ... will not be borne by individuals not so covered, and the costs with respect [sic] to individuals not so covered will not be borne by such insurance programs. ... 22. For utilization review under Medicare, see 42 U.S.C. §§ 1395h(b)(1)(B), 1395x(k)(2), 1395y(a)(2) (1976).
23. See Wing & Craige, this Symposium, at note 5.
24. See text accompanying notes 13-17 supra.
necessary capital expenditures. Requirements for utilization review were imposed on all providers participating in federal programs.\textsuperscript{30} Under section 223, HEW was also authorized to impose maximum limits on allowable costs under Medicaid and Medicare—a limited but notable departure from the cost reimbursement approach that had been previously used under those programs.\textsuperscript{31} While there was little indication of an intent to retrench drastically on federal spending for health care,\textsuperscript{32} the 1972 amendments clearly represented an intent to limit the potential scope of federal funding for health services, most notably by expanding the discretion allowed to the states in imposing limitations on their Medicaid programs.\textsuperscript{33}

The National Health Planning and Resources Development Act of 1974\textsuperscript{34} further demonstrated congressional concern for controls on health spending and an increased willingness to impose government controls on health care providers. Efforts were made to consolidate the major programs for facility construction and program development.\textsuperscript{35} Additional regulatory authority was delegated to health planning agencies, including a requirement that states enact certificate of need programs and engage in a variety of planning activities as a condition for receipt of federal funding.\textsuperscript{36} The role of HEW in administering the federal legislation was expanded, indicating an increased willingness to allow the federal executive a major role in administering health planning programs.\textsuperscript{37}

During this period the Nixon Administration, under the authority of the Economic Stabilization Program, also issued regulations for the control of prices and wages in the health care industry.\textsuperscript{38} In fact, the

\begin{itemize}
\item \textsuperscript{30} 42 U.S.C. § 1396a(a)(30) (1976); \textit{see note 25 supra}.
\item \textsuperscript{32} Federal appropriations for Medicare for fiscal years 1973 and 1974 amounted to $9.0 and $10.7 billion respectively, and Medicaid appropriations for the same period were $4.4 and $5.6 billion respectively. \textit{Statistical Abstract of the United States} 297 (1976).
\item \textsuperscript{33} Social Security Amendments of 1972, Pub. L. No. 92-603, § 223(a), 86 Stat. 1410 (1972) (codified at 42 U.S.C. § 1396(a) (1976)).
\item \textsuperscript{34} Pub. L. No. 93-641, 88 Stat. 2225 (codified at 42 U.S.C. § 300k (1976)).
\item \textsuperscript{35} \textit{See} National Health Planning and Resources Development Act of 1974, Pub. L. No. 93-641, § 4, 88 Stat. 2257 (codified at 42 U.S.C. §§ 300a, 300p, 300q, 300r, 300s (1976)).
\item \textsuperscript{36} \textit{See} 42 U.S.C. § 300m-2(a)(4) (1976). \textit{See also} Wing & Craige, this Symposium, at text accompanying notes 186-96.
\item \textsuperscript{37} \textit{See} Wing & Craige, this Symposium, at text accompanying notes 186-96.
\end{itemize}
final phase of the Nixon program served as the model for the Carter Administration’s initial proposal for hospital cost containment.

Present proposals for hospital cost containment represent an extension of this trend towards increased federal regulation of health care providers that began in the early 1970s. With a forty percent share of total health expenditures, an annual rate of inflation in excess of fifteen percent, and a dominant role in the provision of all medical services, the hospital industry is an obvious target for further regulatory controls. Originally billed as an interim holding action to control health cost inflation until a more permanent solution could be devised (presumably as part of a national health insurance scheme), hospital cost containment is now the centerpiece of Carter’s regulatory strategy.

The theory underlying hospital cost containment is to control cost by imposing a ceiling on collected revenues. To implement this theory the Ninety-Fifth Congress considered two basic schemes from which a number of variations evolved: a comprehensive plan governing virtu-

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39. Acute care hospitals represent a 40% share of total hospital expenditures and have experienced an annual rate of inflation in excess of 15% over the past several years. See Wing & Craige, this Symposium, at text accompanying notes 41-43. Thus, the Hospital Cost Containment Act was an attempt at controlling the largest and most inflationary portion of the health care cost problem.


41. There was, in effect, a third basic option. Under a compromise that arose during the congressional debate, authorized cost containment controls would be imposed only if voluntary efforts by the hospital industry failed to achieve specified results. This compromise was proposed after the Federation of American Hospitals, American Medical Association and American Hospital Association announced that they were forming a joint venture called the “Voluntary Effort” for the purpose of lowering the rate of increase in total hospital expenditures by 2% for 1978 and 1979, in order to reduce the gap between the rates of increase in hospital expenditures and gross national product. See Press Release by the Voluntary Effort in Washington, D.C. (Jan. 16, 1978). Obviously, however, the “Voluntary Effort” was as much a political ploy as a good-faith commitment by the industry to control costs. Nonetheless, Congress, eager to avoid a confrontation, accepted the venture at face value.

In considering the comprehensive plan, both the Ways and Means Health Subcommittee and the Interstate and Foreign Commerce Committee created a trigger mechanism: if the nation’s hospitals failed to meet their voluntary goals, then the trigger would be pulled and a mandatory federal hospital cost containment program would be initiated. At various points in the congressional debate a second trigger was created: if the federal goal was not met, then HEW would have to determine on a state-by-state basis whether hospitals met the voluntary goals. See H.R. 5285, 95th Cong., 2d Sess., § 2(b), 124 CONG. REC. S18368 (daily ed. Oct. 12, 1978). In the end, the failure of Congress to press hospital cost containment left the Voluntary Effort as the only attempt at containing costs. Early indications were that the Voluntary Effort would not be successful in curbing hospital cost inflation.
ally all hospitals and all sources of revenue, and a limited proposal imposing cost containment only on Medicaid and Medicare reimbursement.

Under the comprehensive plan, total revenues for covered hospitals from all sources, including government programs, private insurance and out-of-pocket payments by consumers, would be limited to an

42. See HOSPITAL WEEK, April 13, 1979, at 1. The comprehensive plan was proposed by President Carter and was included in legislation sponsored by Senator Edward Kennedy, S. 1391, 95th Cong., 1st Sess., 123 CONG. REC. S6403-S6408 (daily ed. Apr. 26, 1977), and Rep. Paul Rogers, H.R. 6575, 95th Cong., 1st Sess., 123 CONG. REC. HR3546 (daily ed. Apr. 25, 1977). The original versions were modified on numerous occasions to accommodate various interests and effect political compromises. A similar proposal, the Hospital Cost Containment Act of 1979, was sent to Congress by President Carter in March of 1979. HOSPITAL WEEK, March 9, 1979, at 1.

43. The limited plan was introduced by Senator Herman Talmadge as S. 1470, 95th Cong., 1st Sess., 123 CONG. REC. S7106 (daily ed. May 5, 1977), and remained virtually unchanged until its final adoption by the Senate, when Senator Gaylord Nelson successfully merged a weak form of the comprehensive plan with the limited plan, H.R. 5285, 95th Cong., 2d Sess., § 2, 124 CONG. REC. S18329, S18394, S18408 (daily ed. Oct. 12, 1978). See note 68 infra for a discussion of the Nelson compromise.

44. The hospitals included under the comprehensive plan were defined as short-term acute care facilities that are not federal hospitals or health maintenance organizations. STAFF OF HOUSE COMM. ON INTERSTATE & FOREIGN COMMERCE, 95TH CONG., 2D SESS., SUBSTITUTE TO THE COMMITTEE PRINT OF OCTOBER 20, 1977 OF H.R. 6575 (Comm. Print 1978) [hereinafter cited as ROGERS SUBSTITUTE PRINT].

45. As originally formulated, the revenue limitation was imposed only on the inpatient portion of a hospital's budget. Thus, outpatient services were left free from federal controls. S. 1391, 95th Cong., 1st Sess. § 102(a), 123 CONG. REC. S6403 (daily ed. Apr. 26, 1977). Over 85% of hospital revenues are derived from inpatient revenues. AMERICAN HOSPITAL ASS'N, HOSPITAL STATISTICS 188 (Table II) (1978). By controlling inpatient revenues, the lion's share of hospital costs would be controlled and the relatively less expensive outpatient services would be utilized more often.

Throughout the congressional debate, the Administration's bill was slowly drained of its coverage. First, organized labor was accommodated by the exclusion or "pass-through" of nonsupervisory wage increases. Second, rural interests were protected with the exclusion of all small rural hospitals from the limitations of hospital cost containment (HCC).

The original version of HCC, as proposed by the Administration, permitted the pass-through of nonsupervisory wage increases only if the hospital administrator petitioned the secretary of HEW. S. 1391, 95th Cong., 1st Sess. § 124, 123 CONG. REC. S6403, S6406 (daily ed. Apr. 26, 1977). Organized labor, fearing that nonsupervisory personnel would bear the burden of revenue controls, attempted to exchange their endorsement of HCC for a mandatory and automatic pass-through of nonsupervisory wage increases. See SENATE COMM. ON HUMAN RESOURCES, 95TH CONG., 1ST SESS., THE HOSPITAL COST CONTAINMENT ACT OF 1977: SUMMARY AND ANALYSIS OF CONSIDERATION, 43 (Comm. Print 1977) [hereinafter cited as KENNEDY PRINT]; H.R. 5285, 95th Cong., 2d Sess. § 2(b), 124 CONG. REC. S18368 (daily ed. Oct. 12, 1978).

State administered cost containment programs that could give assurances concerning their comprehensiveness and effectiveness would have been exempted from the mandatory federal program. S. 1391, 95th Cong., 1st Sess. § 102(t), 123 CONG. REC. S6403 (daily ed. Apr. 26, 1977). As the debate continued in Congress, the standards were relaxed to permit several additional states to obtain an exemption from the federal program. See ROGERS SUBSTITUTE PRINT, supra note 44, at § 121. While HEW originally wanted a requirement that state programs have had significant operating experience, subsequent versions of HCC limited this requirement, and an amendment by Senator Edmund Muskie to Senator Gaylord Nelson's limited version of HCC did away with the need for any prior operating experience. 124 CONG. REC. S18380 (daily ed. Oct. 12, 1978).
increase of approximately nine percent per year\textsuperscript{46} for each category of payor. Various adjustments to this limit are allowed for changes in number of admissions,\textsuperscript{47} services provided or the facility's capacity.\textsuperscript{48} If the revenue limit on either Medicaid or Medicare is exceeded in a given year, the federal government will deny further reimbursement for Medicaid or Medicare services to that hospital\textsuperscript{49}; if the limit is exceeded for private insurance or out-of-pocket payors, the plan imposes a 150% tax on any revenue collected from these sources.\textsuperscript{50}

\textsuperscript{46} The 9% limitation was derived from a number of differing formulas. Under the original Administration proposal, the allowable increase was derived from a weighted average of general inflation, determined by the gross national product (GNP) implicit price deflator (roughly 6%), and a health inflation index, to be derived by the Secretary of HEW (assumed to be about 15%). A hospital was permitted to increase revenues by the amount of the GNP implicit price deflator, plus one-third the difference between the GNP implicit price deflator and the health inflation index. See S. 1391, 95th Cong., 1st Sess. § 112(b), 123 CONG. REC. S6404 (daily ed. Apr. 26, 1977). Later versions of HCC derived the 9% limitation by allowing a rate of increase equal to one and one-half times the GNP implicit price deflator. See SUBCOMM. ON HEALTH OF HOUSE COMM. ON WAYS & MEANS, 95TH CONG., 2D SESS., H.R. 6575: A BILL § 112 (Comm. Print 1978) [hereinafter cited as ROSTENKOWSKI PRINT].

\textsuperscript{47} The basic limitation on allowable increases in inpatient revenues was adjusted for moderate increases or decreases in admissions over the base year. See Lipscomb, Raskin & Eichenholz, The Use of Marginal Cost Estimates in Hospital Cost-Containment Policy, in HOSPITAL COST CONTAINMENT 514 (M. Zubcoff, I. Raskin & R. Hanft eds. 1978); Lave & Lave, Hospital Cost Function Analysis: Implications For Cost Controls, in id. at 538.

\textsuperscript{48} Numerous exceptions for unusual circumstances were provided to the overall limitation on increases in hospital inpatient revenues, giving HEW discretion to raise the allowable increase. Two of the exceptions permitted under the comprehensive plan are (1) major increases in capacity or services provided, and (2) major renovation or replacement of the physical plant. Under the early versions of HCC, such exceptions were provided only if the facility met an initial financial hardship test. See S. 1391, 95th Cong., 1st Sess. § 115(a)(2), 123 CONG. REC. S6404 (daily ed. Apr. 26, 1977).

\textsuperscript{49} For further analysis of these provisions, see SENATE COMM. ON HUMAN RESOURCES, 95TH CONG., 1ST SESS., THE HOSPITAL COST CONTAINMENT ACT OF 1977: SUMMARY OF ANALYSIS AND CONSIDERATION 17 (Comm. Print 1977); STAFF OF HOUSE COMMITTEE ON INTERSTATE AND FOREIGN COMMERCE, 95TH CONG., 2D SESS., SUMMARY OF H.R. 6575, AS REPORTED BY THE SUBCOMM. ON HEALTH AND THE ENVIRONMENT 11 (Comm. Print 1978).

\textsuperscript{49} The comprehensive plan permits the continuation of reimbursement under Medicare and Medicaid using interim payments and a final settlement at the end of the year. See S. 1391, 95th Cong., 1st Sess. § 116(a)(b)(c), 123 CONG. REC. S6405 (daily ed. Apr. 26, 1977), for the relationship of HCC to reimbursement under Medicare and Medicaid. Such reimbursements may not exceed the revenue increase limitation established under the comprehensive plan (i.e., roughly a 9% increase in those revenues derived from Medicare and Medicaid). See S. 1391, 95th Cong., 1st Sess. § 116(a)(b), 123 CONG. REC. S6405 (daily ed. Apr. 26, 1977).

\textsuperscript{50} The 150% tax on any charges or cost reimbursements in excess of the revenue limitation established under the comprehensive plan could be avoided by assurances to HEW of appropriate downward adjustments for the following year or establishment of an escrow account for the excess collections. The tax penalty provision remained virtually unchanged under every variation of the comprehensive plan. See S. 1391, 95th Cong., 1st Sess. § 128(a), 123 CONG. REC. S6406 (daily ed. Apr. 26, 1977).

In addition to the limit set on revenues, the original Carter proposal established a ceiling on annual capital expenditures by hospitals of $2.5 billion. See S. 1391, 95th Cong., 1st Sess. § 201, 123 CONG. REC. S6405 (daily ed. Apr. 26, 1977). Unable to justify the original $2.5 billion limitation, the amount was increased during committee consideration until it approached $4.0 billion. STAFF
The limited plan would establish revenue limitations only on Medicare and Medicaid reimbursement, and not on private insurers or out-of-pocket payments.\textsuperscript{51} Furthermore, rather than placing a fixed ceiling on total Medicaid and Medicare inpatient revenues,\textsuperscript{52} under this proposal hospitals would be grouped by size, type, location and other criteria,\textsuperscript{53} and using these groups, an average group cost for routine services per patient day would be established for a base year.\textsuperscript{54} This base year average is then increased by an inflator for each subsequent year;\textsuperscript{55} reimbursement for routine costs would be allowed up to 120\% of the hospital’s group average.\textsuperscript{56} Some versions of this plan would allow for bonus payments to hospitals with costs below their group’s average.\textsuperscript{57} Like the comprehensive plan, the limited plan would also allow a series of exceptions or adjustments for unusual circumstances.\textsuperscript{58}

All the hospital cost containment proposals anticipate an unprece-
dented expansion of the federal role in determining the cost of health care and the distribution of resources. At least under the comprehensive plan, cost containment would entail direct federal involvement in the costs of all health services, not just those that are federally financed. The adoption of this new federal posture, however, may not be entirely predicated on the enactment of specific cost containment legislation.

As mentioned above, HEW has been markedly more cost-conscious in its reimbursement determinations in the last several years. Through stricter reimbursement policies, HEW has been able to increase significantly federal influence on both service costs and resource allocation by Medicaid and Medicare providers. There is also a range of other possible options for a “get tough” policy under existing statutory authorization. Existing federal involvement and control could be considerably expanded without further legislation if, for example, the discretionary authority of HEW under the 1974 health planning legislation were fully implemented.59 While the program has yet to achieve measurable results, HEW also could exercise substantial control over new capital expenditures by virtually all hospitals and nursing homes if the “section 1122” certificate of need program were administered in a more vigorous way.60 Similarly, the program implemented by HEW under section 223 of the Social Security Amendments of 197261 has already imposed some cost controls that resemble in form, if not in magnitude or impact, the proposed hospital cost containment programs.62 These section 223 controls could also be expanded beyond

59. See note 12 supra.
60. See Schonbrun, Making Certificate of Need Work, this Symposium, at text accompanying notes 109-11.
61. See note 31 supra.
62. 42 Fed. Reg. 53,679 (1977). All hospitals are first divided by their location into SMSA and non-SMSA groups and then further broken down by per capita income (a proxy of area costs) into five subgroups. The other variable utilized is bed size, which creates a 20 cell schedule (5x4) for hospitals located within SMSAs, and a 15 cell schedule (5x3) for hospitals located outside SMSAs, with special provisions for Alaska and Hawaii. HEW currently applies a grouping methodology to reduce the rate of reimbursement for hospitals that have routine costs that greatly exceed those of comparable facilities. Under the current formula, a maximum routine per diem reimbursement is established at the 80th percentile of the group, plus 10% of the group average. This maximum routine per diem is then generously inflated (by approximately 14%) to establish current year limits that affect only the most expensive providers. While these regulations do not represent major constraints on costs, they do, in fact, mark the establishment of prospective rate ceilings and a departure from traditional notions of individual cost determination. Since the regulations permit full reimbursement up to the 80th percentile, plus 10% of the group average and a generous inflation factor, very few hospitals are affected. Furthermore, any amount in excess of the limitation may be charged to the beneficiary, at least under specified conditions. At present HEW is reevaluating its per capita income variable because it has had an adverse impact in Boston, where per capita income has dropped in recent years and thus lowered allowable reimbursement to area hospitals. See Memorandum to the Under-Secretary, Hale Champion,
their present scope.

On the other hand, any attempt to further expand the federal government's regulatory role will encounter substantial political resistance. The health care industry, despite existing regulatory programs, possesses a high degree of autonomy, and can be expected to mount an extensive campaign to prevent any further extension of federal authority. Furthermore, the traditional opposition of state and local governments to expanded federal influence will add to the difficulty of extending federal authority. Thus, the political climate in the Ninety-Sixth Congress will not offer the Carter Administration fair weather for the enactment of hospital cost containment or further implementation of its regulatory strategy.

The record of the Ninety-Fifth Congress provides some insights into the political controversies that lie ahead. Despite extensive Administration efforts, the Congress adjourned without enacting any major health legislation. The fate of the hospital cost containment proposals is demonstrative of the political mood that prevailed. After lengthy hearings in both houses and consideration of a variety of cost containment strategies, not even the weakest version of hospital cost


If rigorously applied, the broad mandate contained in § 223 could result in a significant increase in federal control and in a much stricter form of cost containment. For example, HEW could expand § 223 to cover more than the routine portion of hospital costs, to include institutions in addition to hospitals or to utilize a more stringent methodology for determining reimbursement.

63. See Wing & Craige, this Symposium, at text accompanying notes 1-16.
64. This has become a major issue in regard to health planning programs. See note 45 supra.
66. See note 8 supra.

containment became law. Although Senators Gaylord Nelson and Edward Kennedy were able to muster enough votes to pass a very limited version of hospital cost containment in the last days of the session in the Senate, the House tacitly accepted the hospital industry's offer to control hospital inflation voluntarily.

The controversy over the federal role in controlling the cost of health care was hardly settled in the Ninety-Fifth Congress, and the overall direction of federal policy for the next decade remains to be decided. The Carter Administration will again introduce hospital cost containment and, presumably, will make other regulatory proposals to the Ninety-Sixth Congress; at the same time, the Administration will continue with renewed vigor to implement its existing regulatory authority. One can expect a major confrontation as a coalition of powerful opponents, including provider associations and political conservatives, attempt to defeat the President's regulatory strategy.

While the controversy may remain unresolved well into the next decade, the unrelenting pace of inflation makes it unlikely that Congress can avoid adopting some type of national strategy. Although reluctant to enact regulatory controls, future administrations or Congress simply may opt to limit federal spending, but only a major program limitation would have a significant impact. Yet, any program limitation severe enough to have a visible impact on federal spending would have a serious, even life threatening, impact on the increasing number of people who cannot afford health services without governmental assistance. Politically, we may not be ready for nationalized health insurance, but there is no indication that a major reduction in government spending for health would be a politically acceptable policy either. Other cost containing strategies have been proposed: the indus-

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68. H.R. 5285, 95th Cong., 2d Sess., 124 Cong. Rec. S18368, S18408 (daily ed. Oct. 12, 1978). Senator Talmadge's limited version of hospital cost containment, S. 1470, 95th Cong., 1st Sess., 123 Cong. Rec. S7106 (daily ed. May 5, 1977) as amended, H.R. 5285, 95th Cong., 2d Sess., 124 Cong. Rec. S18328-S18338 (daily ed. Oct. 12, 1978), was attached to the Tariff Schedules of the United States in an attempt to pass a bill in the last few days before the 95th Congress adjourned. At the outset, Senator Kennedy attempted to substitute his version of HCC for the limited approach to HCC. Amendment 2064, 95th Cong., 2d Sess., 124 Cong. Rec. S18353-S18358 (daily ed. Oct. 12, 1978). Senator Kennedy's substitute amendment was tabled by a 69-18 vote, indicating very little support for a comprehensive HCC program. Id. at S18362. Senator Gaylord Nelson then offered a weaker compromise version of HCC as a substitute for the Talmadge approach. Id. at S18368-S18371. This version was further amended by Senators Muskie and Dole, id. at S18380, S18304, and then accepted, id. at S18394. The bill was passed by the Senate and sent to the House. Id. at S18408.

69. See note 41 supra.
try has claimed that through voluntary efforts at least the hospital portion of health care costs can be contained, and free market theorists have claimed that competition free from existing market restraints could control costs more effectively than public control and that, by comparison, existing regulatory programs have given little evidence that any regulatory strategy can be comparably effective.

Perhaps Congress will embrace these alternative strategies and reject the regulatory strategy proposed by the current Administration, but such a departure, at least for the moment, seems unlikely. Rather than abandon the regulatory strategy, Congress, as well as the Carter Administration, seems committed to testing its effectiveness and propriety. Whether that commitment will lead to an expansion of federal authority beyond existing programs is difficult to predict; at the least, significant increases in federal authority, such as a program of hospital cost containment, will be given serious consideration by Congress and actively sought by the Carter Administration. At the same time, the Administration will seek to increase the effectiveness of existing regulatory programs. Thus, the limits of federal authority over health care delivery will be debated, examined, and, quite likely, tested.

II. THE PARAMETERS OF FEDERAL AUTHORITY

Any attempt to have a significant impact on the cost of health care, even if ultimately unsuccessful, will represent a substantial expansion of federal authority. Indeed, the intent of the Carter administration to inject a "get tough" element into the federal regulatory posture, whether under existing statutory authority or through new legislation, presupposes the emergence of a new federal role, not only in the relationship between the federal government and health care providers, but also in the relationship between the federal government and state and local governments.

Pending legislative proposals to expand federal authority have therefore generated substantial controversy, highlighting the as yet unresolved political attitude in Congress towards such fundamental issues as the role of the private sector in determining the cost and distribution of health care services and the role of state and local governments as regulators and as providers of services. So far these issues have been debated in Congress in largely political terms, but if cost containing

70. See id.
71. See Wing & Craige, this Symposium, at note 15.
legislation is enacted, or if new programs are developed under existing authority, the locus of the debate will probably shift to the courts, and these issues will be examined in constitutional terms.

A. The Spending Authority

The basic constitutional principle that circumscribes the federal spending authority is easily summarized: Article I, Section 8 of the United States Constitution grants to Congress the power to "lay and collect taxes . . . and provide for the general welfare." Modern courts have consistently taken an expansive view of this authority and applied a broad interpretation to both the concept of "general welfare" and the discretion vested in Congress to define it specifically. Earlier in our history, federally authorized, health-related spending may have

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73. Prior to the 1930s, some authorities argued that the power to tax and to spend was limited to only those matters upon which Congress was explicitly authorized to legislate, the so-called enumerated powers. That position has been refuted, however. Justice Roberts in United States v. Butler, 297 U.S. 1 (1935), wrote that the general welfare clause confers a power separate and distinct from those later enumerated, is not restricted in meaning by the grant of them, and Congress subsequently has a substantive power to tax and to appropriate, limited only by the requirement that it shall be exercised to provide for the general welfare of the United States. Id. at 65-66. (The Butler court held, however, that the Agricultural Adjustment Act of 1935, Pub. L. No. 73-10, ch.25, 48 Stat. 31, was an unconstitutional invasion of rights traditionally reserved to the states. See discussion of state sovereignty, infra.) See Note, 34 Wash. & Lee L. Rev. 1133, 1134 n.7, 1141-42 nn.52 & 53 (1977); Comment, The Federal Conditional Spending Power: A Search For Limits, 70 NW. L. Rev. 293, 297-98 (1975).

The Butler concept of the general welfare clause was expanded two years later. In Steward Machine Co. v. Davis, 301 U.S. 548 (1937), the Court upheld the constitutionality of a portion of the Social Security Act of 1935 that required employers to pay into state unemployment programs: "It is too late today for the argument to be heard with tolerance that in a crisis as extreme as this the use of the moneys of the nation to relieve the unemployed and their dependents is a use for any purpose narrower than the promotion of the general welfare." Id. at 586-87. And in Helvering v. Davis, 301 U.S. 619 (1937), decided the same day as Steward Machine Co., the Court upheld the constitutionality of the provision of the Social Security Act that taxed employers and employees for the purpose of creating a retirement benefits program. In both cases, federal authority to tax and to spend for the general welfare was held to include authority over matters that had previously been perceived as local in nature, despite the apparent concern for state sovereignty voiced in Butler. Justice Cardozo in Davis said:

The line must still be drawn between one welfare and another, between particular and general. Where this shall be placed cannot be known through a formula in advance of the event. There is a middle ground or certainly a penumbra in which discretion is at large. The discretion, however, is not confided to the courts. The discretion belongs to Congress unless the choice is clearly wrong, a display of arbitrary power, not an exercise of judgment. Nor is the concept of the general welfare static. Needs that were narrow or parochial a century ago may be interwoven in our day with the well-being of the Nation. What is critical or urgent changes with the times.

301 U.S. at 640-41.
been subject to constitutional challenge,74 but the modern view of the spending authority, coupled with the well-documented national significance of health care services and costs, has erased any doubts concerning Congress' authority to spend federal revenues for virtually anything related to health care.75

Furthermore, the judicial interpretation of the conditions that can


Health was traditionally considered a matter exclusively within the province of the individual states. In Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1 (1824), Justice Marshall declared, albeit in dictum, that while the federal government had the power to regulate interstate commerce, "health laws of every description . . . are component parts . . . of that immense mass of legislation, which embraces everything within the territory of a State, not surrendered to the general government: all which can be most advantageously exercised by the States themselves." Id. at 203.

In the early days of the Republic, however, the federal government was concerned with other national problems, and issues related to health were rarely raised. In 1796, after a yellow fever epidemic had forced the government to flee from Philadelphia, a national quarantine bill was debated in Congress. This debate brought to the fore the Federalist and Antifederalist positions, with the Antifederalists eventually winning: the quarantine bill was defeated. See Chapman & Talmadge, Historical and Political Background of Federal Health Care Legislation, 35 LAW & CONTEMP. PROB. 334 (1970).

After a yellow fever epidemic had swept up the Mississippi River Valley in 1878, however, Congress passed a national quarantine law. Though this bill was more hotly debated in Congress than its forerunner in 1796, and though the law was allowed to expire in 1882, the handwriting on the wall was clear. When a cholera epidemic threatened the eastern seaboard in the early 1890's, Congress passed a national quarantine law that, although amended several times, still stands today. See id. at 337-40. Aside from the original federal food and drug laws enacted at the turn of the century, Act of June 30, 1906, ch. 3915, and the maternal and child health services program enacted in 1921, Act of Nov. 23, 1921, ch.135, however, the federal role in the nation's health remained as limited as Justice Marshall's opinion had dictated until the 1940s. Chapman & Talmadge, supra, at 342-43. With the enactment of the Hill-Burton program in 1946, a new federal role in health care began to emerge. See Wing & Craig, this Symposium, at text accompanying notes 159-66 supra.

75. See text accompanying notes 113-56 infra.

For a legislative statement of the national importance of health care, see § 2 of the National Health Planning and Resources Development Act of 1974:

(1) The achievement of equal access to quality health care at a reasonable cost is a priority of the Federal Government.

(2) The massive infusion of Federal funds into the existing health care system has contributed to inflationary increases in the cost of health care and failed to produce an adequate supply or distribution of health resources, and consequently has not made possible equal access for everyone to such resources.

(3) The many and increasing responses to these problems by the public sector (Federal, State, and local) and the private sector have not resulted in a comprehensive, rational approach to the present—

(A) lack of uniformly effective methods of delivering health care;
(B) maldistribution of health care facilities and manpower; and
(C) increasing cost of health care.

(4) Increases in the cost of health care, particularly of hospital stays, have been uncontrollable and inflationary, and there are presently inadequate incentives for the use of appropriate alternative levels of health care, and for the substitution of ambulatory and intermediate care for inpatient hospital care.

be constitutionally imposed on recipients of federal funds, and the discretion vested in Congress to impose those conditions have been equally generous. In fact, the courts have rarely invalidated a spending condition imposed by the federal government on either a private or a public recipient. Heavy reliance has been placed on the rationale that (a) recipients always remain free to forego federal funds and thus avoid unwanted conditions and (b) Congress should have broad authority to control the way in which federally funded activities are administered.

Conditional spending authority, however, can be exercised even when these arguments are not clearly applicable. Particularly in an age when reliance on federal spending is both commonplace and essential to many private and public institutions, the decision to refuse federal funds is not always an available option, at least in any practical sense. Moreover, imposing conditions on the recipient of federal funds has become more than a means for controlling expenditures under a particular program. Rather, such conditions frequently are enacted by Congress in order to achieve particular policy choices, using the receipt of federal funds under one or more programs, which arguably might be unrelated to the policy, as leverage to achieve that policy.

Thus, in reviewing the constitutionality of conditions imposed on health care providers who are recipients of federal funds, it is clear that Congress has extremely broad discretion. The scope and nature of congressional authority, however, may be challenged, at least when the condition imposed strains the logic of the traditional constitutional justifications for the conditional spending authority.

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77. In Massachusetts v. Mellon, 262 U.S. 447 (1922), the Supreme Court upheld the constitutionality of the federal maternal and child health program, which conditioned disbursement of federal funds to states upon compliance with federal conditions: "the powers of the State are not invaded, since the statute imposes no obligation but simply extends an option which the State is free to accept or reject." Id. at 480.


79. See note 108 infra.
1. The Issue of Voluntary Participation

In examining the constitutionality of conditional spending by the federal government, the courts have frequently distinguished between spending that encourages or induces compliance with a condition and spending that coerces compliance by the recipient of federal funds. In a recent case involving the State of North Carolina, for example, a federal district court upheld the constitutionality of federal health legislation that required states to enact certificate of need laws as a condition on the receipt of federal funds for health planning and for a variety of other public health programs. The court considered, but dismissed, North Carolina's argument that the legislation was an improper exercise of the spending authority, holding that the estimated loss of $50 million in federal funds was not sufficiently "catastrophic" or "coercive" to be "coercion in any constitutional sense."

While the distinction between conditions that are mandatory or coercive and those that are voluntary and provide only inducements to compliance has been made repeatedly, courts have rarely invalidated an exercise of conditional spending because of its coercive effect, and have given little indication of the real meaning of this apparent limitation. Moreover, the argument that coercive conditions would be improper is most persuasively and most frequently stated in reference to

80. Massachusetts v. Mellon, 262 U.S. 447, 480 (1922). The majority in United States v. Butler, 297 U.S. 1 (1935), while acknowledging that the taxing and spending authority of Congress is a power separate and distinct from the enumerated powers, see discussion note 73 supra, held that the condition attached to the Agricultural Adjustment Act was a "scheme for purchasing with federal funds submission to federal regulation . . . ." Id. at 72. In later cases, courts did not ignore the coercion issue raised in Butler; they simply held that the spending conditions in question were not coercive. See Oklahoma v. United States Civil Serv. Comm'n, 330 U.S. 127 (1947); Helvering v. Davis, 301 U.S. 619 (1937); Steward Machine Co. v. Davis, 301 U.S. 548 (1937); Comment, supra note 73, at 302-03; Note, supra note 73, at 1141-44.


82. The court stated:

The validity of the power of the federal government under the Constitution to impose a condition on federal grants made under a proper Constitutional power does not exist at the mercy of the State Constitutions or decisions of State Courts. Moreover, the "coercive" effect of a termination of federal assistance on the plaintiff North Carolina seems quite unreal. The actual loss to North Carolina should it lose all federal assistance health grants would be less than fifty million dollars; in 1974, its State revenues totalled some 3.1 billion dollars. The impact of such loss could hardly be described as "catastrophic" or "coercive."

Id. at 535. See also note 77 supra.


84. But see United States v. Butler, 297 U.S. 1 (1935), and text accompanying note 91 infra.

85. See Massachusetts v. Mellon, 262 U.S. 447, 480 (1922); Comment, supra note 73, at 302; Note, supra note 73, at 1134.
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spending conditions imposed on state and local governments, an argument raising the related but distinct issues of federalism and state sovereignty. If the coercive effect of conditional federal spending is a relevant constitutional consideration, then significant questions can be raised concerning existing and proposed federal regulatory conditions imposed on health care providers. With respect to the modern health care delivery system, the threat of denial or withdrawal of federal funds may be so large that the provider-recipient is denied any effective choice regarding its participation. Obviously, a health care provider under any comprehensive national health insurance program would be in this position. More to the point, almost every hospital and many nursing homes currently depend so heavily on federal financial support, principally through Medicare and Medicaid reimbursements, that there is little choice but to comply with any condition or regulatory requirement imposed by the federal government. Medicare and Medicaid providers have reluctantly accepted numerous conditions imposed on their participation.

Similarly, an undeniably coercive effect can be achieved by imposing a condition on health care providers that involves not just Medicare and Medicaid or any specific program, but rather ties the condition, usually through independent legislation, to the receipt of federal funds from any program or source. Even providers who can risk nonpar-

86. See text accompanying notes 113-56 infra.
87. See Wing & Craige, this Symposium, at text accompanying notes 80-81 supra.
88. See id. at text accompanying notes 120-22 infra.

Title VI provides in part: "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 assistance." 42 U.S.C. § 2000d (1971). It goes on to state that compliance will be exacted by "termination of or refusal to grant or to continue assistance under such program or activity to any recipient as to whom there has been an express finding . . . of a failure to comply with such requirement . . . ." Id. § 2000d-1. Title VI provides further that any such termination or refusal of funds "shall be limited in its effect to the particular program, or part thereof, in which such noncompliance has been so found . . . ." Id. Thus, a government agency is prohibited by the language of Title VI from withholding funds from programs that do not specifically violate Title VI. This was underscored in Board of Pub. Instruction v. Finch, 414 F.2d 1068 (5th Cir. 1968), in which the court vacated an order by HEW cutting off funds to a Florida school district because there was no evidence that any of the three affected federally funded programs in the district was in violation of Title VI.

In FERPA, however, there is no language limiting the cut-off of funds to those recipients who violate the law. FERPA gives parents the right to inspect and review their children's school records and to consent before such records can be released to other organizations. 20 U.S.C. § 1232g(a)(1), (b)(1) (1975). In case of noncompliance by a school, Congress provided that federal
ticipation in Medicaid or Medicare may not be able to risk nonparticipation in all federal programs.

Despite the fact that health facilities have little choice but to comply with federally imposed conditions, no court thus far has been persuaded to invalidate, on this ground, any condition or regulatory program imposed on Medicare or Medicaid providers.\textsuperscript{90} Apparently so long as participation by a provider is literally voluntary (Medicaid and Medicare providers are not legally required to participate) the coercive economic effect, at least for private providers, will not affect the constitutionality of federal regulation through conditional spending.\textsuperscript{91} Perhaps under a comprehensive national health insurance scheme, whether explicitly requiring provider participation or giving providers no feasible alternative, the sheer magnitude of the economic coercion may convince the courts that coercion in economic effect is equivalent to coercion in law, and thus, that a different result should be reached. But even if courts were to engage in a factual analysis of the economic circumstances facing participating providers, they are likely to maintain a rather circumscribed view of coercion.\textsuperscript{92}

\textsuperscript{90} In Rasulis v. Weinberger, 502 F.2d 1006 (7th Cir. 1974), the court rejected a constitutional challenge to a regulation establishing professional standards for physical therapists participating in Medicaid and Medicare, relying heavily on the finding that the regulation "merely provides standards for the dispensation of Federal funds. The economic incentives of participation in the Medicare Program does not constitute coercion or control." \textit{Id.} at 1010 (citing Steward Machine Co. v. Davis, 301 U.S. 548 (1937)).

The court in Association of Am. Physicians & Surgeons v. Weinberger, 395 F. Supp. 125 (N.D. Ill. 1975), held that utilization review requirements imposed by the PSRO program, see note 30 \textit{supra}, were not mandatory, that participation of providers in Medicaid and Medicare was voluntary and that therefore the requirement was a valid exercise of the spending authority. \textit{Id.} at 134.

In Briarcliff Haven, Inc. v. Department of Human Resources, 403 F. Supp. 1355 (N.D. Ga. 1975), the court held that providers do not have to participate in Medicaid and Medicare, but that if they do, they must comply with both state and federal law. \textit{See also} Alabama Nursing Home Ass'n v. Califano, 433 F. Supp. 1325 (M.D. Ala. 1977); Coe v. Hooker, 406 F. Supp. 1072 (D.N.H. 1976); Shaak v. Schmidt, 344 F. Supp. 99 (E.D. Wis. 1971); Opelika Nursing Home, Inc. v. Richardson, 323 F. Supp. 1206 (M.D. Ala. 1971), \textit{rev'd on other grounds}, 448 F.2d 658 (5th Cir. 1971); Gould v. Klein, 150 N.J. Super. 516, 376 A.2d 196 (1976). None of these cases recognizes that institutional providers have little actual choice but to participate.

\textsuperscript{91} \textit{But see} text accompanying notes 113-49 \textit{infra}.

\textsuperscript{92} \textit{But see} note 101 \textit{infra}.
2. The Relationship Between The Condition and The Funding Program

Congressional authority to impose policy conditions or cost regulation on health care providers in return for federal funds can also be questioned when the condition is not simply a matter of Congress' concern for the manner in which federal funds are spent, but is, in effect, an attempt to achieve other objectives.

Although there is little judicial precedent for the proposition, recent legal commentary has argued that a proper reading of the spending authority and the due process clause of the fifth amendment would require that a condition imposed on federal spending be reasonably related to the purpose of the funding program to which it is attached. To state the issue in more specific terms, aside from whether the condition promotes the general welfare or is, as it must be, a proper governmental objective in its own right, it can be argued that any condition must relate to the particular general welfare objective of the funding program to which it is attached, or at least to some significant national policy that, presumably, is important enough that all funding programs should adhere to it.

Most existing, and several proposed, federal attempts to impose cost controls on health care providers apply only to the services funded by the program to which they are attached. For example, only services funded by government programs are subject to the PSRO and utilization review requirements of Medicaid and Medicare. In addition, the sanction imposed on providers for unnecessary capital expenditures under the section 1122 federal certificate of need program is a reduction in federal reimbursement; there is no prohibition on unnecessary capital expenditures. Yet another example is suggested by the limited hospital cost containment plan considered in the last session of Congress. Like existing Medicare and Medicaid conditions on participa-

93. See text accompanying note 78 supra.
94. See Comment, supra note 73, at 305 (suggesting that this limitation is grounded in the fifth amendment).
95. Justice Stone, dissenting in United States v. Butler, 297 U.S. 1, 85-86 (1935), also argued that the conditions must be related to the spending program, but the Supreme Court has never explicitly adopted this position. See also Ivanhoe Irrigation Dist. v. McCracken, 357 U.S. 275 (1958).
96. See text accompanying notes 73-75 supra.
98. Schonbrun, this Symposium, at text accompanying notes 127-49.
99. See text accompanying notes 8-12 supra.
tion, this plan would only limit revenues collected by providers under federal programs and would not impose any conditions relating to services funded by nonfederal sources. Thus limited, regulatory efforts fit neatly into the traditional justification for conditional federal spending, and there is an obvious relationship between the spending program and the condition. In each case the condition is intended to provide a limitation on federal expenditures incurred by the program and thus would undoubtedly be within constitutional limits. Indeed, indications are that such conditions will be upheld with a minimum of judicial scrutiny of the condition or the relationship of the condition to the program's objectives.

100. Commentators have suggested, however, that Congress has intentionally restricted the scope of federal legislation in light of the constitutional implications of expanding the conditional spending power. See, e.g., Comment, supra note 73, at 294.

101. In the face of increasing federal efforts to impose cost controls under the Medicaid and Medicare programs, participating providers have attempted to argue that reimbursement for Medicaid and Medicare services involves a fundamental right or interest, either a right to privacy inherent in the patient-provider relationship or a right of providers to practice their profession. Rasulis v. Weinberger, 502 F.2d 1006 (7th Cir. 1974); AMA v. Weinberger, 395 F. Supp. 515 (N.D. Ill.), aff'd, 522 F.2d 921 (7th Cir. 1975); Association of Am. Physicians & Surgeons v. Weinberger, 395 F. Supp. 125 (N.D. Ill. 1975).

Providers have contended that both the objective sought to be achieved by conditions imposed on Medicaid and Medicare participation and the means sought to achieve the objective should receive close judicial scrutiny, citing the close scrutiny given to the means used to accomplish the objectives of state abortion statutes. See Doe v. Bolton, 410 U.S. 179 (1973); Roe v. Wade, 410 U.S. 113 (1973). See also Planned Parenthood v. Danforth, 428 U.S. 52 (1976). The apparent assumption behind this argument is that under stricter examination the general objective of conditions on Medicaid and Medicare—saving federal program funds—would not be a sufficient rationale to justify interference with the fundamental interest at stake, or that under closer examination conditions such as utilization review requirements could not be shown to have a sufficiently convincing connection with their intended objective. Cf. Doe v. Bolton, 410 U.S. 179 (1973), in which the Court concluded that there was no demonstrated relationship between the statutory objective and the requirement of a second opinion.

Generally, courts have declined to adopt this view of the provider's interest in reimbursement, and have treated the provider's interest in much the same manner as the entitlement interest of beneficiaries to social welfare programs; i.e., legislative determinations regarding the dispensation of funds for social welfare programs need only be rational to meet the standards of substantive due process. Association of Am. Surgeons & Physicians v. Weinberger, 395 F. Supp. 125, 132 (N.D. Ill. 1975). See Maher v. Doe, 432 U.S. 464 (1977); Dandridge v. Williams, 397 U.S. 471 (1970). Indeed, the Supreme Court's opinion in Maher would seem virtually to preclude this line of argument. In Maher, the Court held that a state opting to provide a Medicaid program for the indigent can exclude coverage for "non-therapeutic abortions" without interfering with the fundamental right to privacy recognized in Roe v. Wade, 410 U.S. 113 (1973); the Maher Court specifically rejected the closer scrutiny of the classifications made by the statutory program and inquired only whether the legislation had a reasonable basis. Maher v. Doe, 432 U.S. 464, 474, 479 (1977).

Assuming the Court would hold the federal government to similar standards under a due process analysis, if the beneficiary of the Medicaid program has no fundamental interest in the receipt of services, then any provider interest in reimbursement must have no greater constitutional protection, particularly since the precedential basis for arguing that either beneficiary or provider has a fundamental interest at stake must come from the same line of cases. For a line of cases reflecting this attitude toward provider reimbursement, see the analysis of depreciation recapture in Springdale Convalescent Center v. Mathews, 545 F.2d 943 (5th Cir. 1977); Hazelwood
A more analytically complex issue arises when federal funding is conditioned on compliance with regulatory controls that affect not only the costs of the services funded by the program but health costs in general. Arguably, that is already the intent of some federal conditions on spending. More importantly, as the pressure mounts to "do something" about the overall cost problem, it seems quite likely that Congress will attempt to control both the costs of services funded by government programs and the costs of services in general, as in the case of the comprehensive cost containment proposal. Congress may opt to use its conditional spending authority for this purpose.

There should be no constitutional problem if policy conditions or attempted regulation attached to a spending program serve both the broader objective and the objective of the program. For example, the threat of reduced or denied Medicaid and Medicare reimbursement under the federal certificate of need program may successfully discourage health facilities from unnecessary capital expenditures altogether or encourage compliance with health planning guidelines; in either case the costs of health care in general would be affected along with the costs of those federal programs. So long as the attempted objective of the policy condition or regulation imposed is to control the cost, efficiency or quality of the funding program, or to facilitate in any other way the general goals of the program, then the condition would obvi-

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Chronic and Convalescent Hosp. v. Weinberger, 543 F.2d 703 (7th Cir. 1976). See also Daughters of Miriam Center for the Aged v. Mathews, 590 F.2d 1250 (3d Cir. 1978).

Thus, unless the current judicial attitude towards the constitutional importance of entitlement programs changes, it is unlikely that providers' reimbursement interests will receive anything more than cursory examination. Note, however, that while holding social welfare programs to a lesser standard of scrutiny, these cases could be cited as support for the proposition that the objective of the condition must relate—at least reasonably—to the objective of the program to which they are attached.

One important implication of this lesser standard of review may be that regulatory conditions that rely on "guestimates," aggregate or partial data, or arbitrary ceilings on costs, are more likely to survive judicial examination.

102. The various regulatory controls imposed by the 1972 amendments to the Social Security Act, Pub. L. No. 92-603, 86 Stat. 1329, are generally directed towards federal expenditures, but the distinction between controlling overall health costs and controlling the costs of Medicaid and Medicare is not complete; for example, § 223 imposes limits on the ability of participating providers to bill beneficiaries for costs excluded by the § 223 program. See 42 U.S.C. § 1395x(v)(1)(B) (1976).

More recent federal legislation obviously seeks to achieve broader purposes. The National Health Planning and Resources Development Act of 1974 is clearly intended to achieve both the broader purpose of controlling costs and the more direct purpose of limiting federal expenditures, see 42 U.S.C. § 300k (1976); the 1974 legislation attempts to interrelate some of the cost control conditions of the Medicaid and Medicare programs with the new health planning program established by the legislation.

103. See text accompanying notes 39-50 supra.
ously be constitutional despite the relation of the regulation or policy condition to a broader objective as well.

A more difficult connection between the condition and the program objective arises when a condition is imposed on severable activities and the clear purpose of the condition is to control not only the costs of those activities that are funded with federal dollars, but of those that receive funding from nonfederal sources as well. For example, the utilization review requirements imposed on Medicaid and Medicare participants might be extended to require providers to perform utilization review on all services rendered, not just those funded under the programs. Or to consider the most extreme example, Congress could establish a hospital cost containment program similar to the comprehensive proposal sought by the Carter Administration, requiring hospitals participating in Medicaid and Medicare to accept a limit on revenues collected from all sources or face denial of participation in Medicaid and Medicare. In both cases, the condition would be imposed on activities that are clearly not federally funded, and therefore, with respect to those activities, the condition would serve only the broader objective of controlling general costs.

Even under these circumstances, the condition may be valid. First, to distinguish between the objective of programs such as Medicaid and Medicare and the objective of controlling costs in general may be artificial. If the broadly worded legislative intent of those programs is to be taken seriously, the purpose of funding these programs is to assure financial access to health services and to provide for those Americans who cannot afford health care. The argument can thus be made that

104. See text accompanying notes 25-30 supra. Currently the program is limited to review of inpatient services that are funded by federal programs and rendered by institutional providers. For a description and in-depth discussion of this program, see Price, Katz & Provence, An Advocate's Guide to Utilization Review, 11 CLEARINGHOUSE REV. 307 (1977).

105. See text accompanying notes 39-50 supra.

106. The intent was to enable[e] each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care . . . .


107. Medicaid and, more particularly, Medicare have substantial “cost-sharing” provisions. For a description, see Butler, supra note 106, at 15-16. See also Butler, An Advocate's Guide to the Medicare Program, 8 CLEARINGHOUSE REV. 831, 833-35 (1975). Therefore, beneficiaries of those
the imposition of cost controls that affect the costs charged to consumers not financed under the programs may still be achieving the broader purposes of these programs. As indicated above, courts have generally given rather minimal scrutiny to governmental program objectives and their relationship to program conditions.

Moreover, even truly unrelated conditions attached to federal programs may be constitutional if courts continue to rely heavily on the persistent, if unrealistic, notion that participation in Medicaid and Medicare is voluntary. The courts may well take the position that programs are directly affected by the costs of providers, and beneficiaries are at the same time both private patients—for those services not covered or those costs not reimbursed—and program beneficiaries. Thus, the government has a strong interest in the costs charged to private patients, and this interest is directly related to the objectives of those federal programs. For example, as one of the conditions of participation by Medicare providers, the Medicare regulations define the circumstances under which beneficiaries can be billed. 42 C.F.R. § 405.601 (1977).

Another argument that relates the costs of government funding programs to the costs of health care in general is that controls on all payors may be necessary to prevent the costs of government funded services from being shifted to private patients, thus allowing providers to avoid cost controls on such programs as Medicaid and Medicare by "taxing" non-program patients. Again, the degree of scrutiny by the courts of the relationship between program and condition is as important as the substance of the argument. See note 101 supra. Also note that an unrelated condition may be justified because it facilitates a significant national policy (for example, compliance with civil rights laws). See note 89 supra. An interesting, if somewhat minor, example of what might be seen as an unrelated condition (which is probably not related to a significant national policy) is the recent concern over the composition of the boards of directors of fiscal intermediaries under Medicare and Medicaid. HEW Secretary Joseph E. Califano recently announced that he would require Blue Cross plans that provide fiscal intermediary services to the Medicare and Medicaid programs to include more consumer representatives on their boards of directors. See Washington Rep. on Health Legis., January 3, 1979, at 3. Opponents of this move undoubtedly will argue that it is difficult to document a factual basis for concluding that provider-dominated boards of directors somehow lead to bad performance of intermediary services. Thus, they will argue, there is no connection between the condition and the purpose of the program in which they are participating. On the other hand, HEW will argue that it is free to contract with anyone for such services and on whatever terms it may choose. Thus postured, the issue does suggest the way courts have looked at conditions imposed on reimbursement of providers, that is, provider participation is comparable to a contract and therefore HEW can attach any condition so long as the provider's participation is voluntary and not coerced. The argument is more persuasive when applied to the true contract, as is the case with fiscal intermediaries, because there are significant differences between the spending of funds pursuant to a contract with a fiscal intermediary and the spending of funds to reimburse participating providers.

Obviously, an extension of Medicaid and Medicare or the enactment of nationalized health insurance with mandatory participation by providers would require a different analysis. The issue, however, may be raised under current circumstances. The argument can be made that some providers must participate in Medicaid and Medicare under existing law because of Hill-Burton agreements to do so, see Rose, Federal Regulation of Services to the Poor Under the Hill-Burton Act: Realities and Pitfalls, 70 NW. L. REV. 168, 194-200 (1975), or because of the consequences that would result from the loss of their tax exempt status, see Bromberg, Financing Health Care and the Effect of the Tax Law, 39 Law & Contemp. Prob. 156 (1975).

Thus, federal law can be seen as "mandating" participation. But in both cases, participation is still, theoretically, voluntary. Providers voluntarily accepted Hill-Burton funds and voluntarily sought tax exempt status. Having done so, their required participation in federal programs is the quid pro quo for those voluntary acts.
the government is free to attach any condition to a voluntary spending program, whether related to the program objectives or not, so long as recipients are free to withdraw or decline participation in the program.

Thus, the federal spending authority could be extended to impose any type of regulatory controls on health care providers who rely on government spending, provided the imposition of the regulatory control or policy is in the form of a condition on the receipt of federal funds. On the other hand, the logic of this expansive view of federal authority would also indicate that conditions are valid only so long as they are true conditions, that is, so long as the sanction for noncompliance relates only to the continuation of the funding or the reimbursement received. The penalty tax portion of Carter’s comprehensive hospital cost containment program may not, therefore, be entirely justified as a proper extension of the conditional spending authority. The penalty tax, which is affixed to revenues collected from private sources above the imposed limit, might be subject to challenge, not because it serves an unrelated objective, but because the enforcement mechanism of the condition is accomplished by means other than the withdrawal or reduction of federal funds or the denial of participation in federal programs. In fact, since the Carter comprehensive plan would apply to all hospitals regardless of whether they participate in Medicaid and Medicare, the portion of the plan limiting collection of revenue from private sources is literally mandatory, not voluntary. It is best viewed as a separate statutory provision, and independent constitu-

110. Obviously this would not mean that the only sanction available would be termination of future participation. The current structure of the reimbursement process allows periodic payments to providers and retrospective adjustments at the end of each fiscal year. 42 U.S.C. § 1395f (1970). Providers are frequently penalized for failing to adhere to conditions and reimbursement is adjusted accordingly; it is not simply terminated. Id.; 42 C.F.R. § 100.103 (1978).

Providers might even be required to return reimbursement from private patients (or not collect it), if the ultimate sanction for not doing so were a comparable adjustment in reimbursement or denial of the provider’s participation in the program.

111. Carter’s proposal could be limited to only those providers participating in Medicaid and Medicare. Only participating providers would have to comply with revenue limitations on all patients; failure to comply would lead to denial of participation or a reduction of reimbursement. But if the revenue limitation is also enforced by another sanction, for example, the imposition of a civil penalty, presumably enforced with appropriate criminal sanctions, then it is questionable whether this could still be properly regarded as merely conditional spending since the requirement is more than a true condition.

In Hospital Ass’n v. Toia, 435 F. Supp. 819 (S.D.N.Y. 1977), the court held that a condition imposed by the Medicaid statute on participating states, which required that the state, under certain conditions, waive immunity to suits by providers seeking reimbursement, was a valid exercise of the congressional spending authority. 42 U.S.C. § 1396(a)(9) (1970) (repealed 1976). The court treated the requirement as a voluntary condition, even though it led to a judicially enforceable obligation. Note, however, that the sanction for noncompliance was related to participation in the program (failure to sign the waiver resulted in a 10% penalty on all Medicaid reimbursements, 42
tional justification would be required.112 A similar program, however, with sanctions relating only to the provider's participation status or reimbursement, may be a constitutionally permissible condition on federal spending.

B. State Sovereignty and The Spending Authority

Even if a federal policy condition or an attempt to impose cost controls on providers that receive federal funds clearly falls within the constitutional principles defining the federal spending authority, the exercise of that authority may nonetheless be considered unconstitutional if it interferes too greatly with the sovereignty of individual state governments.113 The exact parameters of this notion of federalism are difficult to define.114 In recent years the Supreme Court has shown an increased concern for the protection of state sovereignty and a willingness to assert state sovereignty as an affirmative limitation on federal authority, effectively reviving a constitutional doctrine that had been

112. The penalty tax on revenues collected could, however, be independently sustained as a proper exercise of the congressional taxing power under U.S. Const. art. I, § 8. Although the taxing power has not been used frequently in recent years for regulatory purposes, federal taxes imposed not solely as revenue measures, but with the purpose of regulating the taxed activity, have generally been upheld. See, e.g., United States v. Sanchez, 340 U.S. 42 (1950) (tax on marijuana); Sonzinsky v. United States, 300 U.S. 506 (1937) (tax on firearms); McCray v. United States, 195 U.S. 27 (1904) (tax on artificially colored oleomargarine). Apparently, if some revenue is raised, the courts are reluctant to examine the other motives of Congress. As the court in Sonzinsky stated with reference to a tax on firearms:

[w]e are not free to speculate as to the motives which moved Congress to impose it, or as to the extent to which it may operate to restrict the activities taxed. As it is not attended by an offensive regulation, and since it operates as a tax, it is within the national taxing power.


113. Precedent for this principle can be derived from United States v. Butler, 297 U.S. 1 (1935). In Butler, the Agricultural Adjustment Act of 1935, Pub. L. No. 73-10, ch. 25, 48 Stat. 31 (1935) (imposing a tax on cotton processors and making payments to farmers who reduce production), was held to be unconstitutional even if properly within the scope of the taxing and spending authority because it invaded an area of legislation reserved to the states. Later cases did not ignore this principle, but held that inducing states to participate in Federal programs with the offer of federal funds was constitutional since it did not “coerce” state participation. See note 80 supra. Thus, federal spending for the general welfare has been generally accepted as constitutionally permissible even when it involves activities or interests of traditional state concern. The issue that must be addressed, however, is whether, in light of recent renewed interest in state sovereignty, see notes 114-16 infra, conditional spending can transgress the line from inducement to coercion or violate the increasingly emerging, but largely undefined, principles of federalism.

See also discussion of interstate commerce authority and state sovereignty in text accompanying notes 213-26 infra.

114. See Michelman, States' Rights and States' Roles: Permutations of “Sovereignty” in National League of Cities v. Usery, 86 Yale L.J. 1165 (1977); Comment, supra note 73; Note, 76 Colum. L. Rev. 990 (1976); Note, supra note 73.
virtually dismissed in prior decisions. In *National League of Cities v. Usery*, a sharply divided Court declared unconstitutional the extension of the federal fair labor standards law to include employees of state and local government. Writing for the majority, Justice Rehnquist argued:

If Congress may withdraw from the States the authority to make those fundamental employment decisions upon which their systems for performance of these functions must rest, we think there would be little left of the States' "separate and independent existence." . . . Thus, even if appellants may have overestimated the effect which the Act will have upon their current levels and patterns of governmental activity, the dispositive factor is that Congress has attempted to exercise its Commerce Clause authority to prescribe minimum wages and maximum hours to be paid by the States in their capacities as sovereign governments. In so doing, Congress has sought to wield its powers in a fashion that would impair the States' "ability to function effectively in a federal system . . . ." 117

While the *National League of Cities* Court expressly refrained from applying its analysis to other federal powers,118 the principles of federalism pronounced in that case could logically apply to exercises of the spending authority as well.119 Although this special concern for state sovereignty may be confined to an examination of the tremendous scope of the federal commerce authority, it might also be relevant in an examination of the scope of federal power under the spending authority, which can be quite broad as well.120 If *National League of Cities* has signaled an intensified judicial concern for the separate and independent existence of state and local government, it could translate into the recognition that there are affirmative limitations on the federal spending authority, particularly in an age in which state and local governments depend so heavily on federal funding for almost every public


117. Id. at 851 (citations omitted).

118. Id. at 852 n.17. Subsequent opinions of the Court have analyzed federal legislation enacted under other sources of federal authority in a much different fashion. Cf. *Fitzpatrick v. Bitzer*, 427 U.S. 445 (1975) (federal legislation under the power conferred by the fourteenth amendment).

119. Note, supra note 73, at 1155.

120. There are, however, obvious qualitative differences between federal legislation enacted under the spending authority and legislation enacted under the commerce authority. For instance, commerce legislation is mandatory, and spending authority legislation is, at least theoretically, voluntary. For an interesting perspective on this point, see *Montgomery County v. Califano*, 449 F. Supp. 1230, 1248 (D. Md. 1978).
service they provide, not the least of which are social welfare and health programs. 121

Having recognized the possibility of this affirmative limitation on the spending power, it is difficult even to sketch the specific application of the limitation in this context. So far, the judiciary, including the Supreme Court, has been reluctant to expand the National League of Cities analysis to other federal powers, 122 and the opinion understandably provides little more than general guidance for future applications

121. See Wing & Craige, this Symposium, at note 5.

122. The application of National League of Cities has, for the most part, been limited to the commerce power. Courts have repeatedly rejected application of National League of Cities to the congressional powers conferred by the fourteenth amendment. See, e.g., Fitzpatrick v. Bitzer, 427 U.S. 445 (1976); Marshall v. City of Sheboygan, 577 F.2d 1 (7th Cir. 1978); United States v. City of Chicago, 573 F.2d 416 (7th Cir. 1978); Arritt v. Grisell, 567 F.2d 1267 (4th Cir. 1977); Love v. Waukesha Joint School Dist. #1, 560 F.2d 285 (7th Cir. 1977); Usery v. Charleston City School Dist., 558 F.2d 1169 (4th Cir. 1977); Usery v. Allegheny County Institution Dist., 544 F.2d 148 (3d Cir. 1976), cert. denied, 430 U.S. 946 (1977).


National League of Cities has been construed as not imposing a limitation upon federal anti-racketeering statutes, In re Grand Jury Proceedings, 563 F.2d 577 (3d Cir. 1977); as not imposing a tenth amendment limitation upon the SEC's authority to order a preliminary investigation into a city's bond proposal, even though such investigation might force the city into an alternative and possibly more expensive means of raising money, City of Philadelphia v. SEC, 434 F. Supp. 281 (E.D. Penn. 1977); and as not prohibiting the preemption of health insurance statutes that conflicted with federal statutes, Standard Oil Co. v. Agsalud, 442 F. Supp. 695 (N.D. Cal. 1977).

With respect to the spending authority, National League of Cities has uniformly been interpreted not to limit congressional power based on the spending authority. See, e.g., City of Macon v. Marshall, 439 F. Supp. 1209 (M.D. Ga. 1977) (conditions imposed upon states for receipt of federal funds under Urban Mass Transportation Act, no violation of tenth amendment); Stiner v. Califano, 438 F. Supp. 796 (W.D. Okla. 1977) (Social Security Act regulations may, without violating tenth amendment, require day-care centers receiving federal funds to maintain minimum staffing ratios); Dupler v. City of Portland, 421 F. Supp. 1314 (D. Me. 1976) (city violated federal Food Stamp Act by reducing local welfare funds to recipients by amount recipients received in food stamps); City of Boston v. Hills, 420 F. Supp. 1291 (D. Mass. 1976) (federal statute granting HUD power to control rents on federally subsidized housing projects, even though in conflict with city rent control ordinance, not violative of tenth amendment). See also cases cited note 141 infra.

Nevertheless, there is no doubt that National League of Cities stands for a resurrection, however modest, of a concern for state sovereignty. Though it has been limited almost to its facts, it does provide a jumping-off point for more drastic curtailments of federal power. See, e.g., Davids v. Akers, 549 F.2d 120 (9th Cir. 1977) (power of Speaker of Arizona House of Representatives to appoint only Republicans to committees is an "essential decision regarding the conduct of integral governmental functions," and thus action challenging that power presents no cognizable federal claim under the first and fourteenth amendments). But see Elrod v. Burns, 427 U.S. 347 (1976) (Democratic sheriff violated first amendment by firing his Republican predecessor's employees); United States v. Best, 573 F.2d 1095 (9th Cir. 1978) (federal magistrate is without power to suspend California driver's license of person arrested for drunken driving on a federal enclave); Donohoe Constr. Co. v. Montgomery County Council, 567 F.2d 603 (4th Cir. 1977), cert. denied, 438 U.S. 905 (1978) (federal courts unwilling to intervene in local condemnation proceedings absent egregious abuse of the condemnation power).
of the federalism principles it recognizes. It is even difficult to characterize the exact nature of the state sovereignty interest being protected.

Rehnquist's opinion can be seen as emphasizing at least two different aspects of state sovereignty: his stated concern for "essential state functions" suggests that the proper inquiry should focus exclusively on the survival of the state as provider of certain services or as performer of specific functions; yet his analysis also suggests that he is willing to balance state and federal interests, and that his concern is not for specific state functions, but for the overall impact on the federal system. As applied to spending programs, this balancing test could call for a renewed examination of the coercive effect of federal funding on state and local government and provide a more flexible approach to the federalism problem.

Whatever specific line of analysis will be employed, undeniably the impact of federal health care cost controls on what could be considered essential or traditional functions of state and local government is already substantial and will likely increase under both existing federal authority and pending hospital cost containment proposals. State, as well as county and municipal, governments are major providers of health care. States traditionally have directly provided care for the mentally ill, developmentally disabled and people with chronic diseases. Most large cities and many counties maintain hospitals and clinics for the poor, in addition to providing a variety of related public health services. Already, the various conditions of participation

123. Justice Rehnquist was clearly concerned with the survival of "States as States," 426 U.S. at 842, and in specifying his concern, he relied heavily on the concept of "functions essential to separate and independent existence," id. at 845 (quoting Coyle v. Oklahoma, 221 U.S. 559, 580 (1911)). The majority opinion also forbids federal legislation displacing any state function that "may substantially restructure traditional ways in which the local governments have arranged their affairs." Id. at 849. See also Justice Brennan's discussion of the essential services and functions concept in his dissent. Id. at 864.

124. As has been suggested by the considerable legal commentary generated by this case, Rehnquist's various rhetorical expressions of his concern and his weighing of the impact of the federal legislation indicates that he is in fact employing a balancing test, and that he is not concerned solely with the survival of specific state functions, but with the overall impact of the federal legislation on the sovereign state. See id. at 848. See also Michelman, supra note 114, at 1167 n.11; Note, supra note 73, at 1151. By overruling Maryland v. Wirtz, 392 U.S. 183 (1968), but distinguishing Fry v. United States, 421 U.S. 542 (1975), the majority opinion effectively balanced the state's interest in sovereignty against a variety of federal policy considerations. 426 U.S. at 852-54.

125. See generally Koran, Mental Health Services, in Health Care Delivery in the United States (S. Jonas, ed. 1977).

126. See text accompanying notes 80-92 supra.

127. See Wing & Craige, this Symposium, at text accompanying notes 62 & 63.

under the federal Medicaid and Medicare legislation substantially impact on these public providers: utilization review requirements and federal certificate of need restrictions on capital expenditures substantially regulate internal administrative decisions as well as expressions of local preferences. If hospital cost containment legislation were enacted, the federal impact on the hospital portion of these local government activities could be quite drastic, unless public providers are exempted from coverage.

Federal cost control efforts also impact on the state, not as a provider of services, but as a regulator of health care and as an administrator of health programs—functions that may be perceived as "essential." This impact has already led to controversy. There is an increasing tension between states administering their Medicaid programs and HEW, which is attempting to increase federal influence over those programs and to use those programs to achieve federal policies. For example, HEW has tried to use available sanctions, including reimbursement penalties, to require states to impose federal cost control requirements on Medicaid providers. In some cases, controversies have arisen when states have sought to implement their own cost strategies in administration of their Medicaid programs, but HEW has opposed these attempts as incompatible with federal Medicaid law or policy.

The 1974 federal health planning legislation effectively extended federal control over not only all state planning and resource development activities, including state certificate of need laws, but also over the internal administration of the state programs and the structure of state agencies. The federal legislation sets a specific timetable for the enactment of state legislation to conform to the requirements outlined in the federal law. Hospital cost containment would go even

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129. Not all public providers of health care are eligible to participate in federal programs. For example, inpatient psychiatric hospital services are excluded from Medicaid coverage (for beneficiaries over 20 years old). 42 U.S.C. § 1396d(a) (1976 & Supp. I 1977).
130. See note 30 supra.
131. See note 29 supra.
132. See note 44 supra.
133. Many of the functions now performed by states as administrators or regulators are hardly traditional state functions.
134. See notes 141 & 144 infra.
135. See id.
136. See Wing & Craig, this Symposium, at text accompanying notes 184 & 185.
138. Id. § 300m-2(b)(2)(A).
further: it would provide for direct federal regulation of health care costs and might even replace some existing state agencies with a federal regulatory body.\(^\text{139}\)

Despite the substantial impact on what could be considered essential elements of state sovereignty, thus far, federal cost control efforts that affect state and local governments by imposing conditions on federal health-related spending programs have been upheld. State and local governments, as providers of health care, have not been singled out for separate treatment by courts reviewing the validity of conditions imposed on providers participating in the Medicaid and Medicare programs.\(^\text{140}\) Courts have uniformly held that states must conform to the dictates of federal law in administering their Medicaid programs.\(^\text{141}\) Although courts have been careful to note that federal law intends the states to have a great deal of autonomy in administering Medicaid, they have nonetheless analyzed conditions imposed on states as administrators of Medicaid in virtually the same manner as conditions imposed on providers. Relying heavily on the assumption that participation by a state in Medicaid is voluntary,\(^\text{142}\) courts have upheld a variety of federal conditions imposed on the manner in which states administer the program.\(^\text{143}\)

Similarly, state challenges to the conditions imposed by the 1974 federal health planning legislation have not been successful, although the impact of that legislation on state sovereignty has been given more thorough examination.\(^\text{144}\) In *North Carolina ex rel. Morrow v.*

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\(^\text{139}\) See note 44 *supra*, for proposals to exempt states that have state hospital cost containment mechanisms.

\(^\text{140}\) Virtually no explicit consideration of "state sovereignty" has been given to the impact of Medicaid and Medicare conditions on state or local governments that are participating providers.


\(^\text{142}\) *See text accompanying notes 80-92 supra.*

\(^\text{143}\) Medicaid is frequently characterized as a joint state-federal cooperative effort, and much discretion is given to each state to administer its own program under the dictates of the federal statute. *See White v. Beal*, 555 F.2d 1149 (3d Cir. 1977). Nonetheless, the state must conform to any condition in the federal statute or program executed by the state. *See also* *Hospital Ass'n v. Toia*, 435 F. Supp. 819 (S.D.N.Y. 1977).

\(^\text{144}\) Thus, courts have effectively discounted the impact on state sovereignty, continuing the traditional distinction between inducement and coercion and continuing to characterize federal spending programs as inducements.

Califano, the federal district court upheld the requirement that states enact certificate of need legislation despite the impact on state sovereignty and rejected North Carolina's argument that such legislation violated state constitutional law.

The validity of the power of the federal government under the Constitution to impose a condition on federal grants made under a proper constitutional power does not exist at the mercy of the State Constitutions or decisions of the State courts. Moreover, the "coercive" effect of a termination of federal assistance on the plaintiff seems quite unreal. The actual loss to North Carolina should it lose all federal assistance health grants would be less than fifty million dollars in 1974, its State revenues totalled some 3.1 billion dollars. The impact of such loss could hardly be described as "catastrophic" or "coercive".

It must be remembered that this Act is not compulsory on the State. It does not impose a mandatory requirement to enact legislation; it gives the States an option to enact such legislation and, in order to induce that enactment, offers financial assistance. Such legislation conforms to the patterns generally of federal grants to the states and is not "coercive" in the constitutional sense.

It is important to note that more recent decisions, prompted by National League of Cities and other related decisions, have not only given greater consideration to the concept of federalism, but also have re-opened the coercion issue as applied to federal spending programs, implying that there may be a point—not yet achieved—at which the inducement of federal funding may become so great that state participation is coerced both in practical effect and in the constitutional sense.

that the 1974 federal health planning legislation "preempts" the field of health planning and that a state is required to comply with federal procedural requirements even when the state is carrying out substantive powers (for example, facility closure) not included in the federal legislation.

147. 445 F. Supp. at 535-36 (1977). (Note that the analysis of the impact is incorrect. Nonparticipation by a state would result in some loss of funds under a variety of federal health programs, but would not result in the loss of all federal health assistance, and particularly not Medicaid. See 42 U.S.C. §§ 300m to 300m-2 (1976 & Supp. 1 1977).
148. For a related case also evidencing increased judicial concern for state sovereignty, see Maryland v. EPA, 530 F.2d 215 (4th Cir. 1975), vacated on other grounds sub nom., EPA v. Brown, 431 U.S. 99 (1977).
149. For example, in Montgomery County v. Califano, 449 F. Supp. 1230 (D. Md. 1978), the court held that federal spending must (1) be for the general welfare and (2) not coerce states into giving up their sovereign status:

While the withholding of federal funds in some instances may resemble the imposition
If implemented under the federal spending authority, federal cost controls such as hospital cost containment may test the application of this newly revived concern for state sovereignty and federalism. These controls will present the states with federal inducements to participation and compliance with regulatory conditions that are at least tantamount to coercion. Medicaid and other federal health funds make up a considerable portion of state budgets, and many state and local government providers, such as public hospitals and clinics, literally rely on Medicaid and Medicare reimbursement for their survival—far more so than most private providers. If federal cost control conditions are imposed on public providers receiving federal funds or participating in Medicaid and Medicare, state and local governments would have little choice but to comply. Similarly, any health planning or regulatory requirement that conditioned continued Medicaid, Medicare or other federal funds on compliance with the federal requirement by a state’s health planning or regulatory programs would also leave the state with little choice. And, of course, a nationalized health insurance scheme would raise the stakes even higher and would, for all practical purposes, require compliance by state and local governments—as providers or as administrators—with any federal health policy or cost control condition.

But whether this coercive impact or the resulting imbalance in federal and state authority over health care will persuade the courts to of civil or criminal penalties and while economic pressure may threaten such havoc to a state’s well-being as to cause the federal legislation to cross the line which divides inducement from coercion, that line is not crossed in this case.

*Id.* at 1247.

150. For example, the municipal hospitals in New York City reported the following percentages of inpatient revenues from Medicaid and Medicare patients in 1977 and 1978:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>1977</th>
<th>1978</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bronx Municipal</td>
<td>74.6</td>
<td>75</td>
</tr>
<tr>
<td>Lincoln</td>
<td>74.9</td>
<td>N/A</td>
</tr>
<tr>
<td>North Central Bronx</td>
<td>72.0</td>
<td>76</td>
</tr>
<tr>
<td>Coney Island</td>
<td>72.3</td>
<td>71</td>
</tr>
<tr>
<td>Cumberland</td>
<td>67.2</td>
<td>72</td>
</tr>
<tr>
<td>Green Point</td>
<td>68.7</td>
<td>65</td>
</tr>
<tr>
<td>Kings County</td>
<td>73.0</td>
<td>69</td>
</tr>
<tr>
<td>Bellvue</td>
<td>73.6</td>
<td>70</td>
</tr>
<tr>
<td>Harlem</td>
<td>78.8</td>
<td>80</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>78.4</td>
<td>78</td>
</tr>
<tr>
<td>Sydenham</td>
<td>72.9</td>
<td>76</td>
</tr>
<tr>
<td>Elmhurst</td>
<td>63.9</td>
<td>64</td>
</tr>
<tr>
<td>Queens</td>
<td>73.5</td>
<td>72</td>
</tr>
</tbody>
</table>

NEW YORK CITY HEALTH POLICY TASK FORCE, A PLAN FOR IMPROVING THE EFFECTIVENESS OF HOSPITAL SERVICES IN NEW YORK CITY app. A (June 20, 1979).
limit federal attempts to regulate or control health care costs through its spending authority is virtually impossible to predict. Certainly if a federal policy condition or regulatory program is attached as a condition to federal funds that are totally unrelated to the purpose of the condition, then a state can make a persuasive case: not only is the condition coercive, it is also unrelated to the purpose of the conditioned funding; therefore, the traditional constitutional justification for the validity of the conditional spending authority is weakened. 151 When such conditions are applied to state or local governments, as opposed to private providers, this exercise of the conditional spending authority has the additional constitutional problem of interfering with notions of federalism and state and local government sovereignty. As noted earlier, courts have been generally unresponsive to constitutional attacks on conditional spending, but when they have expressed concern for issues such as the relationship of a condition to the funding program to which it is attached or the problem of coercion-inducement, the case has involved circumstances in which the state has had to bear the burden of the federal condition, not private recipients of federal funds. 152 Particularly if the regulatory condition is intended to be a major, direct effort to control health care costs—as opposed to the marginal efforts that have characterized federal policy until very recently 153—the federal exercise of the spending authority simply by virtue of its intended impact may be the sort of exercise of otherwise valid authority that offends those who jealously guard the sovereignty of state and local governments. It is worth noting, however, that recent federal legislative proposals for hospital cost containment programs have provided for statutory exemption of existing state cost containment programs. 154 In fact, during legislative consideration of hospital cost containment proposals in the Ninety-Fifth Congress, there was substantial support for an exemption for public hospitals from the federal requirement. 155 Thus political constraints may, as they traditionally have, provide the safeguards for federalism that constitutional doctrine may not. 156

151. See text accompanying notes 77 & 78 supra.
152. See text accompanying notes 80-92 supra.
153. See programs described in text accompanying notes 24-41 supra.
154. See note 44 supra.
155. See notes 44 & 45 supra.
156. One commentator has hypothesized that political restraints have limited the potential use of the federal spending authority and thus the validity of that authority if fully extended has never been tested. See Comment, supra note 73, at 307. It is not insignificant, for example, that public hospitals were exempted from the proposals for hospital cost control. See note 44 supra. Moreover, even during the expansion of federal control over health care in the last two decades, the
It seems clear that unless there are sudden doctrinal changes in the judicial interpretations of the spending authority, Congress has tremendous discretion to expand federal control over the costs of health care, meaning both costs generally and costs of government health care programs in particular. Although an aggressive administrative effort to expand federal control under existing authority may encounter significant political constraints—and its own inability to administer effective programs—it could, nonetheless, greatly increase current authority and still be within constitutional bounds.

Nearly any attempt to control the costs associated with federal health care programs, including cost control conditions imposed on Medicaid and Medicare providers that also have the effect of controlling the costs of health care in general, is within the substantive limitations on the federal conditional spending authority. Attempts to directly regulate the costs of health care providers associated with non-federally funded activities should be valid if imposed as conditions on the receipt of federal funds. Even if judicial interpretation of the spending authority requires that such conditions only be imposed when there is a relationship between the condition and the conditioned funding, this requirement may be satisfied by existing programs and will most certainly be satisfied as federal financial involvement in health care expands in the direction of nationalized health insurance.

Federal cost control efforts that affect state and local governments as providers or administrators of health care programs may be examined for their impact on state sovereignty; at this point in time, however, it is difficult to predict how notions of federalism will be applied to exercises of federal spending in this context.

C. The Interstate Commerce Authority

Congressional authority to regulate the health care industry, including control of health care costs, can also be derived from the interstate commerce authority.\(^\text{157}\) Despite Congress' traditional reluctance

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\(^{157}\) The United States Constitution grants Congress the power "to regulate commerce with foreign Nations, and among the several States, and with the Indian Tribes." U.S. CONST. art. I, § 8, cl. 3.
to invoke the commerce authority with specific reference to health care providers, a variety of federal regulatory programs have been extended to include health care institutions and have been upheld as proper exercises of the congressional commerce authority. Thus Congress has—should it choose to use them—broad regulatory powers in addition to those outlined in the previous section and an established constitutional basis for the control of health care costs.

As with the congressional spending authority, the general principles defining the interstate commerce authority have been applied fairly consistently in recent decades. In an unbroken line of cases since the 1930s, the Supreme Court has viewed the interstate commerce authority as an independent and plenary grant of power giving Congress virtually unlimited discretion over private conduct so long as that conduct can be characterized as either affecting or moving through interstate commerce. Even local, intrastate activities have been held

158. See text accompanying notes 167-94 infra.
159. The general basis for the modern view of the interstate commerce authority was originally established by Chief Justice Marshall in Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1 (1824):

The genius and character of the whole government seem to be, that its action is to be applied to all the external concerns of the nation, and to those internal concerns which affect the States generally; but not to those which are completely within a particular State, which do not affect other States, and with which it is not necessary to interfere, for the purpose of executing some of the general powers of the government. The completely internal commerce of the State, then, may be considered as reserved for the State itself.

160. In United States v. Darby, 312 U.S. 100, 114 (1941), the Court held that Congress was free to follow its own notion of public policy, including the achievement of policy objectives related to the public health or safety—matters traditionally reserved to the states. Whether this is literally true or whether there are any limits on permissible congressional purposes is not clear. Later cases suggest that Congress must have an “end permitted by the Constitution” and “a means reasonably related to that end.” National League of Cities v. Usery, 426 U.S. 833, 840 (1976); Heart of Atlanta Motel, Inc. v. United States, 379 U.S. 241, 262 (1964). But the majority of the cases do not mention even this qualification, and it would appear that the regulation of interstate commerce per se is a constitutionally permissible end.

161. In Wickard v. Filburn, 317 U.S. 111 (1942), the Court stated:

The commerce power is not confined in its exercise to the regulation of commerce among the states. It extends to those activities intrastate which so affect interstate commerce, or
to be valid subjects for congressional control if they fall into a class of activities that taken in the aggregate have a substantial impact on interstate commerce, or if the control of the intrastate activity is necessary or proper as part of the overall regulatory program. Congress has been allowed to ensure that interstate commerce conforms to federal policy (for example, fair wages paid in the production of goods that will pass through interstate commerce), and also to impose federal policy on activities within a state that are related to interstate commerce after that commerce has occurred (for example, nondiscrimination requirements imposed on public accommodations).

Indeed, once it is established that an activity is within the reach of the commerce authority, Congress has been allowed to impose federal policy or to regulate that activity through any reasonable means to achieve virtually any objective it considers appropriate. The willingness of the Supreme Court to defer to congressional discretion and to find that an activity affects or moves through interstate commerce has led many commentators to suggest—at least prior to the Supreme Court decision in *National League of Cities v. Usery*—that the Court has virtually abandoned all limits on congressional discretion under this authority.

The power of Congress over interstate commerce is plenary and complete in itself, may be exercised to its utmost extent, and acknowledges no limitations other than are prescribed in the Constitution. It follows that no form of state activity can constitutionally thwart the regulatory power granted by the commerce clause to Congress. Hence the reach of the power extends to those intrastate activities which in a substantial way interfere with or obstruct the exercise of a granted power.

*Id.* at 124 (quoting United States v. Wrightwood Dairy Co., 315 U.S. 110, 119 (1942) (citations omitted)).


164. The initial cases in this area generally involved federal policy imposed on goods that had not yet entered the stream of interstate commerce, for example, minimum wage or maximum hour limits on the production of goods to be shipped in interstate commerce, or on the goods of intrastate competitors. *E.g.*, *United States v. Wrightwood Dairy Co.*, 315 U.S. 110 (1942); *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1 (1937). Later cases expanded this notion to include regulation of activities occurring after the goods had entered the stream of interstate commerce or after the transactions constituting the interstate commerce connection had occurred—substantially broadening the effective scope of congressional power.

165. See note 160 supra and note 166 infra.

166. The most recent formulations of the commerce authority indicate that the Supreme Court is willing to allow Congress to regulate activities or entities with only a minimal connection to
the interstate commerce authority, it is hard to imagine that Congress could not opt to regulate almost any aspect of health care delivery. The Supreme Court has continually affirmed the notion that comparable enterprises can be regulated, and that the method and terms of regulation are firmly vested in the discretion of Congress. Both the courts and Congress may have been reluctant to include health care providers within this sweeping authority in the past, but both have come to apply the interstate commerce authority to a variety of health care providers in recent years with little discussion or resulting controversy.

While the interstate commerce authority has not been used as a basis for enacting any of the programs specifically intended to regulate health care providers, in the last decade hospitals, nursing homes and a variety of other health care providers have been found to be engaged in interstate commerce and therefore subject to various federal regulatory schemes enacted under the commerce authority.

When Congress adopted the Fair Labor Standards Act in 1938, establishing minimum wage and working condition requirements for certain generally defined categories of employers engaged in interstate commerce, it apparently intended that health care providers be exempted. Amendments in the 1960s, however, specifically extended actual interstate commerce, such as financial transactions with other entities engaged in interstate commerce. See Daniel v. Paul, 395 U.S. 298 (1969) (paddleboats and food supplies purchased from out-of-state held sufficient to satisfy commerce clause); Katzenbach v. McClung, 379 U.S. 294 (1964) (purchase by a restaurant of $150,000 in supplies from local supplier engaged in interstate commerce had sufficient effect to come within Congress' commerce power). See also Perez v. United States, 402 U.S. 146 (1971). The Court has been particularly liberal in its interpretation of congressional authority when Congress' intent to include an entity or activity within commerce-based regulation is clear; the cases restricting the reach of the commerce authority generally involve situations in which the intent of Congress is not clear, as when private litigants claim that certain activities are within interstate commerce for the purpose of the application of federal antitrust laws. See text accompanying notes 178-92 infra.

168. In considering the FLSA in 1938, the Chairwoman of the House Committee on Labor gave her assurances to a colleague that hospitals were not covered by the FLSA because they were not engaged in interstate commerce. 83 Cong. Rec. 7299 (1938) (response of Rep. Norton to inquiry by Rep. Dempsey). Similarly, assurances were given in the Senate that the Act did not reach local retail or service businesses. 83 Cong. Rec. 9176 (1938) (remarks of Sen. Walsh).

The 1961 amendments to the Act specifically exempted hospitals, nursing homes, and mental institutions. Pub. L. No. 87-30, § 9(a)(2), 75 Stat. 71. Previously, nonprofit health care providers had been exempted from the Act's definition of "enterprise." The 1966 amendments, however, both repealed the exemption and amended the definition of "enterprise" to include nonprofit health care providers. See Pub. L. No. 89-601, §§ 102, 201, 80 Stat. 830.

The FLSA now includes:

An enterprise which has... employees handling... goods or materials that have been moved in or produced for interstate commerce by any person and which... .

. . .

. . . is engaged in the operation of a hospital, an institution primarily engaged in the
the Act's requirements to health care institutions engaged in interstate commerce, and the courts have consistently upheld the application of the Act to a variety of hospitals, nursing homes and other providers.171

The National Labor Relations Act (NLRA), which imposes collective bargaining requirements on employers engaged in interstate commerce, has also been applied to health care providers. Although until 1974 the NLRA specifically exempted nonprofit hospitals, the National Labor Relations Board (NLRB) has successfully

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Thus the Act includes a range of health care providers but still requires a specific finding that the individual provider is engaged in interstate commerce.


The 1961 and 1966 amendments also extended the scope of the FLSA to include some public employers, including state operated schools and hospitals. These amendments were upheld in Maryland v. Wirtz, 392 U.S. 183 (1968). After the Act was amended in 1974 to include virtually all public employers, the amendments were held to be an unconstitutional invasion of state sovereignty, National League of Cities v. Usery, 426 U.S. 833 (1976), and Maryland v. Wirtz was specifically overruled. Id. at 855. Both opinions, however, implicitly upheld the extension of congressional authority as a proper exercise of the interstate commerce authority. Id. at 841-42.


173. The NLRA's jurisdiction is defined as follows: "The term 'commerce' means trade, traffic, commerce, transportation, or communication among the several States . . . ." 29 U.S.C. § 152(6) (1976). "The term 'affecting commerce' means in commerce, or burdening or obstructing commerce or the free flow of commerce, or having led or tending to lead to a labor dispute burdening or obstructing commerce or the free flow of commerce." Id. § 152(7).

174. In 1947, prior to the express exemption of nonprofit hospitals, the NLRB's assertion of jurisdiction over a nonprofit hospital was upheld by the federal courts. Central Dispensary & Emergency Hosp., 44 N.L.R.B. 533 (1942), enforced, 145 F.2d 852 (D.C. Cir. 1944), cert. denied, 324 U.S. 847 (1945). The court of appeals held that hospitals were in commerce, within the meaning of interstate commerce, citing AMA v. United States, 130 F.2d 233 (D.C. Cir. 1942), aff'd, 317 U.S. 519 (1943) and Jordan v. Tashiro, 278 U.S. 123 (1928), and that the hospital in question had sufficient connections to interstate activities to satisfy the jurisdictional requirement. 145 F.2d at 853.


claimed jurisdiction over a wide variety of institutional providers, and now claims jurisdiction over almost all hospitals and nursing homes.\textsuperscript{177}

the nonprofit hospital exemption of 29 U.S.C. § 152(2), and added, in § 1(b), a new § 152(14):

"The term 'health care institution' shall include any hospital, convalescent hospital, health maintenance organization, health clinic, nursing home, extended care facility, or other institution devoted to the care of the sick, infirm, or aged person." 29 U.S.C. § 152(14) (1976).

Parenthetically, the 1974 amendments, in § 1(d) and § 2, provide special procedures for labor arbitration and strikes to prevent disruption of health care delivery. 29 U.S.C. § 158(d)(4), (g), § 183 (1976). For a discussion and explanation, see Vernon, \textit{Labor Relations in the Health Care Field Under the 1974 Amendments to the National Labor Relations Act: An Overview and Analysis}, 70 NW. L. REV. 202 (1975).

176. Throughout the 1960s and 1970s, the NLRB extended its jurisdiction to a variety of providers other than nonprofit hospitals. \textit{See}, e.g., \textit{Von Solbrig Hosp., Inc. v. NLRB}, 465 F.2d 173 (7th Cir. 1972) (application to proprietary hospital with over $1 million in revenues).

Until 1968, the NLRB's discretionary assertion of jurisdiction over nursing homes was limited to proprietary nursing homes. In Council 19, Am. Fed'n of State, County & Mun. Employees v. NLRB, 295 F. Supp. 1100, 1105 (N.D. Ill. 1968), however, the court found no reason for treating nonprofit and proprietary homes differently, and the NLRB began to assert jurisdiction over all nursing homes with gross revenues in excess of $100,000. The Ninth Circuit upheld the NLRB's decision to extend its jurisdiction to nonprofit nursing homes in NLRB v. Evangelical Lutheran Good Samaritan Center, 477 F.2d 297 (9th Cir. 1973). \textit{See also} Glen Manor Home for the Jewish Aged v. NLRB, 474 F.2d 1145, 1149 (6th Cir.), \textit{cert. denied}, 414 U.S. 826 (1973).

The NLRB has also claimed jurisdiction over visiting nurses associations, clinics and physician group practices. \textit{See District Nursing Ass'n, 210 N.L.R.B. 476 (1974)} (interstate commerce found in the receipt of over $100,000 in combined reimbursements received from Medicare, welfare programs, Veterans Administration and private insurance); Visiting Nursing Ass'n, 187 N.L.R.B. 731 (1971); Quain & Ramstad Clinic, 173 N.L.R.B. 1185 (1968) (partnership of physicians with $3.2 million in gross revenues); Mayo Clinic, 168 N.L.R.B. 557 (1967) (respondent-clinic agreed to assertion of jurisdiction; only substantive issues were contested).

The Fifth Circuit approved the assertion of jurisdiction over a large clinic with 200 physicians in Ochsner Clinic v. NLRB, 474 F.2d 206 (5th Cir. 1973). The Board has also asserted jurisdiction over a variety of clinics. \textit{See, e.g., Malcolm X Center for Mental Health, Inc., 22 N.L.R.B. 944 (1976)} (mental health facility); East Oakland Health Alliance, 218 N.L.R.B. 1270 (1975) (outpatient clinic); Pius XII School, Inc., 218 N.L.R.B. 711 (1975) (alcohol treatment and rehabilitation center); Planned Parenthood Ass'n, 217 N.L.R.B. 1098 (1975) (abortion-family planning clinic); Biomedical Applications, 216 N.L.R.B. 631 (1975).

Jurisdiction has also been asserted over the suppliers of clinics and doctors. \textit{See, e.g., Metropolitan Orthopedic Ass'n, 237 N.L.R.B. 51 (1978)} (provider of orthopedic devices and services is a health care facility); Damon Medical Labs, 234 N.L.R.B. 55 (1978) (jurisdiction asserted, but not as health care facility); Atwood Leasing Corp., 227 N.L.R.B. 1668 (1977) (dismissed for lack of jurisdiction; insufficient revenues involved); San Diego Blood Bank, 219 N.L.R.B. 116 (1975) (jurisdiction asserted, but blood bank held not to be a health care institution).

On certain occasions, the NLRB has chosen not to exercise its jurisdiction over small clinics and private practices, while indicating it could do so in its discretion. \textit{See Choice, Inc., 212 N.L.R.B. 50 (1974)} (NLRB declined to assert jurisdiction over essentially local abortion clinics); Cleveland Ave. Medical Center, 209 N.L.R.B. 537 (1974) (ten osteopaths in group practice; NLRB dismissed, declining to assert jurisdiction); Almeda Medical Group, Inc., 195 N.L.R.B. 312 (1972). The NLRB may attempt to expand its jurisdiction to include sole practitioners. In Jack L. Williams, D.D.S., 219 N.L.R.B. 1045 (1975), jurisdiction was asserted over a dentist who employed four other dentists and a staff of twenty-one and had over $250,000 in gross revenue; the NLRB rejected the argument that the practice of dentistry was per se local. \textit{See also} Dr. George Szele, Anesthesiologist, 238 N.L.R.B. 197 (1978); Vernon, \textit{supra} note 175, at 203.

177. The NLRB now may claim jurisdiction over all nursing homes or visiting nurse associa-
The involvement of health care providers in interstate commerce also has been established under the application of federal antitrust legislation. As originally enacted, the Sherman Act made no specific reference to health care providers or the practice of medicine. Furthermore, in interpreting the Act in the past, many courts, including the Supreme Court on at least one occasion, were unwilling to conclude that health care providers had a sufficient connection to interstate commerce to invoke federal jurisdiction. In the last ten years, however, a "modern view" of health care providers has developed, and the Supreme Court in its recent antitrust decisions has indicated that it has

tions if their gross annual revenues exceed $100,000, and over hospitals if their revenues exceed $250,000. See East Oakland Health Alliance, Inc., 218 N.L.R.B. 1270, 1271 (1975).


The Sherman Act's jurisdiction currently extends to: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States . . . ." 15 U.S.C. § 1 (1976). And to: "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce among . . . the several States . . . ." Id. § 2.

Thus, the jurisdiction of the Sherman Act is essentially coincident with the scope of congressional authority under the interstate commerce clause. See Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738, 743 n.2 (1976); Rasmussen v. American Dairy Ass'n, 472 F.2d 517, 521-22 (9th Cir. 1972), cert. denied, 412 U.S. 950 (1973); cf. Gulf Oil Corp. v. Copp Paving Co., 419 U.S. 186, 194 (1974).

179. It is unlikely that institutional providers were specifically considered at the time of the enactment of the Sherman Act; at the turn of the century, hospitals and nursing homes were virtually nonexistent, and even the practice of medicine was still at a primitive state of development. See Wing & Craig, this Symposium, at text accompanying notes 22-28.

180. In AMA v. United States, 317 U.S. 519 (1943), the Supreme Court held that the acts of a medical society to restrain the activities of a prepaid hospital insurance plan could be a violation of federal antitrust laws. The court also held that the plan's activities were in commerce within the meaning of the Act and that the society was not otherwise exempted from the restrictions of the law.

In United States v. Oregon Medical Soc'y, 343 U.S. 326 (1951), however, the Court held that the activities of competing prepaid group practices had not been shown to have a sufficient connection with interstate commerce:

So far as any evidence brought to our attention discloses, the activities of [prepaid group practices] are wholly intrastate. The Government did show that Oregon Physicians' Service made a number of payments to out-of-state doctors and hospitals, presumably for treatment of policyholders who happened to remove or temporarily to be away from Oregon when need for service arose. These were, however, few, sporadic, and incidental.

Id. at 338-39 (citation omitted).

Citing Oregon Medical Soc'y, a number of federal courts subsequently held that a variety of health care providers were not engaged in interstate commerce. In Spears Free Clinic & Hosp. for Poor Children v. Cleere, 197 F.2d 125 (10th Cir. 1952), the court held that an alleged conspiracy against a chiropractic hospital by the local medical society involved exclusively local activities and that any effect on interstate commerce was "fortuitous and remote." Id. at 128. See also Elizabeth Hosp., Inc. v. Richardson, 269 F.2d 167 (8th Cir.), cert. denied, 361 U.S. 884 (1959); Riggall v. Washington County Medical Soc'y, 249 F.2d 266 (8th Cir. 1957), cert. denied, 355 U.S. 954 (1958). A few courts persisted in this view until very recently. See Wolf v. Jane Phillips Episcopal-Memorial Medical Center, 513 F.2d 684 (10th Cir. 1975); Hospital Bldg. Co. v. Trustees of Rex Hosp., 511 F.2d 678 (4th Cir. 1975) (en banc), rev'd, 425 U.S. 738 (1976).
changed its view of federal commerce jurisdiction over health care providers. 181

The Court’s 1976 decision in Hospital Building Co. v. Trustees of Rex Hospital, 182 is demonstrative of that new attitude. In that case a small proprietary hospital claimed that another hospital in its area had conspired with local physicians and the local health planning agencies to prohibit plaintiff’s relocation and expansion. 183 The federal district court dismissed the complaint for failure to allege a sufficient nexus with interstate commerce to invoke jurisdiction of the Sherman Act. 184 The court of appeals affirmed, holding that hospital services were purely local in nature and that neither plaintiff nor defendants were engaged in 185 or had an effect 186 on interstate commerce.

The Supreme Court, in a unanimous opinion, reversed, holding

181. Even prior to Hospital Bldg. Co. v. Trustees of Rex Hosp., 511 F.2d 678 (4th Cir. 1975) (en banc), rev’d, 425 U.S. 738 (1976), some courts adopted the “modern view” of health care providers. In Doctors, Inc. v. Blue Cross, 490 F.2d 48 (3rd Cir. 1973), the court held that a nonprofit hospital could claim a Sherman Act conspiracy against Blue Cross and local planning agencies since loss of Blue Cross affiliation would have a substantial impact on the flow of interstate supplies to plaintiff’s and other area hospitals. In a similar case involving a proprietary hospital and a Blue Cross plan, the United States Court of Appeals for the Fifth Circuit accepted jurisdiction under the Sherman Act and reversed a lower court decision holding that as a matter of law medical services were local in nature. See St. Bernard Gen. Hosp., Inc. v. Hospital Serv. Ass’n, 510 F.2d 1121, 1123-25 (5th Cir. 1975). See also note 189 infra.


183. Among the alleged acts were bad faith tactics in opposition to plaintiff’s application for a certificate of need, bringing of frivolous lawsuits, and malicious distribution of false information—all for the purpose of blocking plaintiff’s proposed relocation and expansion. See id. at 740-41.

The exact factual background is not clear from the opinion, and since the complaint was dismissed there was no development of the facts in the courts below. In that complaint, however, the following scenario was alleged: Two large nonprofit hospitals entered into an agreement to participate in a “Joint Long Range Hospital Planning Committee,” which included cooperative arrangements for the expansion of facilities and services in the Raleigh, North Carolina area. Under the then existing certificate of need program (since declared unconstitutional by the North Carolina Supreme Court), defendant hospitals allegedly used their influence over the local health planning agency and before the state certificate of need agency to block plaintiff’s planned expansion.

When Mary Elizabeth Hospital (Hospital Building Co.) sought permission to expand and relocate, defendants and their employees opposed the project before the local planning agency and before the state agency. After the application was finally approved by the state agency, defendants filed an action for judicial review of the agency decision. (This decision was pending at the time that the antitrust suit was filed.) Plaintiff also alleged that defendants had circulated false information about plaintiff privately and publicly in an effort to impede plaintiff’s business. Complaint for Damages and Equitable Relief, Hospital Building Co. v. Trustees of Rex Hosp., 511 F.2d 678 (4th Cir. 1975) (en banc).


185. Id. at 682. The majority relied heavily on United States v. Oregon Medical Soc’y, 343 U.S. 326 (1952); Elizabeth Hosp., Inc. v. Richardson, 269 F.2d 167 (8th Cir. 1959); Spears Free Clinic & Hosp. for Poor Children v. Cleere, 197 F.2d 125 (10th Cir. 1952).

186. 511 F.2d 678, 685 (1975). But see id. at 687 (Winter, J., dissenting).
that plaintiff's purchase of medicine and supplies from out-of-state sources, reimbursement from out-of-state insurance companies and the federal government, management fees paid to plaintiff's out-of-state parent corporation and out-of-state financing for the proposed expansion presented allegations that were certainly sufficient to establish a substantial effect on interstate commerce. In effect, the Court accepted a characterization of health care providers that more accurately reflects the actual nature of the modern American health care delivery system than the anachronistic "local in nature" characterization. The case was remanded to allow plaintiff to proceed on its allegations.

The impact of the application of the Sherman Act and other antitrust laws to health care providers will depend on the resolution of a number of unsettled issues; cases such as Hospital Building Co. may herald the beginning of an era of antitrust litigation against providers, their associations and related institutions. The interstate commerce

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187. The Court summarized the allegations as follows:

According to the amended complaint, petitioner purchases a substantial portion—up to 80%—of its medicines and supplies from out-of-state sellers. In 1972, it spent $112,000 on these items. A substantial number of the patients at Mary Elizabeth Hospital, it is alleged, come from out of State. Moreover, petitioner claims that a large proportion of its revenue comes from insurance companies outside of North Carolina or from the Federal Government through the Medicaid and Medicare programs. Petitioner also pays a management service fee based on its gross receipts to its parent company, a Delaware corporation based in Georgia. Finally, petitioner has developed plans to finance a large part of the planned $4 million expansion through out-of-state lenders. All these involvement with interstate commerce, the amended complaint claims, have been and are continuing to be adversely affected by respondents' anticompetitive conduct.

425 U.S. at 740-41. The Court then went on to hold:

The complaint, fairly read, alleges that if respondents and their co-conspirators were to succeed in blocking petitioner's planned expansion, petitioner's purchases of out-of-state medicines and supplies as well as its revenues from out-of-state insurance companies would be thousands and perhaps hundreds of thousands of dollars less than they would otherwise be. Similarly, the management fees that petitioner pays to its out of state parent corporation would be less if the expansion were blocked. Moreover, the multimillion-dollar financing for the expansion, a large portion of which would be from out of State, would simply not take place if the respondents succeeded in their alleged scheme. This combination of factors is certainly sufficient to establish "substantial effect" on interstate commerce under the Act.

Id. at 744.

188. The implications of Hospital Bldg. Co. v. Trustees of Rex Hosp., 425 U.S. 738 (1976), should not be overstated. The Court held only that the complaint could not be dismissed on its face, and that on further examination the providers involved might be shown not to have sufficient interstate impact. Id. at 746 & 747 n.5. It also attempted to avoid overruling U.S. v. Oregon Medical Soc'y, 343 U.S. 326 (1952). 425 U.S. at 747 n.5. Moreover, the hospital in Hospital Bldg. Co. had more interstate connections (for example, the out-of-state corporate parent) than do most health facilities.

189. Hospital Bldg. Co. suggests, and even encourages, a litigation strategy that may be employed by health care providers opposed to government controls: given the peculiar nature of government planning, cost limitation, and quality control programs—particularly the tendency to delegate responsibility for administration to private or quasi-public agencies, such as HSAs, PSROs and fiscal intermediaries—noncompetitive practices and restraints on trade can readily be
jurisdictional issue, however, appears to be relatively well settled, at least in terms of the constitutional scope of federal antitrust legislation.

A similar observation can be made for the scope of congressional authority to regulate health care providers specifically. While in the past the courts, as well as Congress, have had trouble linking health care delivery to interstate commerce in the application of antitrust leg-

alleged by providers aggrieved by those agencies' activities. Similarly, cost-controlling efforts by fiscal intermediaries to limit the costs of government programs or private insurance companies may be claimed to be price fixing and anticompetitive. See Group Life & Health Ins. Co. v. Royal Drug Co., 99 S. Ct. 1067 (1979). Or antitrust violations can be claimed in cooperative planning efforts among private providers or between providers and government agencies—efforts that have been actively encouraged by virtually all government planning programs since the early 1960s. See, e.g., City of Fairfax v. Fairfax Hosp. Ass'n, 562 F.2d 280 (4th Cir. 1977), vacated, 435 U.S. 992 (1978). For that matter, the "Voluntary Effort" offered by the American Hospital Association to Congress in 1978 as an alternative to hospital cost containment legislation, see note 41 supra, may well violate federal antitrust laws, although the effort may be specifically exempted from enforcement activities.

190. Hospital Building Co. has been followed in a number of related but factually distinct cases.

In Ballard v. Blue Shield, 543 F.2d 1075 (4th Cir. 1976), cert. denied, 430 U.S. 922 (1977), a group of chiropractors sued individual physicians, the state medical society and the state Blue Cross/Blue Shield insurance plan, alleging that the failure to include chiropractors' services in insurance policy coverage was a result of Sherman Act violations. The Fourth Circuit held that after Hospital Building Co. the court "cannot say with certainty that the effect on commerce is so insubstantial as to deny federal jurisdiction." Id. at 1078. See also City of Fairfax v. Fairfax Hosp. Ass'n, 562 F.2d 280 (4th Cir. 1977), vacated, 435 U.S. 992 (1978).

In Boddicker v. Arizona State Dental Ass'n, 549 F.2d 626 (9th Cir.), cert. denied, 434 U.S. 825 (1977), the United States Court of Appeals for the Ninth Circuit took a similar view. In Boddicker the district court dismissed an action by local dentists alleging Sherman Act violations by local and state dental societies that required membership in the national dental association as a prerequisite to membership. Citing Hospital Building Co., the court of appeals held that Sherman Act jurisdiction existed. Id. at 628. The court suggested that an effect on interstate commerce with respect to any one provider could be aggregated. Id. at 629 n.4. See also Zamiri v. William Beaumont Hosp., 430 F. Supp. 875 (E.D. Mich. 1977) (denial of staff privileges to individual physicians; jurisdiction based on receipt of federal funds).

191. Physicians' services are apparently no longer exempt from federal antitrust laws under the "learned professions" exemption. Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975); AMA v. United States, 130 F.2d 233 (D.C. Cir. 1942), aff'd, 317 U.S. 519 (1943). The Court in Goldfarb, however, intimated that, while not absolutely exempt, learned professions might be treated differently. 421 U.S. at 788 n.17.


islation, labor laws and other federal regulatory schemes, the courts have in recent years reversed the implications of their earlier decisions. The reasons for this new judicial attitude are abundantly clear: as the structure, financing, cost and nature of health care delivery have evolved in the last two decades, health care has moved from an activity that could be described as local in nature to a major, complex service industry with undeniable impact on interstate activities. If Congress wanted to exempt some or all health care providers from economic regulation in the 1930s or 1940s, there was ample justification for doing so. Even in the 1950s, before the real impact of technological medicine, government spending and regulatory programs, and the cost inflation spiral that characterized the 1960s and 1970s, Congress could have found that health care delivery was a relatively unique industry, made up primarily of individual and institutional medical care providers with—arguably—incidental interstate ties.

All that, of course, has changed dramatically. The delivery of health care is now characterized by extensive private and public third-party payors, complex corporate provider organizations, and revenues and expenditures necessarily calculated in the millions of dollars—factors that modern courts have relied upon in finding the requisite connection between health care providers and interstate commerce.

While there may be room to argue that under close examination a given facility, certain small clinics or individual physicians in their private offices may not be involved in interstate commerce, there is no doubt that Congress would be upheld were it to make the specific finding that health care providers are involved in interstate commerce. Many of the factors considered in Hospital Building Co., however, can be found even in the small clinic or the physician's office, and thus the physician's office, even if seen as local in nature, may still be regulated under the aggregation concept. See note 187 supra and the NLRB cases cited in note 176 supra. Given the latitude granted to congressional discretion in these matters, there is little doubt that Congress's decision to regulate the small clinic or physician's office would be upheld as constitutional.

192. For another example of a valid extension of federal commerce authority over health care providers, see Marshall v. West Essex Gen. Hosp., 575 F.2d 1079 (3d Cir. 1978). The statute involved simply applies to any employer affecting interstate commerce. The court rejected the argument that the failure of Congress to include hospitals in its definition of employer required the negative implication that hospitals should not be included. The court found that the statute represented the full exercise of congressional commerce power and had no trouble finding that a hospital affected interstate commerce. Id. at 1082 n.4. See also Occupational Safety and Health Act of 1970, 29 U.S.C. §§ 651-678 (1976).

193. See Wing & Craige, this Symposium, at note 4.

194. See id. at notes 29-43.

195. See id. at notes 43-48.


197. Many of the factors considered in Hospital Building Co., however, can be found even in the small clinic or the physician's office, and thus the physician's office, even if seen as local in nature, may still be regulated under the aggregation concept. See note 187 supra and the NLRB cases cited in note 176 supra.
that regulation of health care providers is necessary to achieve the objective of regulating an interstate activity. The discretion granted to Congress is too great, and the interstate nature of the modern health care delivery system is too obvious, to warrant any other conclusion.

There is little doubt that health care providers are subject to the congressional commerce authority and, therefore, that Congress can opt to impose regulatory controls or federal policy conditions on the activities of those providers, including the control of the costs of services or the prices charged. Once private conduct is found to be within the reach of the commerce authority, the courts have, with surprisingly little discussion, approved a variety of federal regulatory controls on that conduct, ranging from requirements of nondiscrimination\(^\text{198}\) to the regulation of working conditions\(^\text{199}\) to the fixing of prices charged or wages paid.\(^\text{200}\) The scope of congressional discretion to formulate the policy or objective of federal legislation enacted under this power is virtually unlimited.\(^\text{201}\) The few courts that have even discussed the issue while considering the scope of the commerce authority have indicated that at best the means chosen by Congress need only be reasonably related to the objective sought.\(^\text{202}\) In general, challenges to commerce-based legislation have either questioned the existence of a sufficient link between interstate commerce and the regulated activity\(^\text{203}\) or claimed that the commerce authority as applied affects other constitutionally protected interests, most notably state sovereignty.\(^\text{204}\)

These challenges have not attacked the regulatory means or the objec-

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\(^{199}\) See cases cited note 176 supra.

\(^{200}\) See cases cited notes 160 & 161 supra.

\(^{201}\) See note 166 supra.

\(^{202}\) See, e.g., Katzenbach v. McClung, 379 U.S. 294, 303-05 (1964). In Heart of Atlanta Motel, Inc. v. United States, 379 U.S. 241 (1964), the Court said:

We, therefore, conclude that the action of the Congress in the adoption of the Act as applied here to a motel which concededly serves interstate travelers is within the power granted it by the Commerce Clause of the Constitution, as interpreted by this Court for 140 years. It may be argued that the Congress could have pursued other methods to eliminate the obstructions it found in interstate commerce caused by racial discrimination. But this is a matter of policy that rests entirely with the Congress not with the courts. How obstructions in commerce may be removed—what means are to be employed—is within the sound and exclusive discretion of the Congress. It is subject only to one caveat—that the means chosen by it must be reasonably adapted to the end permitted by the Constitution.

Id. at 261-62.

\(^{203}\) See notes 161-63 supra.

\(^{204}\) See note 226 infra.
tive of the legislation.\textsuperscript{205}

Thus, any of the regulatory controls that have been imposed by Congress on health care providers participating in federal programs under the conditional spending authority\textsuperscript{206} could be imposed on all health care providers engaged in interstate commerce—arguably all health care providers—if Congress opted to do so. Once the provider is linked to interstate commerce, Congress is free to regulate or set policy for that provider’s activities within the wide bounds of discretion that it has traditionally been granted. For example, utilization review requirements imposed on all health care providers could be justified not only as an attempt to control the costs of government-financed health care services or in the terms necessary to sustain the regulation as an exercise of the spending authority, but also as an attempt to control the cost and quality of health care services in general, objectives that are presumably within the discretion of Congress once health care is linked to interstate commerce. Similarly, Congress could find that unnecessary capital expenditures would result in higher service costs or a mal-distribution of resources and therefore require that all health care providers engaged in interstate commerce comply with the mandates of health planning programs or the requirements of state or federal certificate of need programs.

There is little doubt that cost containment programs such as those described earlier in this article could be constitutionally justified as an extension of the commerce authority.\textsuperscript{207} Whether billed as a temporary

\textsuperscript{205} The extent of congressional authority under the commerce clause has been examined in cases challenging federal wage and price controls. See Fry v. United States, 421 U.S. 542 (1975), distinguished in National League of Cities v. U.Sery, 426 U.S. 833, 854 (1976); United States v. Pro Football, Inc., 514 F.2d 1396 (Emer. Ct. App. 1975); Derieux v. Five Smiths, Inc., 499 F.2d 1321 (Emer. Ct. App.), cert. denied, 419 U.S. 896 (1974). But note that these cases generally raise other constitutional arguments and do not directly attack the authority to regulate prices in interstate commerce.

\textsuperscript{206} See text accompanying notes 59-62 supra.


Hospital cost containment represents a similar governmental exercise of power, but it is confined to a portion of a single industry that has been shown to have extraordinary effects on inflation in health care costs and the cost of living in general. See Wing & Craig, this Symposium, at notes 41-43.

A number of the earlier commerce power cases also involved regulatory programs that included maximum prices to be charged. See, e.g., Wickard v. Filburn, 317 U.S. 111 (1942).
measure pending the development of a more permanent solution to the problem of inflation or, as it now appears to be, a relatively permanent attempt to control costs,\textsuperscript{208} even a comprehensive hospital cost containment program would appear to be a reasonable means to achieve a permissible congressional purpose.\textsuperscript{209} Controls on hospital costs would have a substantial effect on the price of services and supplies, costs to patients, capital expenditures, revenues from insurance and government—all of the factors that courts have relied on in drawing the relationship between health care providers and interstate commerce.\textsuperscript{210}

Thus, President Carter's comprehensive cost containment proposal, parts of which might not have survived constitutional challenge if analyzed as an exercise of the spending authority,\textsuperscript{211} would be sustained if enacted as an exercise of the commerce authority.\textsuperscript{212}

\section*{D. Interstate Commerce and State Sovereignty}

Congress' continued reluctance to use its interstate commerce powers to extend federal involvement in the delivery of health care may be based on real political constraints, but it is not required by any constitutional limitation on the scope of that authority standing alone. This is not meant to suggest, however, that there are not constitutional limitations on the commerce authority as applied to the delivery of health care; the commerce power is subject to various affirmative constitutional limitations on government authority.\textsuperscript{213} As discussed earlier

\begin{itemize}
\item \textsuperscript{208} See notes 8-10 supra.
\item \textsuperscript{209} The 1977 Carter proposal was limited to health facilities with 4,000 or more admissions per year. H.R. 5285, 95th Cong., 2d Sess. § 2(dd)(l), 124 CONG. REC. S18368-S18371 (daily ed. Oct. 12, 1978).
\item As a comparison, a 70-bed hospital would have on the average less than 2,500 admissions, whereas a 140-bed hospital would have approximately twice as many. See AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS 10 (Table III) (1977). But even if small hospitals were included, there is no doubt that the linkage to interstate commerce could be provided given the factors relied upon by modern courts. See note 187 supra. Note also that the NLRB has claimed jurisdiction over much smaller facilities. See note 176 supra.
\item \textsuperscript{210} See discussion of Hospital Bldg. Co. v. Trustees of Rex Hosp. and cases that have followed it at note 190 supra.
\item \textsuperscript{211} See text accompanying notes 110-12 supra.
\item \textsuperscript{212} None of the 1977 bills, however, included language specifically linking hospitals and interstate commerce.
\item \textsuperscript{213} While beyond the scope of this article, several other constitutional issues of relevance in this context can be suggested. Obviously, the requirements of procedural due process would have to be met by any federal regulatory efforts. Of more substantive importance, providers may also raise the argument that limiting their ability to expand or modernize existing facilities, or even their opportunity to provide services, is a "taking" of property. With regard to cost containment or regulatory controls of the type currently being used, the argument seems to lack merit, but more strenuous regulatory controls, particularly those that have the effect of closing or decertifying existing services, would raise more serious issues. For a discussion of the legal basis of de jure
\end{itemize}
with respect to the spending powers, even if properly enacted under the interstate commerce authority, federal policy conditions or regulatory schemes may still be invalid if the federal regulation interferes too greatly with the sovereignty of state or local governments or offends judicial notions of federalism.

The exact parameters of this constitutional constraint are difficult to assess, and predictions of future applications are necessarily speculative. The Supreme Court's ruling in *National League of Cities v. Usery* and the decisions that have followed it, however, clearly require that the impact of commerce-based legislation on state and local government be given serious consideration, even if the basis for that consideration remains unclear. In the context of legislation that attempts to extend federal influence over the delivery of health care in ways that have not been attempted before, even a court with a narrow view of *National League of Cities* will be hard pressed to distinguish federal regulation of wages and working conditions from the regulation of capital expenditures by health care providers, limitations on revenues collected or other health care cost controls. Justice Rehnquist's admonitions concerning the adverse impact of federal minimum wage requirements on "States as States" and the resulting imbalance in state and federal power are readily applied to cost containment strategies, and, in fact, a substantial impact on state and local government may exist—both in terms of a financial burden and a displacement of the state's decisionmaking autonomy. Unless exempted from federal policy conditions or regulatory controls, state and local governments as providers of hospital, clinic, and public health services will be substantially affected if mandatory federal controls on costs are imposed or if the existing planning or policy conditions that are now imposed on


A commerce-based regulatory scheme might also be challenged as interfering with a constitutional right to practice medicine, drawing on the right to privacy recognized in the abortion decisions. See, e.g., Planned Parenthood v. Danforth, 428 U.S. 52 (1976); Doe v. Bolton, 410 U.S. 179 (1973); Roe v. Wade, 410 U.S. 113 (1973). Similar arguments, however, have been uniformly rejected by the courts. See note 101 supra.

214. See text accompanying notes 113-56 supra.

215. See text accompanying notes 123-25 supra.


218. 426 U.S. at 845, 848, 851.

219. See text accompanying note 155 supra.
participants in Medicaid or Medicare or other federal programs were mandated under commerce-based legislation. Unlike federal regulation attached as conditions to spending programs, the option—realistic or not—to forego the funds and avoid the condition cannot be claimed to mitigate the effect of the commerce-based legislation. State or local governments would have no choice but to reduce or eliminate services, alter allocation decisions, or, in the case of a cost containment program, not collect revenue for costs incurred, shifting the impact of the cost to the local or state tax base. Whether analyzed in terms of the impact on "essential services" or in terms of the overall balance of state and federal power, substantial impact could be shown. Similarly, the state as administrator or regulator of health-related programs would be affected by mandatory federal regulatory controls on costs, particularly in regard to any state regulatory efforts. Even if federal regulatory controls are delegated to state or local agencies, as has been the pattern for virtually all previous federal regulatory efforts, federal requirements imposed on state regulatory programs, even though incident to federal funding for those programs, has not been readily accepted by state governments.

The traditional opposition of state governments to federal inroads on state autonomy will certainly be fueled by any expansion of federal

220. See text accompanying notes 59-62 supra.
221. 426 U.S. at 845, 851. See also note 223 infra. Note that Justice Rehnquist does refer to hospitals in a manner that indicates he considers them traditional state services. Id. at 855.
222. See note 124 supra.
223. See text accompanying notes 126-35 supra.
224. But see note 154 supra.
225. See Wing & Craige, this Symposium, at notes 148-80.

The short-term strategy for Congress may not be to require participation by all states in all regulatory efforts, particularly at a time when many programs must be described as experimental. Eventually, however, a national cost containing strategy will require the participation of most if not all states. Bypassing state government, Congress could create programs directly administered by the federal government, although politically this would be difficult to justify. Or Congress could delegate some administrative role to private organizations, as has been done in federal planning programs, but this approach would raise substantial delegation of authority issues. Thus far the issue has not been raised frequently in the planning context, probably because planning programs have rarely become fully operational. See, e.g., Simon v. Cameron, 337 F. Supp. 1380 (C.D. Cal. 1970).
authority over health care under the commerce authority, and if states and, to a lesser extent, local governments are not either exempted from federal regulatory efforts or satisfied with the role those efforts allow them, courts will be forced to interpret the as yet unsettled principles of federalism that apply in this context.

Since National League of Cities, most courts have treated the decision rather narrowly and tended to prefer a balancing approach to an analysis of the interplay of federal and state interests.\textsuperscript{227} Thus, the objectives, as well as the specific design of the federal regulatory efforts as they affect state and local governments as providers and as administrators or regulators, will likely be examined on a case by case basis rather than a delineation of certain state services or functions immune from federal regulatory efforts.

With regard to hospital cost containment, the Ninety-Fifth Congress was apparently willing to exempt public hospitals from coverage and to allow states with cost containment programs to be exempted from the program altogether. While the merits of these exemptions can obviously be questioned, they do indicate that consideration of state sovereignty or autonomy is a potent political limitation on congressional authority regardless of the exact magnitude of the constitutional basis for such an exemption.

Congress has not yet opted to apply its authority to regulate interstate commerce to the problems of health care costs or health resource allocation. Should Congress choose to do so, however, there is little doubt that the sweeping power to regulate that has been granted Congress under the commerce authority could be used as the basis for establishing regulatory controls over health care providers or for mandating adherence to health policy conditions. Federal programs enacted under the commerce authority to regulate labor practices, competition and working conditions have been extended to include health care providers, leaving little doubt that both individual and institutional providers are engaged in interstate commerce in the eyes of modern courts. Once an activity is included within the purview of the commerce authority, Congress is free to regulate that activity in nearly any way it sees fit, and, of course, in the case of regulatory programs such as hospital cost containment, even a court that did inquire into congressional purpose would find ample support for the national significance of health care problems.

\textsuperscript{227} See note 124 supra.
Notwithstanding the broad scope of Congress' discretion, however, should federal authority over interstate commerce be exercised in such a way that state or local governments are affected, either as providers of health care or as administrators of health-related programs, judicial scrutiny of federal discretion may be more carefully applied.

III. CONCLUSION

The ability of the current or future administrations to wield meaningful regulatory controls over health care delivery and its costs should not be overstated. The track record of the Carter Administration in securing congressional support for its legislative programs generally has not been impressive, but the results of its efforts to secure congressional support for its health care policies have been particularly dismal—a witness to the politics of our times, but also to the considerable political opposition to the expansion of federal controls over health care delivery. To the extent that a health care regulatory strategy relies on new legislative authority, the current political obstacles are great.

Moreover, critics of regulatory strategies are quick to point out that, if history is any guide, any regulatory agency or program will likely be dominated by the very entities it seeks to control. Even if Congress or the Administration attempts to extend regulatory controls over health care, it remains to be seen whether the federal bureaucracy can effectively implement these controls if authorized, or even mandated, to do so. The past performance of federal agencies attempting to regulate health care providers has not been impressive either.

Even if the authority exists and serious efforts are made to carry it out, critics can still question whether the administrative or technical expertise exists to make sufficiently accurate—and legally defensible—decisions to carry out regulatory programs. The experience of the last decade indicates that it would take months, if not years, to tool up and operationalize a hospital cost containment or comparable program. Regulation requires data and the ability to compile and understand it; the technical ability to accomplish this task may not exist. Again, thus far regulatory efforts in the health care industry have been unimpressive.

228. See text accompanying notes 65-69 supra.
229. See Wing & Craig, this Symposium, at note 15.
230. See Schonbrun, this Symposium, at notes 35-55.
These reservations only provide more ammunition to the already powerful coalition of opponents of cost containment programs—the provider community, state and local governments, political conservatives, and even free market theorists opposed to a regulatory strategy, although sympathetic to the objective of such programs. But while it can be debated whether regulatory programs should be enacted or, if enacted, whether they will be successful, it is certain that the debate, better characterized as a battle, will take place. As an anxious and somewhat befuddled public looks on, the Ninety-Sixth Congress will be faced with major health policy choices, ranging from cutbacks in some federal spending programs to hospital cost containment programs to nationalized health insurance schemes. The opening salvos have been fired: President Carter has resubmitted his cost containment proposal231 and indicated that he has modified his ambitions for national health insurance;232 congressional liberals led by Senator Edward Kennedy have proposed a "Health Care for All Americans Act,"233 a plan that includes both comprehensive insurance coverage and extensive regulatory controls on costs and quality. Undoubtedly industry representatives are mixing with fiscal conservatives and other likely political allies to meet these proposals with a counter-volley of their own. The specifics of the proposals, and perhaps even the proposals themselves, will be altered and amended, but the basic issues will remain the same. As far as the politics of health care are concerned, the Ninety-Sixth Congress will look much like the Ninety-Fifth, as will—in all probability—those that follow through the next decade. Health insurance, cost controls, resource allocation regulation, and the direction and scope of government health spending will all be debated in a political battle with enormous implications and an unpredictable outcome.

The issues are easily blurred and discolored by the political process; even an aroused public will find it hard to coalesce around specific proposals or even the various ideological perspectives. Yet, barring overwhelming public support, it is hard to imagine that vigorous Administration efforts or a coalition of liberal political factions will gather enough momentum to overcome the political obstacles. As costs continue to rise at extraordinary rates and the problems of access to health care and the distribution of health resources become realities for more Americans, however, a confused, unfocused public will still indignantly

231. See text accompanying notes 69 & 70 supra.
232. See text accompanying notes 8-10 supra.
demand that "something" be done; health care regulation will continue to be a major public policy dilemma.

Compared to the politics of health care regulation, the constitutional dimensions appear rather pale and straightforward. There are loose, and loosely defined, limits on what Congress can do, but basically Congress is constitutionally free to regulate health care costs, resource allocation and quality in any way that it sees fit. Unless interpretations of the basic division of authority between the legislative and judicial branches, or of the power of the federal government over private and, perhaps, state and local interests, change drastically, the post-1930 judicial philosophy that has deferred almost completely to legislative discretion in matters of economic and social legislation should embrace the concept of congressionally imposed federal regulation of health care without difficulty. Substantial constitutional issues requiring more rigorous judicial attention lie ahead, but they generally involve the incidentals of how regulatory programs are carried out, not whether controls can be established.