AGRICULTURAL EMPLOYMENT LAW AND POLICY

A Study of the Impact of Modern Social and Labor Relations Legislation on Agricultural Employment

by

Donald B. Pederson
Professor of Law
The Law School
Capital University
Columbus, Ohio

and

Dale C. Dahl
Professor of Agricultural and Applied Economics
and Adjunct Professor of Law
University of Minnesota
St. Paul, Minnesota

Minnesota Agricultural Experiment Station
University of Minnesota
St. Paul, Minnesota
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HEALTH CARE POLICY AND THE HIRED FARMWORKER FORCE

Health care services in rural areas are not nearly as available as in urban areas. Former President Ford indicated:

> The physician and dentist shortages are more acute in rural America, emergency medical services are less available, occupational injury and accident rates are far higher, and comprehensive health and public health services are less available.1/

The problem, which has persisted for decades, is particularly acute for the hired farmworker force. As a class, hired farmworkers have poorer health, lower wages, less insurance, and live and work with greater health risks than most other inhabitants of rural America.

Arguably, the health problems of the hired farmworker force are in part the product of past and present farm labor policy. The absence of hour laws and the lack of effective regulation of dangerous working conditions has produced and continues to produce the ingredients for a high accident rate.2/ Lack of year-round employment and pay scales that hover around the minimum wage rates lead to low income with resulting poor nutrition, inability to pay for medical services, and the consequences which follow.3/ Child labor laws, which continue to some extent to sanction dangerous employment for youthful workers, can also be pointed to as a contributing factor.4/ Housing for seasonal farmworkers, whether employer supplied or not, has tended to be substandard and sanitation problems continue to be common.5/ The nonexistence of private accident, medical, and health insurance for many farmworkers and their families has meant that some problems have been compounded through lack of care. The lack of workers' compensation and Social Security benefits has aggravated the situation for some workers. Further, migrant farmworkers have, until recently, frequently been excluded from Medicaid coverage because they fail to meet state residency requirements and other eligibility standards.6/

Thus, hired farmworkers have been the disadvantaged among the disadvantaged. They have suffered not only from the general lack of health care services in rural areas, but their problems have been compounded by the circumstances of their life and work. While the health care problems of the hired farmworker force are serious generally, the migrant subgroup has suffered from particularly acute and chronic disadvantage.

Recent studies in the migrant community reveal shocking data:

> In Texas, less than 50% of the children were adequately immunized against diptheria, pertussis, tetanus, polio and measles. In Colorado, 40% of preschoolers were below one standard deviation and 18% below two standard deviations for head circumference. Infant mortality is 2 1/2 to 3 times the national average, and the post-neonatal death rate is twice the national average. Problems of infection and infestation are high as is the incidence of recurrence. Dental caries are common to nearly the entire population and extractions constitute 25% of all dental services; in Hidalgo County, Texas, just under 20% of the migrant families have clinical evidence of failure to thrive, vitamin or protein deficiencies or nutritional anemia.7/

A 1977 followup of the 1967 Field Foundation Study found living and working conditions for migrant farmworkers in Florida to have improved very little over the 10-year period. Medical and housing facilities had improved slightly, but many still suffered skin diseases and respiratory problems from exposure to pesticides.8/ A 1978 Inter-America Research Associates Study, commissioned by the U.S. Children's Bureau, found migrant conditions in the United States to be "deplorable."9/

While the above data and observations date from the last half of the 1970s, reports from earlier years read much the same. A study published in 1949 indicated:

> Studies by the Public Health Service and the Department of Agriculture reveal the tremendous burden of disease and disability carried by the migrants follow-

> ing the crops. In great measure the cause of this heavy toll of ill-health is to be found in the proverty of these workers, the unsanitary rural slums where most migrants make their homes, and their difficult working conditions. Public health and welfare medical services are especially meager in those areas where the concentration of migrants is often heaviest—40% of the counties are without the services of full-time local health departments. Moreover, residence requirements and local settlement laws make it frequently impossible for migrants to receive even such public health and welfare services as are available to local residents.10/

The documentation could continue for many pages. The fact is, the problems are very real and persistent. To the extent that the underlying causes are generated or aggravated by current farm labor policy, the situation is unconscionable. To the extent that the problems are aggravated by the lack of health care services, the situation may be unnecessary. There are strong indications that there has been a redirection in policy in this area in recent years, that changes have started to take place and that more are coming.

Health arguments have already been used from time to time to put across legislative proposals in a number of areas, and to some extent working conditions have been improved and underlying causes attacked. However, it is plain that protections and benefits for hired seasonal and migrant farmworkers lag far behind those in other industries.

Historical Development

The Farm Security Administration 11/ began to attack rural health problems around 1936. The initial purpose of the agency was to supervise a loan program designed to get farmers off relief and on the road to self-sufficiency. When loan failures were analyzed, it was discovered that about half were related to bad health.12/ Thus, the Farm Security Administration became interested in promoting a program of group medicine in rural areas. The idea was to let a large group of families contribute to the pool and let the fund thus created pay private physicians for treating illness and injuries occurring among the subscribing families. Farm Security Administration borrowers were required to sign an agreement to participate in the health program in their area and to contribute to the trust fund. The idea had considerable appeal and grew in those years when the rural community was recovering from the "Great Depression." The number of hired farmworkers reached is not recorded, and the commentaries on the period tend to speak primarily of farm owners and tenant farmers and their families.13/

However, in 1938 the Agricultural Workers Health and Medical Association (AWHMA) was formed in California to help provide services to hired farmworkers on a "pay-as-you-can" basis. The program peaked in 1940-41 with a budget of $1.4 million, and 55,000 persons enrolled.14/ The AWHMA operated acute diagnostic and treatment centers and referral centers utilizing public health nurses and local physicians in their own offices. The Farm Security Administration program was eventually transferred to the War Food Administration and to the Production Marketing Division of the U.S. Department of Agriculture. It was phased out in 1947.15/

In the ensuing years, until 1962, there is little evidence of legislative activity aimed at the health problems of rural farmworkers. On paper, the Hospital Survey and Construction Act, later known as the Hill-Burton Act,16/ was a major development for the rural poor. This legislation was designed to aid states in the construction of hospitals which could furnish adequate hospital-clinic and similar services to all people in an area. Priority was to be given to the construction of hospitals and facilities to serve areas with relatively small financial resources and, at the option of the states, rural communities.17/ Further, as a condition for the federal aid, the state was required to give assurance that the facility would provide a "reasonable volume of services" to "persons unable to pay."18/ Many facilities were constructed across the country, some in rural areas. However, it has only been in recent years that there has been any concerted effort to enforce provisions with respect to delivery of services to persons unable to pay. While Hill-Burton has had a beneficial impact generally, it has not served to meet the health needs of hired farmworkers to any substantial extent. Recent developments, including using Hill-Burton as a defense to a hospital collection suit and new federal regulations effective September 1, 1979, signal important change.

In the interim years until 1962, such legislation as Title V of the Housing Act of 1949,19/ amended in 1961, began to attack certain underlying causes. The legislation provided insured loans and low-rent housing grants to programs for domestic farmworkers. The program has continued into the

1970s. In 1973, for example, applications for insured loans totaled $10.2 million and for housing grants $1.7 million.20/

In 1962, Congress amended the Public Health Service Act 21/ with the Migrant Health Act. This legislation provided federal support for clinics offering services to domestic migrant workers and their families. Thus commenced the "classical period" in migrant health care, with programs focused on mobility aspects, sanitation, and direct medical care, but without adequate laboratories and physician time.22/ In 1965, the Migrant Health Act was amended to include provisions for hospital care.23/ Since less than $500,000 a year has been allocated for the program, hospitalization has been limited to emergency cases.24/ In 1970, the Migrant Health Act was further amended to allow delivery of health services to local seasonal farmworkers and their families in communities which experience seasonal influxes of migrant farmworkers.25/ With the increase in the scope of the program, the classical period ended, but many underlying deficiencies persisted.

A massive study by Dr. Shenkin resulted in proposals involving substantial redirection of the migrant health program.26/ Many of the Shenkin proposals became law when Congress further amended the Migrant Health Act in 1975.27/

For administrative purposes, the migrant health programs are now part of the Rural Health Initiative which seems to link a number of Bureau of Community Health Services programs, including Migrant Health Programs, Health Underserved Rural Areas Programs, Community Health Centers Programs, Family Planning Programs, Maternal and Child Health Programs, Appalachian Demonstration Health Projects, and the National Health Service Corps Personnel Program.

Another development which does not appear to be of particular significance to the hired farmworker force is the emergence of the HMO, a product of the Health Maintenance Organization Act of 1973.28/ HMOs have not yet offered a great deal to the poor, urban or rural.29/ With one possible exception, HMOs have not been established where there are significant populations of seasonal and migrant farmworkers.30/

In reviewing health care programs for hired farmworkers, private efforts should not be overlooked. For example, the United Farmworkers Union (UFW) has established the Rodrigo Terronez Memorial Clinic to serve the rural poor in the vicinity of Delano, California.31/ A 1975 report indicates that pursuant to UFW contracts the farm employer contributed 10 cents per worker per hour to the health plan which operates without government funds.32/ The clinic staff members worked for minimum wages, patients were asked to pay $2 for a visit to a physician up to the first five visits, whereupon succeeding visits for the problem were free. Nominal rates applied to certain other services.33/ In most parts of the United States the hired farmworker force is so seasonal and transient that the chance for workers to develop such a program, through a union or otherwise, is negligible.

Two programs designed to improve nutritional deficiency emerged in 1964. They are the Food Stamp Program, administered by USDA's Food and Nutrition Service and participating state agencies, and the Community Food and Nutrition Program of the Community Services Administration. Neither program is aimed specifically at the hired farmworker force, but both have the potential of reaching persons and family members in that category. Because of erratic employment patterns and transient characteristics, many farmworkers have had difficulty in qualifying for the Food Stamp Program in times of critical need.

Medicare and Medicaid have benefited the population generally. Unfortunately, the hired farmworker force has experienced problems obtaining the benefits afforded by these programs. The Medicaid program has been a particular source of difficulty for migrant workers. As a result of residency requirements, migrant workers have often been unable to qualify for Medicaid benefits. Changes in regulations, effective October 15, 1979, were designed to attack this problem.

Federal programs have been designed to improve the delivery of health services to migrant and seasonal farmworkers and food and nutrition programs have been designed to help root out underlying causes of health problems for these transient farmworkers. The current facilitating statutes and programs include the Migrant Health Act of 1962, the Rural Health Initiative (RHI), Medicare and Medicaid, Nutrition and Food Programs, the Hill-Burton Act, and Health Maintenance Organizations.

Migrant Health Act

The Migrant Health Act was enacted in 1962 and has been amended several times.34/ Initially, the act was codified in 42 U.S.C. §247(d). Major changes resulted from the Migrant and Community Health Centers Amendment of 1978, including a transfer to 42 U.S.C. §254(b).35/

Central to an understanding of the law is a recognition of a legislative distinction between high-impact areas and low-impact areas. The "high-impact area" is defined to mean a "health service area or other area which has not less than 4,000 migratory agricultural workers and seasonal agricultural workers residing inside its boundaries for more than two months in any calendar year."36/ In computing the number of workers residing in an area, it is essential to include the members of the families of such workers.37/ "Low impact areas" are those with fewer than 4,000 migratory and seasonal agricultural workers residing there for more than two months per year.

One of the critical changes that came about as a result of the 1978 legislation was a reduction of the "population requirement" from 6,000 to 4,000 for the purpose of designating high-impact areas. This should increase the number of high-impact areas and increase the effectiveness of the legislative scheme.

"Migratory agricultural worker" is defined as "an individual whose principal employment is in agriculture on a seasonal basis who has been so employed within the last 24 months and who establishes for the purposes of such employment a temporary abode."38/ A "seasonal agricultural worker" is an "individual whose principal employment is in agriculture on a seasonal basis and who is not a migratory agricultural worker."39/ Since 1970, when the classical period of the legislation terminated, the scheme has been to provide health services not only to migratory agricultural workers, but also to permanent local residents who fall into the category of seasonal agricultural workers.

The primary thrust of the legislation is to fund migrant health centers and migrant health programs. Funding is available for the planning, development, and operation of each. Migrant health centers, either through staff and supporting resources or through contracts or cooperative arrangements with other public or private entities, provide primary and supplemental health services for migratory agricultural workers, seasonal agricultural workers, and their families within the catchment area. A center must also provide services to individuals previously in the migratory agricultural worker category but who no longer have that status because of age or disability.

Migrant health programs may also provide "primary health services" but only migrant health centers may provide both "primary health services and supplemental health services." "Primary health services" include services of physicians, physicians' assistants, nurse-clinicians, diagnostic laboratory and radiologic services, preventive health services, emergency medical services, required transportation services, and preventive dental services as may be appropriate.40/ "Supplemental health services" include services which are not included as primary health services but which fall into the following categories: hospital services, home health services, extended care facility services, rehabilitative services, long-term physical medicine, mental health services, dental health services, vision services, allied health services, therapeutic radiologic services, public health services, ambulatory surgical services, and health education servicies including nutrition education.41/

High-impact areas have a priority in the awarding of grants for migratory health centers.42/ Since the migrant health centers are able to give the most comprehensive services, it is encouraging to observe in the 1978 legislation the obvious attempt to increase the number of high impact areas which will be entitled to priority in the establishment of such centers. This, was accomplished by the reduction of the population requirement from 6,000 to 4,000.

The secretary may make grants or enter into contracts to plan and develop migrant health programs in areas where no migrant health center exists and in which no more than 4,000 migratory agricultural workers and their families reside for more than two months.43/ The migrant health programs may be designed to provide emergency medical care, supply primary health services, develop arrangements with existing facilities to provide primary health services, and to otherwise act to improve the health of migrant and seasonal farmworkers and their families.44/

It is encouraging to note that not only in the 1978 legislation, but in previous versions of the Migrant Health Act, there has been a recognition of the fact that health problems are not resolved entirely by clinics.45/ While preventive medicine and dentistry can be practiced, there is no doubt that an attack on nutrition problems, working conditions, living conditions, sanitation problems, and the like is also critical. The Migrant Health Act authorizes the secretary to enter into contracts with public and private entities to assist the states in implementing and enforcing acceptable environmental health standards, including standards of sanitation in migrant labor camps and applicable federal and state pesticide control standards.46/ Further, studies are authorized which explore camp and field sanitation, pesticide hazards, and other environmental hazards to which farmworkers and their families may be exposed.47/ In particular, the secretary is required to conduct a study of the quality of farmworker housing, its effect on health, and the enforcement of standards affecting such housing.

These developments manifest a recognition of the need to change the basic direction of farm labor policy. If concerted attention is given to working conditions, housing conditions, health hazards, the extension of social legislation benefits, and other advantages accruing to most workers in this industrial society, a giant step forward will have been taken for the elimination of the underlying causes of acute and chronic health problems that are so evident in the migrant and seasonal hired farmworker community.

Problems have arisen in the administration of migrant health projects that have given rise to litigation. Included in the requirements for successful application for funding is the stipulation that there be a provision that the governing board of the migrant health center shall be composed of individuals, a majority of whom are being served by the center and who, as a group, represent the individuals being served.48/ A problem with a potential violation of that requirement arose in the case of Martinez v. Matthews.49/ There the court held that migrant and seasonal farmworkers were entitled to a preliminary injunction requiring the Migrant Health Center to comply with the requirements that individuals being served comprise the majority of the governing board. The effect was to require the election of a new governing board. The court indicated that the likelihood of plaintiff farmworkers' success on the merits of the case and the potential harm to farmworkers by virtue of delay would be significant in the achieving a representative voice in the health care area. In other words, to deny the preliminary injunction could, according to the court cause irreparable injury since the wrongs complained of had gone without remedy for an extended period and since potential harm to the operation was inevitable if there was a decision on the merits for the plaintiffs.

Southern Mutual Health Ass'n. Inc. v. Califano 50/ dealt with the critical question of whether a migrant health facility was entitled to a hearing prior to the termination of Department of Health, Education and Welfare (DHEW)funding. The appellant, Southern Mutual Health Ass'n. (SMHA), brought the action challenging a decision by DHEW to disapprove an annual application for the continued funding of appellant migrant health care facility in Franklin, Louisiana. DHEW took its action without providing SMHA with the opportunity for a hearing. The district court granted DHEW's motion for a summary judgment, holding that neither DHEW regulations nor the due process clause required DHEW to hold a hearing. The Court of Appeals for the District of Columbia subsequently held that SMHA had standing to challenge the DHEW decision since SMHA's existence had been endangered by DHEW's refusal to continue funding, and because SMHA's interest was within the zone of interest protected. The court also held that the action taken by DHEW was the termination of funding, and not just a decision to refund. The court ruled, therefore, that by its own regulations, DHEW was obliged to provide SMHA with a hearing.51/

The Rural Health Initiative

Rural Health Initiative (RHI) is an administrative effort by DHEW to combine its existing health resources programs to improve the delivery of health care to underserved rural areas. By seeking to combine existing elements of rural health care into integrated units, RHI hopes to promote local comprehensive health care systems that are self-sufficient and to provide career opportunities which will attract physicians and other health professionals to rural communities.52/ The programs funded under the Migrant Health Act are part of RHI. RHI seeks to link these programs with a number of other Bureau of Community Health Services programs, in particular: Health Underserved Rural Area Programs, Community Health Centers Programs, Family Planning Programs, Maternal and Child Health Programs, Appalachian Demonstration Health Projects, and the National Health Service Corps Programs.

The Health Underserved Rural Area Program, established in 1975, is administered by BCHS and involves the awarding of grants for research and demonstration programs in the area of rural health. There are two principal goals: (1) integration of primary care services into a complete system of health care delivery that is financially viable, professionally attractive, and capable of becoming self-sustaining and (2) development of mechanisms to provide better health care to Medicaid-eligible populations in rural areas.53/

The Community Health Centers Program is designed to develop health services' delivery capacity and to support ambulatory health care projects in rural, as well as in urban, medically underserved areas. Project grants are awarded to public and private non-profit corporations to help meet the cost of planning and development in the ongoing operation of community health centers. In fiscal year 1977, 455 community health centers received federal assistance totaling $215 million.54/

In fiscal year 1976, 2.6 million individuals received services in the 4,410 clinics operated under 227 grants made through the Family Planning Program administered by BCHS. It is estimated that 3 million individuals received such services in fiscal year 1977. The objective is to make comprehensive family planning services available to all persons who want them, with priority being granted to those

who cannot afford to pay. Family planning services are also provided through Migrant Health Centers.55/

The Office for Maternal and Child Health of BCHS administers a program of formula grants to state health agencies to fund maternal and child health and crippled children's services. Research grants are made to support studies designed to improve such services. Special programs deal with infant mortality, maternal mortality, infant morbidity, sudden infant death syndrome, genetic diseases, and hemophilia.56/

The Appalachian region encompasses portions of 12 states and all of West Virginia. Pursuant to the Appalachian Demonstration Health Program, grants have been awarded to support a variety of activities, including hospital construction, sanitary landfills, medical residency programs, and halfway houses for alcoholics. The majority of grants, however, have been used to establish, improve, or systematize the delivery of primary health services, with many rural sites being involved.57/

The National Health Service Corps was created to provide medical services to people living in over 1400 communities designated as critical health manpower shortage areas. While the Corps provides manpower and administrative and financial management assistance, the local community must agree to manage the practice and to provide a physical facility, supplies, and staff support. Those who are able to pay must remit the "reasonable cost" of health services, but patients unable to pay cannot be refused services. While these programs have had an important urban impact, they have also been critical in dealing with manpower shortages in rural areas.58/

RHI is concentrating on areas that are characterized by low population density; high proportions of elderly, needy, or uneducated citizens; poor transportation; and low physician-population ratios. At the end of 1977, RHI had 350 projects providing services to an estimated 666,625 people. Total grants to local non-profit organizations and groups in fiscal year 1977 under RHI totaled more than $7 million.59/

Medicare and Medicaid

The objective of the Medicare program is to provide hospital insurance protection for covered services to persons age 65 and older, and to certain disabled persons. Hospital insurance is also available to persons age 65 and older, not otherwise eligible, through the payment of a monthly premium. Persons under age 65, who have been entitled for at least 24 consecutive months to Social Security disability benefits or to railroad retirement benefits based on disability for 29 consecutive months, are eligible for hospital insurance benefits. Also, most people who have chronic kidney disease and require kidney dialysis or transplant are eligible.60/

Nearly everyone who reached age 65 before 1968 is elibible for hospital insurance, including those not eligible for cash Social Security benefits. However, a person reaching age 65 during or after 1968 who is not eligible for cash benefits needs some work credit to qualify for hospital insurance benefits. Given the peculiarities of the Social Security law as it applies to hired farmworkers, there is concern that some highly transient seasonal farmworkers, who do not work for crew leaders, may be employed season after season without accumulating work credits.61/

The object of Medicare Supplementary Medical Insurance is to provide medical insurance protection for covered services to persons 65 and older and to certain disabled persons. All persons 65 and older and those under 65 who are eligible for hospital insurance benefits may voluntarily enroll. As of July 1, 1979, the monthly premium was $8.70. The monthly premium is increased by 10 percent for each 12 months in which a person could have been, but was not enrolled.62/

The Medicaid program, otherwise known as the Medical Assistance Program, is designed to provide financial assistance to states for payment of medical assistance to eligible recipients. State and local welfare agencies must operate under a DHEW-approved Medicaid state plan and comply with all federal regulations in order to be eligible. Needy persons who are over age 65, blind, disabled, members of families with dependent children, and—in some states—persons under age 21, may apply to a state or local welfare agency for such medical assistance. Individual eligibility is determined by the states in accordance with federal regulations.63/

Under Medicaid, states must provide for the categorically needy as follows: in- and out-patient hospital services; other laboratory and x-ray services; skilled nursing home services; home health services for persons over 21; family planning services; physician services; early and periodic screening, diagnosis and treatment for individuals over 21. For the medically needy, states are required to provide any seven of these for which federal financial participation is available.

The federal funding involves a funding and matching scheme. Federal funds are available to match state expenditures under the state plan, and the federal share ranges from 50 percent to 78 percent according to a formula based upon the relation of the state's per-capita income to national per-capita income. The number of recipients receiving Medicaid assistance in fiscal 1979 is estimated to have been 22,894,000. For fiscal year 1980, it is estimated that 23,000,500 will receive such assistance.

There have been particular problems for migrant agricultural workers in the Medicaid area. The regulations that were in effect before, October 15, 1979, did not specifically address the residency problems of migrant workers.64/ Thus, the states reacted in a variety of ways, but with the general result that the migrant population was often excluded from benefits because of nonresidency status. In order to remedy this situation, revised federal regulations were proposed on August 8, 1978.65/ Final regulations were promulgated and appeared on July 17, 1979, and became effective October 15, 1979.66/

Many migrant agricultural workers were unable under definitions in the old regulations, to establish required residency. Further, many such migrants and family members were unable to meet the "categorical" eligibility requirements. One reason for this was that migrant families tended to be intact and thus did not fall into the category of families deprived of the support of at least one parent. Under the previous regulations, children in intact families could be covered, but this was optional with the states.

The new regulations specify that persons in a state for "purposes of employment" must be considered residents.67/ Individuals under age 21, except for the blind and disabled, must also be dealth with under the AFDC rules.68/ The Social Security Administration has also amended the AFDC residency regulations to correct this problem.69/

Under the new Medicaid regulations, a person is considered to be in a state for "purposes of employment" not only when the person has entered the state with a job commitment, but when the individual has entered seeking employment. Thus, the test is not whether the person is currently employed.70/ A state agency may not deny Medicaid eligibility because an individual has not resided in the state for a specified period. Further, the agency may not deny or terminate a resident's Medicaid eligibility because of temporary absence from the state if the individual intends to return after the purpose of the absence has been accomplished. The only exception is where the individual has been determined to be a resident of another state for purposes of Medicaid.71/

The regulations authorize interstate agreements setting forth rules and procedures to resolve cases in which two states might argue as to whether a particular individual is a resident for Medicaid purposes. The interstate agreement may not result in the loss of residency in both states and must provide a procedure for providing Medicaid to an individual pending the resolution of the dispute.72/

Nutrition and Food Programs

Given the low income of most hired farmworkers and hired farmworker families, the amount of money available to purchase food is more limited than for most other segments of the population. As long as this situation persists, there will be a higher incidence of health problems no matter how much funding is granted for medical and hospital care. While the elevation of the minimum wage and the advance of farmworker unions have brought some improvement in income levels, the overall picture remains largely unchanged and the need to provide resources to improve nutrition for many in the hired farmworker force continues.73/

The Food Stamp Program74/ offers assistance to economically needy families by providing food coupons (stamps) which are redeemable at a value greater than their purchase price. The amount of assistance provided to families varies inversely to family income relative to family size. Families with very low or no income receive stamps free.75/

Hired farmworkers, because of their generally low income status, rarely have the opportunity or eocnomic resources to improve their lifestyles.76/ Accordingly, Food Stamp assistance is of great importance from an economic and nutritional standpoint for many hired farmworkers and their families.77/ About 60 percent of farmworker families participating in the Food Stamp Program in November 1975 received a family income less than $5,000 and fewer than 5 percent had incomes of $10,000 or more.78/ Low-income status is often complicated by large family size. November 1975 statistics indicate that of those families receiving less than $5,000 per year, more than one-third had at least 6 members. About 67 percent of the families with incomes over $5,000 had 6 members or more.79/

The same study indicated that only 50 percent of farmworker families with incomes below $5,000 and with six or more family members receive Food Stamps. Nationally, 59 percent of all such families were recipients. Overall, however, about 10 percent of farmworker families received Food Stamps as opposed to a national figure of 6 percent.80/ The pressing question which emerges is why large numbers of eligible farmworker families have not taken advantage of the Food Stamp Program.

Generally, barriers to Food Stamp participation have included: amount of owned assets; work registration requirements for most able-bodied persons; lack of knowledge about the program; inadequate resources to meet purchase requirements; transportation problems; limited participation in other public assistance programs; negative attitude toward welfare programs and the federal government; and confusion about eligibility, given irregular flow of income and transient status.81/ The problem of inadequate resources to meet purchase requirements is a particular problem for some migrant families, given the outflow of cash and transportation and other expenses related to travel and living away from home. The difficulty of having an accurate determination of eligibility is also a matter of particular concern for the seasonally employed farmworker family.

Households are individually certified by local welfare offices, based on national eligibility standards. The certification period can be up to one year for the unemployable or the elderly and as short as circumstances require for those experiencing frequent changes in household status or income.82/ A problem has frequently arisen for farmworkers because at the time of application for certification there may be no income coming in. However, income may be anticipated for later in the certification period. Yet, the actual receipt of that income remains uncertain. In Gutierrez v. Butz,83/ the court prohibited the attribution of future income as income available at the time of the application on the theory that such income is not reasonably available to the household throughout the prospective certification period. Income actually available must be distinguished from anticipated income.

As a result of this court order, USDA issued an interim letter dated October 21, 1976 governing farmworker application. The confusion that arose over this letter is commented on as follows:

> The letter contemplates an initial certification for a semi-monthly period at a zero income level (or at the low level received by the household on the date of application) in order to introduce the household into the Food Stamp System. The Department's subsequent instructions to the states, however, have tended to confuse the question. Some states have erroneously limited the Gutierrez ruling to newly-arrived migrant households and have excluded seasonal or settled-out farmworker households which suffer fluctuations in income. Some states erroneously apply Gutierrez once a year and continue to anticipate nonexistent farmworker income for the remainder of the year.84/

In 1977, Congress enacted amendments to the Food Stamp Act and provided:

> The State agency, in calculating household income, shall take into account the income reasonably anticipated to be received by the household in the certification period for which eligibility is being determined and the income which has been received by the household in the 30 days preceding the filing of its application for food stamps, so that the State agency may reasonably ascertain the income that is and will be actually available to the household for the certification period.85/

It has been argued that the above enactment manifested the intent of Congress to codify the Gutierrez holding.86/ If this is correct, the projected seasonal income of farmworkers could not be "reasonably anticipated" under the statute and should not be taken into account in calculating eligibility.

Apparently confusion remained. As one commentator noted:

> USDA has failed to adequately communicate this codification to the states. Farmworker advocates have asked USDA to publish a single comprehensive notice summarizing the contours of current law on the question. Until USDA issues such a notice, questions about farmworker Food Stamp eligibility must be solved by reference to the 1977 amendments, to the USDA Instruction of October 21, 1976, and through the court rulings.87/

The Food Stamp Act Amendments of 1980 88/ give the states an option to determine benefits for certain types of households for a given month on the basis of the prior months' actual income. The statute indicates that the secretary may find it inappropriate to use the method for migrant farmworkers' households.89/

Another program, which is administered by the Community Services Administration, makes Community Food and Nutrition Grants to help counteract conditions of hunger and malnutrition among the poor. Included on the lists of eligible recipients are migrant and seasonal farmworker organizations. It is reported that, in fiscal year 1978, $4.2 million went to such programs.90/

Community Food and Nutrition grants are funded under the Economic Opportunity Act of 1964 as amended.91/ Grantees may use funds in a variety of ways to supplement, extend, and broaden other food programs and to provide Food Stamps on an emergency basis to low-income families and individuals.92/ Generally, there are four categories of projects that will be funded: (1) those which improve the opportunities of low-income people to gain access to and participate in various food and nutrition programs including the Food Stamp Program; (2) projects which improve the ability of low-income people to produce and purchase foodstuffs in a manner that fosters self-sufficiency, (3) education programs dealing with diet, nutrition, and health; and (4) emergency assistance.93/ Grants are made on a one-time basis and are generally for a period of one year.

The Hill-Burton Act

The Hill-Burton Act offered hope to the rural poor and thus to the hired farmworker force.94/ However, actual experience with the act since 1944 has been disappointing. The decade of the 1970s, however, has brought developments which may be opening up the possibility that the original intent of the legislation would be realized. Recent developments indicate that we may be moving into a period where a "reasonable volume of services to persons unable to pay" will in fact be delivered.

For some 25 years following its enactment, Hill-Burton remained exclusively a program to support the construction of nonprofit health facilities and let the market determine who would benefit by those facilities.95/ An attempt in the 1960s to compel the original promise of the legislation by legal action resulted in a decision that the distribution of federal money did not create a contract between the United States and the hospital for the benefit of persons needing services but who were unable to pay. The court indicated that the use of federal money did not transform the hospital into a private charity.96/

Lawsuits in the early 1970s were successful, however, in reviving two long-ignored provisions of the act. Those were the familiar provisions requiring grantees to afford a reasonable volume of services to persons unable to pay and to be open to all persons in the area served by the grantee.97/ Cases such as Cook v. Ochsner Foundation Hospital,98/ Euresti v. Stenner,99/ and Organized Migrants in Community Action, Inc. v. James Archer Smith Hospital 100/ suggested that plaintiffs had an implied right to maintain a private civil action under Hill-Burton to compel defendant hospitals to comply with these ignored provisions.

The litigation in the early 1970s precipitated HEW rulemaking activities.101/ The so-called "free service" regulations emerged and Title VI grantees were directed to come into compliance with statutory obligations. It has been argued, however, that the regulations had the effect of undoing to some extent the court victory.102/ The suggestion is that HEW had become "captive" of the viewpoint of the interests they were designed to regulate. This position is supported by pointing out that fairly generous standards were rejected in the rulemaking process and that the final 1972 regulations provided that there would be "presumptive compliance" with the statutory obligation when service to the poor was at 3 percent of cost of operation (less that attributable to Medicare and Medicaid) or 10 percent of the grants received by a facility, whichever was less.103/ In the alternative, a facility could certify that it would turn away no one seeking free care.104/ State supervising agencies were not allowed to require a higher level of services.105/ The maximum time during which the regulation would apply was held to 20 years from the opening of the facility or portion thereof receiving the Hill-Burton grant. There was no provision to make up for a lack of compliance in years prior to the regulations.106/

Various court cases filed after 1972 upheld the 3 percent-10 percent options, as well as the language in the regulations which limited the aided facility's compliance to 20 years for grants or to the time a loan remained unpaid for loan grantees.107/ Regrettably, even after these regulations became effective, there was a notable lack of enforcement.108/

As the 1970s progressed, there was more litigation.109/ The most interesting recent decision is that in Newsom v. Vanderbilt, 110/ where the court held that a facility must make up deficits where compliance from 1973 onward cannot be demonstrated. In addition, the case holds that Hill-Burton may be used as a defense to a hospital collection suit where the defendant is a person who should have received services without charge.111/ The 1972 regulations have been amended effective October 6, 1975,

and facilities at that point were required to make prior determination of eligibility in providing uncompensated services and to post notices of the availability of such services.112/ Those changes in the regulations, however, obviously did not head off the kind of problem that surfaced again in Newsom v. Vanderbilt.113/

Major statutory changes came in 1975. The old Title VI program was replaced by what is now known as Title XVI.114/ Among the important changes in the Hill-Burton scheme were requirements that facilities would be obligated for an unlimited period after receiving aid under Title XVI. Further, those facilities receiving aid under Title VI or Title XVI were required to file periodic reports demonstrating compliance with the statutory and regulatory requirements.115/

Regulations implementing the 1975 legislation were proposed October 25, 1978, and were issued in final form on May 18, 1979, to become effective in most instances no later than September 1, 1979.116/ With respect to Title VI-assisted facilities, the regulations retained a 20-year period of obligation but now provide a lengthening or shortening of the durational limit to allow deficit makeup and to recognize excess compliance. There will, apparently, be no going back to the period between 1972 and the new regulations to assess levels of compliance. Injustices of the past will thus not be recognized. The object is to assure that they do not occur in the future.117/

The 3 percent of operating cost formula and the 10 percent compliance level will remain in the new regulations. However, there is an important provision requiring the adjustment of the 10 percent compliance level by an inflation factor so that the real value of the services provided under the 10 percent standard will stay constant. The socalled "open-door option" has been eliminated.118/ It was felt that a clear dollar standard against which facility performance could be measured would simplify monitoring and contribute to public confidence that a "reasonable volume" of services had been made available.119/

With respect to the facilities receiving Title XVI funds, the situation will be quite different. While the rules setting the levels of "uncompensated services" are the same for Title VI grantees, the obligation of Title XVI grantees continues at all times following the approval of the Title XVI application unless the facility ceases to provide health services.120/

Further, the new regulations provide that where a facility fails to meet its annual compliance level in any fiscal year it will be obliged to adopt an affirmative action plan designed to give wide notice of the wide availability of uncompensated services, to expand the area served by the facility, to arrange for referrals, and take other designated steps.121/

Many of the Hill-Burton facilities operate in areas where migrant and seasonal farmworkers are few. However, of the almost 7,000 institutions which have received Hill-Burton grants, many operate in service areas where migrant and seasonal farmworkers live or work. The residence requirement that must be met by an individual seeking uncompensated services has been drawn in the new regulations in such a way as to not work to the disadvantage of transient workers. Persons are deemed to be residing in the Title VI or Title XVI facility service area if the person is living in the service area with the intention to remain there permanently or for an indefinite period; living in the service area for purposes of employment; or living with a family member who resides in the service area.122/ The intent is that persons residing in an area for purposes of employment, i.e., who are looking for a job, are on a job, or have recently completed a job, are covered as are family members living with them.123/ The object is to make clear that migrant workers and others who reside in a service area of an assisted facility may not be denied services on the grounds that they are not permanent residents. In addition, it appears from the new regulations that in respect to Title XVI facilities only, it is sufficient that one is simply employed in the facility service area without regard to where the person is living.124/

In addition to the uncompensated services requirement, the community service regulations, which also became effective for all facilities as of September 1, 1979, are designed to insure that services are fully accessible to the community. Specifically, the following alternative admission arrangements are enumerated in the regulations: obtaining the voluntary agreement of physicians with staff privileges to accept referrals of Medicaid recipients and patients without a personal physician; requiring physicians, as a condition of obtaining or renewing staff privileges, to accept referrals of Medicaid patients and patients without a personal physician; establishing a hospital-based clinic to which Medicaid patients and others requiring hospitalization may be admitted; contracting with qualified physicians to treat Medicaid patients or those without physicians; and authorizing a patient's physician to treat the patient at the facility even though the physician does not have staff privileges.125/ It has been stated that the "strengthened community service regulations are a major victory for the poor and the working poor."126/

A facility which denies uncompensated services to an eligible individual in violation of the new regulations must take steps to remedy the violation. These steps may include termination of collection action and repayment of wrongfully collected bills.127/

One interesting question remains unresolved. The 1978 decision in Newsom v. Vanderbilt 128/ indicates that a facility must make up deficits for compliance from 1973 onward. The new regulations do not require deficit make-up for periods prior to September 1, 1979. In other words, the new rules are not by their terms to be applied retroactively. Thus, it remains to be seen whether through litigation compliance deficits will in fact have to be made up in spite of the provisions in the regulations to the contrary.

Health Maintenance Organizations

In some respects the HMOs are reminiscent of the health care programs under the Health Care Farm Security Administration. Health Maintenance Organizations are legal entities which provide specific health services to members on a prepaid, fixed-payment basis, rather than on the traditional, fee-for-service basis.129/ One of the rationales for encouraging HMOs is the belief that they will provide a financial incentive to emphasize preventive medicine and control the use of health services to reduce overall health care costs.130/

The Health Maintenance Organization Act of 1973 131/ authorized a program designed to assist in the development of new HMOs and in the expansion of existing ones. Two features stand out in the legislative scheme. First, financial assistance is to be provided through grants, contracts, and loans. Second, certain employers are required to offer their employees the option of membership in an HMO if a "qualified entity" is operating in the service area.132/ The federal grants which have been authorized are designed to fund feasibility studies, planning, and initial development.133/

The act defines the basic health services which "qualified" HMOs must provide directly or indirectly. Under the original version of the act, basic health services included physician services, hospital services, emergency services, outpatient mental health services, alcohol or drug abuse treatment, diagnostic laboratory services, home health services, and preventive health services including voluntary family planning services, infertility services, and preventive dental care and eye examinations for children.134/ The 1976 amendments deleted children's preventive dental services as a required basic health service.135/

Supplemental services were originally to be provided or contracted out. These services include intermediate and long-term care, vision, dental, and mental care not included in the basic benefit package, long-term rehabilitation services, and prescription drugs.136/ The 1976 amendments made supplemental services optional.137/

There is evidence that HMOs have not reached the hired farmworker force. There are just two rural HMOs operating at the present time, one in south-central Colorado, the San Luis Valley HMO at Alamosa, serving a six-county area with a population of about 40,000, and the other in the southwestern quarter of North Dakota, the West River HMO at Hettinger.138/ How many hired farmworkers are enrolled in the two programs is not known at this writing, but given the nature and population of the areas, the potential is not great.

Other factors, beyond the existence of just two rural HMOs, suggest that the potential of HMOs for serving the hired farmworker force is limited. An extensive study of HMOs has suggested that they may not offer a great deal to the poor, whether urban or rural.139/ First, there is the matter of payment of the premiums. It is reasonable to assume that many farmworker families do not have sufficient financial resources to make such payments. Second, there is the matter of the general failure of HMOs to seek out the medically underserved areas.140/ Third, there is the fact that as of a June 1978 report, 94 percent of the studied HMOs' membership was supplied through employee group contracts.141/ Fourth, HMOs have generally enrolled few elderly or indigent individuals.142/ As of December, 1977, only 4 of 14 HMOs examined in a national study had contracted to enroll Medicaid recipients.143/ The following attitude gives one reason:

> The director of one HMO which had no Medicaid members said the HMO did not want Medicaid enrollees because it did not want a 'government subsidized, welfare image.' The president of another HMO said Medicaid was the HMO's 'lowest priority' because the 'bad image' of a 'poor people's program' might jeopardize marketing efforts.144/

Given all these factors, it seems plain that HMOs are not destined to be a significant factor in the delivery of medical services to the hired farmworker force.

This is unfortunate since it has been demonstrated that HMO enrollees spend substantially less time in the hospital and are subject to half the rate of surgery of patients who obtain medical services under the fee-for-service delivery system.145/

The only promising angle is the requirement that a Fair-Labor-Standards-Act-covered employer who employs on an average at least 25 persons per quarter must offer a "qualified" HMO option if there is an organization in the area.146/ The act indicates that the employer does not have to contribute more to the cost of the HMO plan than it contributes to other health benefit plans.147/ No statistics have been uncovered revealing the number of nontransient hired farmworkers employed by such employers and within the service area of a HMO. However, it is reasonable to assume that the number is very small and will remain so.

Evaluation

It is encouraging to observe that policymakers have gone off in new directions in recent years to deal with the ongoing health problems of migrant and seasonal farmworkers. In particular, the shift from an almost exclusive emphasis on migrant workers, to an emphasis on both migrant and seasonal farmworkers has been a welcome development. Dealing with health problems as they exist in the entire hired farmworker community makes substantially more sense than dealing only with the problems of a minority of the workers. Further, recent developments are most encouraging. In particular it is important to point to the recent changes in the Migrant Health Act designed to increase the number of high-impact areas, to the emergence of the Rural Health Initiative which attempts to coordinate and make more effective a variety of rural health care programs, to recent changes in Medicaid rules designed to qualify more migrant farmworkers, to the efforts to make the Food Stamp Program more readily available to migrant and seasonal farmworker families, and to the new regulations under the Hill-Burton Act designed to better fulfill the original objectives of that legislation. In addition, the emphasis on nutrition programs, family planning programs, and preventive medicine programs is to be applauded.

While problems in the delivery of health care services and nutritional services remain, aggressive and imaginative efforts are being made to deal with them. However, as laudable as they are, all of these programs are not likely to markedly reduce the unusually high incidence of certain medical problems in the migrant and seasonal farmworker force. Without detracting in any way from nutritional and preventive medicine programs, it must be conceded that until the pervasive underlying causes of poor health among hired farmworkers are attacked effectively, long-range permanent improvements cannot be expected.

Recommendations

There are no simplistic solutions to the problems under consideration. As necessary and beneficial as the health care and nutrition programs are, they alone cannot be expected to significantly reduce the unusually high incidence of certain medical problems found in the migrant and seasonal farmworker force. It can be argued, however, that the real beginnings of a permanent solution to these problems lies in fundamental economic reform. Welfare-type programs for poorly paid and underemployed local farm employees, government subsidized clinics for seasonal farmworkers and migrant workers, and other such programs are not a substitute for getting at the causes of health problems. If farmer-employers with the help of economists and other experts, can find ways to pass on substantially increased wage and fringe benefit costs, farmworkers could soon be placed on a par with workers in other American industries. With improved living conditions, better working conditions, and adequate medical care on a regular basis, many of the serious problems that persist could be eliminated. If this means further increases in the cost of food and fiber products to ultimate consumers, it is possible that this will result in hardships in some cases. However, it is arguable that it is better to directly subsidize the ultimate consumer through food stamps and other devices than to indirectly subsidize such consumers by perpetuating farm labor policies which result in low incomes for hired farmworkers and the attendant problems. Holding down prices in the supermarket certainly cannot be justification for perpetuating farm labor policies of the past.

With respect to providing health care services and nutritional services, it seems important to recommend that after recent changes have been operative for a reasonable period of time, an extensive study should be done to determine the extent to which migrant and seasonal farmworkers are actually being reached. If it is determined that significant numbers are not within the service areas of the various programs and clinics, further legislative and regulatory changes may be called for. If, on the other hand, it is determined that significant numbers are not taking advantage of available services,

it may be necessary to direct greater outreach and affirmative action programs. It would also be interesting to ascertain the extent to which private health and medical insurance is being made available to the hired farm labor force. Owners and their families may have group policies through farm organizations and the same may also be true of some tenants and sharecroppers. While some permanent farm employees are covered under group policies, the extent of such fringe benefits on a regional or a national basis could probably be ascertained. There is also the possibility that seasonal locals, particularly housewives and children, are covered by the husband and father's policy if he is employed. The concern is, however, that taking into consideration private coverage and all of the programs provided, there may still be many hired farmworkers who have no private insurance and who are not being reached by government programs. Since worker's compensation is still denied to many seasonal and migrant farmworkers, the workers who do not have other types of protection and services available may have no meaningful health program even in connection with job-related accidents and illnesses.

Finally, it is recommended that there be a constant review of the funding levels of the various programs. It is beyond the scope of this study to determine the adequacy of present funding levels, but if insufficient funds are available or if that situation develops in the future, Congress should be advised at once and given the opportunity to make appropriations.

Notes to Chapter 9

1. 41 Fed. Reg. 14363 (1976).

2. Jukes, "Insecticides in Health, Agriculture and the Environment," 61 Naturwissenschaften 6 (1974).

3. "Florida Seasonal Farm Workers: Follow Up and Intervention Following a Nutritients Survey," 66 J. Am. Dietetic Ass'n, 606 (1975).

4. See generally "Child Labor in Agriculture," this monograph.

5. S. Rep. No. 93-1137, 93d Cong., 2d Sess. 23 (1974); See Generally Shenkin, Health Care for Migrant Workers (Hereinafter Shenkin).

6. Legislative History, P.L. No. 94-63, 1 U.S. Code Cong. & Ad. News 469, 567 (94th Cong. 1st. Sess.).

7. Letter (Sept. 6, 1974) and "Briefing Outline for Migrant Health Program" from Ass't. Surgeon General, Director Bureau of Community Health Services, Department of Health, Education and Welfare, to Donald B. Pedersen.

8. Miami Herald, July 23, 1977, p. 17.

9. Miami Herald, Feb. 9, 1978, §4, p. 1.

10. Rod, "Health Problems in Industrial Agriculture," 39 Am. J. Pub. Health 1172 (1949).

11. The original legislative basis for the Farm Security Administration was the Emergency Relief Appropriations Act of 1935, April 8, 1935, c. 48, 49 Stat. 115. The president was given the authority to put the act into operation, and to this end Executive Order 7027, April 30, 1935, was issued establishing the Resettlement Administration. Later, by Executive Order 7530, Dec. 31, 1936, 2 Fed. Reg. 7, the functions and duties of the Resettlement Administration were transferred to the Secretary of Agriculture. By Memorandum 732, Sept. 7, 1937, 2 Fed. Reg. 1800, the secretary changed the Resettlement Administration to the Farm Security Administration.

12. Hellman, "The Farmers Try Group Medicine," 182 Harper's Magazine (1940) at 72.

13. Ib.

14. Shenkin, supra note 5 at 14.

15. Ib.

16. Act of Aug. 13, 1946, ch. 958 §2, 60 Stat. 1041. The statute as amended is codified at 42 U.S.C. §§291-291o (1976).

17. 42 U.S.C. §291c(a)(1) (1976).

18. 42 U.S.C. §291c(e) (1976).

19. Housing Act, ch. 338, 63 Stat. 413, 42 U.S.C. §1401 (1949), as amended 42 U.S.C. §1401 (1964).

20. Shenkin, supra note 5, at 16.

21. P.L. No. 87-692 initially codified at 42 U.S.C. §247(d), later amended by P.L. No. 89-109, §3; P.L. No. 90-574, Title II, §201; P.L. No. 91-209; P.L. No. 93-45, Title I, §105; P.L. No. 93-353, Title I, §102(d); P.L. No. 94-63, Title IV, §401(d); Title VII, §701(c); P.L. No. 95-66, Title I, §101-107; P.L. No. 95-626 which at Title I, Part A, 101 provides that it may be cited as The Migrant and Community Health Centers Amendments of 1978 and transfers the Migrant Health Act to 42 U.S.C. §254(b).

22. Shenkin, supra note 5 at 16.

23. Aug. 5, 1965, P.L. No. 89-109 §3, 79 Stat. 436, as amended, 42 U.S.C. §247d (1976).

24. Legislative History, P.L. No. 94-63, 1 U.S. Code Cong. & Ad. News 469, 566 (94th Cong. 1st. Sess).

25. P.L. No. 91-296.

26. See generally Shenkin, supra note 5.

27. July 29, 1975, P.L. No. 94-63 as codified at 42 U.S.C. §247(d) (1976 and Supp. II 1978).

28. 42 U.S.C. §300e et. seq. (Supp. III 1973).

29. Schneider & Stern, "Health Maintenance Organizations and the Poor: Problems and Prospects," 70 NW.U.L.R. 90 (1975).

30. See note 139, infra, and accompanying text.

31. Rudd, "The United Farm Workers Clinic in Delano, Calif: A Study of the Rural Poor," 90 Pub. Health Rep. 331 (1975).

32. Id. at 332.

33. Ib.

34. See note 21, supra.

35. P.L. No. 95-626.

36. 42 U.S.C. §254b(a)(5) (1976 and Supp. II 1978).

37. 42 U.S.C. §254b(a)(5) (1976 and Supp. II 1978).

38. 42 U.S.C. §254b(a)(2) (1976 and Supp. II 1978).

39. 42 U.S.C. §254b(a)(3) (1976 and Supp. II 1978).

40. 42 U.S.C. §254b(a)(6) (1976 and Supp. II 1978).

41. 42 U.S.C. §254b(a)(7) (1976 and Supp. II 1978).

42. 42 U.S.C. §254b(b)(1) (1976 and Supp. II 1978).

43. 42 U.S.C. §254b(c)(1)(B) (1976 and Supp II 1978).

44. 42 U.S.C. §254b(c)(1)(B) (1976 and Supp II 1978).

45. 42 U.S.C. §254b (1976 and Supp. II 1978).

46. 42 U.S.C. §254b(e) (1976 and Supp. II 1978).

47. 42 U.S.C. §254b(e)(2) (1976 and Supp. II 1978).

48. 42 U.S.C. §254b(f)(3)(g) (1976 and Supp. II 1978).

49. 544 F.2d 1233 (C.A.La. 1976).

50. No. 76-1748 (D.C. Cir., Dec. 23, 1977); 574 F. 2d 518.

51. 11 Clearinghouse Review 876 (1978).

52. See, Bureau of Community Health Services Programs, DHEW/HSA 78-5002 at 4.

53. Id. at 14.

54. Id. at 9.

55. Id. at 11.

56. Id. at 19-20.

57. Id. at 7.

58. Id. at 25.

59. Id. at 4.

60. 1980 Catalog of Federal Domestic Assistance Programs, Item 13.773.

61. See, Social Security for Farmworker, supra this monograph

62. 42 U.S.C. §1395 et.seq. (1976); 1980 Catalog, supra note 61 at Item 13.774.

63. 1980 Catalog, supra note 61 at Item 13.714.

64. 42 C.F.R. §435.403, §436.403 (1978).

65. 43 Fed. Reg. 35077 (1978).

66. 44 Fed. Reg. 41434 (1979).

67. Ib.

68. Ib.

69. 44 Fed. Reg. 41460 (1979), to be codified at 45 C.F.R. §223.40(f).

70. Ib.

71. To be codified as 42 C.F.R. §435.403(h); Castillo v. Creasy (N.D. Ohio, filed April 29, 1980), noted in 14 Clearinghouse Review 476 (1980), involves a challenge to an Ohio regulation which defines residency as physical presence with intent to remain.

72. To be codified as 42 C.F.R. §435.403(i).

73. The Food Stamp Act of 1964, P.L. No. 88-525, 78 Stat. 703, 7 U.S.C. §2011-2026 (1976) as amended.

74. Economic Opportunity Act of 1964, as amended, Title II Sec. 222(a)(1), P.L. No. 95-568, 92 Stat. 2426, 42 U.S.C. §2809 (1976), as amended.

75. Smith & Rowe, Food Stamp Participation of Hired Farmworker Families, USDA/ESCS, Agricultural Economic Report No. 403, at 3.

76. Id. at 2.

77. Ib.

78. Id. at 10.

79. Ib.

80. Id. at 3, note 5.

81. Id. at 9; Gutierrez v. Butz, 415 F. Supp. 827 (D.D.C. 1976).

82. 7 U.S.C. §2012(c) (1976).

83. 415 F. Supp. 827 (D.D.C. 1976).

84. 11 Clearinghouse Review 45 (1978).

85. P.L. No. 95-113, §5(f); codified as 7 U.S.C. §2014(f).

86. Fretz, "Food Stamp Eligibility for Farmworkers," 11 Clearinghouse Review 45 (1978), citing Cong. Rec. 8-9542-9543 (daily ed., Sept. 16, 1977); See recounting of 1976 hearings at 5 U.S. Code Cong. & Adm. News 2079 (1980).

87. Ib.

88. P.L. No. 96-249, 94 Stat. 357, 96th Cong. 2d Sess.

89. P.L. No. 96-249, §107.

90. 1979 Catalog of Federal Domestic Assistance Programs, Item 49.005.

91. Economic Opportunity Act of 1964, as amended, Title II, §222(a)(1), P.L. No. 95-568, 92 Stat 2426, 42 U.S.C. §2809.

92. 1980 Catalog, supra note 61 at Item 49.005.

93. Ib.

94. See note 18, supra, and accompanying text.

95. Rose, "Federal Regulation of Services to the Poor Under the Hill-Burton Act: Relaties and Pitfalls," 70 NW. U.L. Rev. (1975) 168-169.

96. Stanturf v. Sipes, 244 F. Supp. 883 (D.C. Mo. 1963), aff'd 335 F. 2d 224 (8th Cir.), cert. den. 37 U.S. 977, 13 L.Ed. 2d 567, 85 S.Ct. 676 (1965).

97. Rose, supra note 96 at 169.

98. 319 F. Supp. 603, 11 A.L.R. Fed. 677 (D.C. La. 1970).

99. 458 F.2d 1115 (10th Cir. 1972).

100. 325 F. Supp. 268 (S.D. Fla. 1971).

101. 37 Fed. Reg. 182 (1972).

102. Rose, supra note 96 at 174.

103. Id. at 175.

104. Ib.

105. Ib.

106. Id. at 176.

107. 44 Fed. Reg. 2940 (1979).

108. Id.

109. See, e.g., Saine v. Hospital Authority of Hall County, 502 F.2d 1033 (5th Cir. 1974).

110. 453 F. Supp. 401 (M.D. Tenn. 1978).

111. Accord, Magic Valley Credit Bureaus, Inc. v. Baker, (Idaho Dist. Ct., 1979), as noted in 13 Clearinghouse Review 795 (1980); collection suits dismissed where Hill-Burton defense raised, Youngstown Hospital Assoc. v. Martini (Mun. Ct. Ohio, 1979) as noted in 13 Clearinghouse Review 532 (1979), and J.M. Hollister, Inc. v. Schackelford, (Mun. Ct. Cal. 1979), as noted in 13 Clearinghouse Review 625 (1979); contra, St. Mary's Hospital v. Castner (City Ct. N.Y. 1979) as noted in 13 Clearinghouse Review 795 (1980), and St. Peter's Hospital v. Hall, 102 N.Y. Misc. 2d 73 (1979).

112. 44 Fed. Reg. 29400 (1979).

113. 453 F. Supp. 401 (M.D. Tenn. 1978).

114. P.L. No. 93-641.

115. 44 Fed. Reg. 29400 (1979).

116. 44 Fed. Reg. 29372 (1979).

117. 44 Fed. Reg. 29383 (1979).

118. To be codified at 42 C.F.R. §124.503(a)

119. 44 Fed. Reg. 29375 (1979), codified at 42 C.F.R. §124.501-.512.

120. Ib.

121. 42 C.F.R. §124.504.

122. 42 C.F.R. §124.603(a)(2).

123. See, Comments at 44 Fed. Reg. 29399 (1979).

124. To be codified at 42 C.F.R. §124.603(a)(1).

125. 12 Clearinghouse Review 186 (1979).

126. Ib.

127. See, Comments at 44 Fed. Reg. 29396 (1979).

128. 453 F. Supp. 401 (M.D. Tenn. 1978).

129. Comptroller General Report to the Congress: Can Health Maintenance Organizations Be Successful?—An Analysis of 14 Federally Qualified "HMOs," June, 1978 at 1.

130. Id. at 2.

131. 42. U.S.C. §300e (1976).

132. Comptroller General, supra note 130 at 1.

133. Id. at 4.

134. Id. at 10.

135. Ib.

136. Id. at 10-11.

137. Id. at 11.

138. Telephone conference HEW/HMO Program, 1979; See 42 U.S.C. §300e-14a (1976).

139. Schneider & Stern, "Health Maintenance Organizations and the Poor: Problems and Prospects," 70 NW.U.L.R. (1975) at 90.

140. Comptroller General, supra note 130 at 22-23. See, Requirements for a HMO at 44 Fed. Reg. 42063, 42069 (1979).