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FOREWORD

ASPIRATIONS AND REALITY IN THE LAW AND POLITICS OF HEALTH CARE REFORM: EXAMINING A SYMPOSIUM ON (E)QUAL(ITY) CARE FOR THE POOR

*Ann C. McGinley**

INTRODUCTION: AMERICAN MEDICINE'S "OTHER AMERICA"

Rosa Rivera was nine months pregnant and in labor.¹ Because she was unable to pay, she had received no prenatal care throughout her pregnancy. As a result, she was without a doctor. Therefore, she went to the emergency room of DeTar Hospital in Victoria, Texas. When she arrived at approximately

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¹ The facts of the Rosa Rivera story come from *Burditt v. United States Dep't of Health & Human Servs.*, 934 F.2d 1362 (5th Cir. 1991).

4:00 p.m. on December 5, 1986, Rosa was experiencing contractions, one minute in duration every three minutes. Two obstetrical nurses examined her and took her blood pressure. They found that she was in labor and had extremely high blood pressure—210/130. Because Rosa had no doctor and no means to pay hospital bills, the nurses called Dr. Burditt, the next physician on the hospital's rotating call-list for treating "un-aligned" obstetrics patients. Over the telephone, Dr. Burditt told the nurse that she should prepare Rosa for transfer to John Sealy Hospital in Galveston, Texas, 170 miles from Victoria, because he "didn't want to take care of this lady."²

The obstetrical nurses were worried about Ms. Rivera's safety. They told the nursing supervisor and the hospital's administrator that they believed a transfer would put Rosa and her baby at risk. The hospital administrator, Charles Sexton, explained to the nurses that it would be against hospital regulations and federal law to transfer Rosa Rivera unless Dr. Burditt examined her personally and arranged for John Sealy Hospital to admit her before her transfer.³

One of the obstetrical nurses again spoke with Dr. Burditt by telephone to convey Sexton's understanding of hospital regulations and federal law. The obstetrical nurse asked for authorization to start an intravenous push ("IV") to prevent convulsive seizures. Burditt agreed that the nurses should administer the IV, but only if Rivera could be transported by ambulance. If an ambulance was not available, Burditt informed the nurse that he intended to have Rosa Rivera transported by private car. In that case, he instructed the nurse not to start the IV.⁴

Dr. Burditt arrived at about 4:50 p.m. to examine Rosa Rivera. Her blood pressure was the highest he had ever seen. He assumed that she had been hypertensive throughout the pregnancy and knew that the hypertension could kill both Rosa Rivera and her baby. Nonetheless, he called a doctor at John Sealy Hospital who agreed to accept Rosa Rivera as a patient. Within a few moments, the nursing supervisor, Jean Herman, tried to show Dr. Burditt the hospital guidelines

² *Id.* at 1366.

³ *Id.*

⁴ *Id.*

regarding transfers of emergency room patients, but Dr. Burditt refused to read them. Ms. Herman explained that under hospital guidelines and federal law, Dr. Burditt could not transfer Ms. Rivera unless he signed a certificate saying that the medical benefits at John Sealy would outweigh the increased risk of transferring the patient. Dr. Burditt signed the form, but did not list the basis for his conclusion, as required by the form. Instead, he told Herman that Ms. Rivera was a high malpractice risk and "until DeTar Hospital pays my malpractice insurance, I will pick and choose those patients that I want to treat."⁵

The ambulance was not ready to transfer Ms. Rivera until two hours later. Although Dr. Burditt saw Ms. Rivera as medical personnel loaded her into the ambulance, he never examined her during the two hour period before her transfer. Instead, he relied on an examination by a third obstetrical nurse, Anita Nichols. Dr. Burditt also failed to order any medication or life support equipment for Rosa during her transfer.⁶

Rosa Rivera gave birth to her baby 40 miles into the 170-mile trip to John Sealy. Fortunately the baby was healthy. Nurse Nichols directed the ambulance to a nearby hospital to get a drug to slow Rivera's bleeding. Afterwards, Rosa Rivera wanted to return to DeTar Hospital. Nurse Nichols returned with Rivera to DeTar, where Dr. Burditt refused to see her and told the staff to discharge her if her bleeding was not excessive. Fortunately for Ms. Rivera, a DeTar official pressured Dr. Burditt to permit another obstetrician to take over the case. Under the care of Dr. Shirley Pigott, Ms. Rivera spent three days in the hospital and left in good health.⁷

Rosa Rivera's story raises many disturbing questions about the health care system in this country. At the very least, there seems to be some consensus that the health care system should take care of persons who are suffering from emergency medical conditions. Indeed, Congress has enacted a statute to prevent Rosa Rivera's experience from happening to others.⁸

⁵ *Burditt*, 934 F.2d at 1367.

⁶ *Id.*

⁷ *Id.*

⁸ The Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd (1988 & Supp. IV 1992), requires that the emergency room of a hospital receiving federal funds perform an "appropriate medical screening" of a

The federal law, however, has been largely ineffective in preventing "patient-dumping," the practice of transferring or refusing to treat patients because of their lack of insurance.⁹

There is a temptation to vilify Dr. Burditt. Clearly, he allowed his personal economic concerns to control his professional decision-making. His fear of a malpractice suit outweighed good medical judgment and a legal and moral duty to care for Ms. Rivera. But perhaps Congress's piecemeal attempts to "fix" the health care problem are also partially responsible. Perhaps hospitals and doctors alone should not bear the economic burden of treating patients with emergencies that clearly could have been prevented by the delivery of good health care. Perhaps it is now society's responsibility to assure that its Rosa Riveras get needed prenatal care to prevent an emergency before it occurs.

Many would ask why Ms. Rivera had no prenatal care, no insurance and no guarantee of needed medical attention.¹⁰ Of course, the "reason" Rosa Rivera faced this horror story was that she was poor and lived in the United States rather than another industrialized nation. But her near-tragedy is not the archetypical story that dominates American attitudes about

patient who presents herself at the emergency room of a hospital to determine whether an emergency medical condition or active labor exists. If the patient has an emergency medical condition, the hospital cannot legally transfer the patient unless it stabilizes the patient to assure that no material deterioration results from the transfer. *Id.* § 1395dd(b)(1)(A), (e)(4)(B). If the hospital finds that the patient is in active labor, it cannot transfer the patient unless the woman is in an "uncomplicated labor" and, within reasonable medical probability, will arrive at another hospital before delivering her baby. *Burditt*, 934 F.2d at 1369.

⁹ Public Citizen Health Research Group, *Patient Dumping Continues in Hospital Emergency Rooms: 268 Hospitals That Have Violated the Law*, 9 HEALTH LETTER 2 (June 1993) (at the end of 1992, the United States Department of Health and Human Services had identified 302 "patient dumping" violations in 268 different hospitals). For one author's explanation of the failure of EMTALA, see Maria O'Brien Hylton, *The Economics and Politics of Emergency Health Care for the Poor: The Patient Dumping Dilemma*, 1992 B.Y.U. L. REV. 971.

¹⁰ According to Raphael Metzger, Director of Special Initiatives for the National Coalition of Hispanic Health and Human Services Organizations, 12.1% of Hispanic women, 10.9% of black women and 4.1% of non-Hispanic white women had either late or no prenatal care in 1988. See Raphael Metzger, *Hispanics, Health Care, and Title VI of the Civil Rights Act of 1964*, 3 KAN. J.L. & PUB. POL'Y 31, 31-32 (1993). In 1990, only 61% of pregnant Hispanic women received prenatal care during the first trimester of their pregnancies. *Id.* Moreover, Medicaid does not cover 66% of Hispanics under age 65 who live in poverty and who do not have private health insurance. *Id.*

the state of health care. The stories and sentiments fueling America's current health care debate are largely middle class. And, largely, they have overlooked the magnitude of medical problems facing the poor.

I. IMPROVING THE HEALTH STATUS OF THE POOR: A NATIONAL IMPERATIVE

A. *Health Care for the Poor is Neither Equal Nor Quality*

Middle-class Americans are terribly misinformed about the poor's need for health care reform. Conventional wisdom holds that only middle-class Americans need health care reform. Popular belief posits that the wealthy can pay for needed care while the poor already get sufficient health care through Medicaid or can go to any emergency room for free care.¹¹ Indeed, many middle-class Americans think that every doctor doles out significant free care to poor patients. So, they conclude that the poor do not need health care reform.¹²

A whole body of evidence refutes these common misconceptions.¹³ As Professor Sidney Watson of Mercer University Law School demonstrates, Medicaid covers less than half of those persons who live below the federal poverty level:

[N]ot all poor people are eligible for Medicaid—only those who fit

¹¹ Dick Davidson, president of the American Hospital Association, attributes much of the misinformation to hospitals themselves because they have claimed that they treat anyone who comes through the hospital doors, regardless of the patient's ability to pay. Mr. Davidson finds this boast inaccurate, especially where postponable treatment is concerned. Adam Clymer, *Health Debate Splinters After Initial Consensus*, N.Y. TIMES, Apr. 13, 1994, at B8.

¹² I do not underestimate the very real problems of middle-class Americans who have no health insurance. Rather, I merely stress that the poor and underserved need health care reform at least as much as middle-class Americans.

¹³ For example, Hispanics have less access to health care than blacks and non-Hispanic whites. In 1987, 31% of Hispanics had no insurance, public or private, as compared to 22% of blacks and 12% of non-Hispanic whites. Metzger, *supra* note 10, at 31.

Although this lack of access does not seem to increase the mortality rates of Hispanics, it substantially increases their morbidity rates. *Id.* at 32. For example, Hispanics have a much higher rate of diabetes than non-Hispanic whites; they have a much higher incidence of AIDS than non-Hispanic whites; they are more than four times more likely than non-Hispanic whites to contract tuberculosis; and their preschool children are seven times more likely than non-Hispanic white preschool children to get measles. *Id.*

within certain categories defined by federal law. Medicaid does not cover those who are temporarily or partially disabled, young adults, childless couples, unemployable people below age sixty-five, undocumented aliens, or anyone else who does not fit within the federal statutory categories. In addition, income eligibility levels vary drastically from state to state. Many states, faced with declining revenues, ever increasing health care costs, and expanding federal categories of people eligible for Medicaid, have attempted to limit the number of people on Medicaid by holding down their Medicaid financial eligibility levels. Currently, only 42% of people living at or below the federal poverty level receive Medicaid. Seventy-five percent of those ineligible are workers or their dependents, most of whom are newly employed or employed at jobs that pay enough to disqualify them for Medicaid, but do not provide private health insurance.¹⁴

Moreover, even poor persons who are eligible for Medicaid often go untreated. They must surmount tremendous barriers to care, including the lack of providers who are willing to treat them.¹⁵

In addition, the common perception that the uninsured urban poor can receive medical treatment in the emergency rooms of private, local hospitals is misguided.¹⁶ Although private hospitals who accept Medicare patients are required by federal statute to treat patients such as Rosa Rivera, regardless of insurance status,¹⁷ this statute has a number of flaws. First, it was never designed to require hospitals to treat patients with non-emergency conditions.¹⁸ Second, the courts

¹⁴ Sidney D. Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C. L. REV. 1647, 1657-58 (1993); see also Ellen M. Yacknin, *Helping the Voices of Poverty to Be Heard in the Health Care Reform Debate*, 60 BROOK. L. REV. 143 (1994). Even the Michel bill, H.R. 3080, 103d Cong., 1st Sess. (1993), the most conservative bill before Congress, would grant benefits to all persons—except those receiving Medicare benefits—whose family income is at or below the federal poverty level. *Id.* § 1601 (d)(2)(A), (e)(1).

¹⁵ See Vernellia R. Randall, *Health Care Reform: Does Clinton's Health Care Reform Proposal Ensure (E)qual(ity) of Health Care for Ethnic Americans and the Poor?*, 60 BROOK. L. REV. 167, 178 (1994); see also Yacknin, *supra* note 14, at 157-58.

¹⁶ See Watson, *supra* note 14, at 1650.

¹⁷ 42 U.S.C. § 1395dd (1988 & Supp. IV 1992). EMTALA requires the hospital to do an "appropriate medical screening examination" to determine whether a medical emergency exists or a woman is in active labor. *Id.* A patient in an unstable medical condition or a pregnant woman in active labor may be transferred if qualified medical personnel certify that the benefits of the transfer outweigh its risks. *Id.* § 1395dd(c)(1)(A)(ii). See *supra* note 8.

¹⁸ See 42 U.S.C. § 1395dd(b)(1) (1988 & Supp. IV 1992).

have interpreted the statute to relieve hospitals of liability if the doctor-in-charge misdiagnoses whether an emergency exists.¹⁹ And third, the statute has proved ineffectual in changing the hospitals' practice of "dumping" poor patients from private emergency rooms.²⁰

Moreover, private hospitals are rapidly disappearing from urban areas.²¹ Poor patients in the inner city are relegated to public hospitals that are "grossly underfunded and suffer from rapidly deteriorating conditions, overcrowding, long waits for emergency treatment, staff shortages, and outdated equipment."²² Thus, even if the "patient dumping" statute works perfectly to prevent hospitals from turning away emergency patients,²³ it does not create hospitals where they do not exist; nor does it require hospitals to provide continuous, accountable care for non-emergencies. In fact, hospital emergency rooms are not the optimal setting for creating the type of patient-provider relationship necessary to provide good care to the poor.²⁴

Although private doctors contribute free care to patients who are unable to pay, their efforts often do not reach the neediest poor persons who live in the inner city. Most private doctors are not located where poor people live and the number of poor needing quality, continuous health care far exceeds the capacity of well-meaning private physicians. Volunteerism by

¹⁹ See, e.g., *Gatewood v. Washington Healthcare Corp.*, 933 F.2d 1037, 1041 (D.C. Cir. 1991) (a hospital using its standard screening procedure is not liable under EMTALA, even if the hospital concluded the patient did not suffer an emergency condition and the procedure resulted in misdiagnosis); *Deberry v. Sherman Hosp. Ass'n*, 769 F. Supp. 1030 (N.D. Ill. 1991) (hospital not liable under EMTALA for misdiagnosing child's spinal meningitis).

²⁰ See *supra* notes 8-9.

²¹ *Watson, supra* note 14, at 1650. Between 1937 and 1977, 210 urban private hospitals with more than 30,000 beds either closed or relocated. *Id.*

²² *Watson, supra* note 14, at 1651.

²³ As a matter of social policy, one could question whether a patient dumping statute without further supporting legislation makes any sense. Instead of evenly spreading the costs of treating uninsured patients to the community at large, it spreads the cost to the insured patients in the hospital. It may make more sense to spread the cost to taxpayers through a progressive federal income tax. Furthermore, a patient dumping statute may actually create an incentive to private hospitals to relocate out of urban areas.

²⁴ See *infra* part V. and text accompanying note 184 (describing Maura Bluestone's symposium comments about what is needed to provide good health care to the poor).

private physicians is simply not a sufficient means of dealing with the health care crisis in the inner city.

The health care crisis is exacerbated by the conditions of urban America. Because of pollution, crime, drugs and a lack of basic preventive care, persons living in the inner city are often less healthy than their middle-class counterparts.²⁵ The confluence of drug abuse and AIDS is rising exponentially throughout the nation, especially in urban areas.²⁶ The health care problems of persons afflicted by AIDS and drug abuse are devastating and require enormous resources for medical and ancillary services. Moreover, even if the society were to overcome the economic barriers and provide good health care and support services for these individuals, public disdain for persons afflicted with these diseases likely would still create a tremendous barrier to care.²⁷

The bottom line is that many of the sick poor go untreated or "obtain medical care only when their condition is beyond treatment."²⁸

²⁵ See Watson, *supra* note 14, at 1648-49. "Inner-city residents suffer from hypertension, heart disease, chronic bronchitis, emphysema, sight and hearing impairments, cancer, and congenital anomalies at a rate 50% higher than suburbanites. The rate of neurological and mental disorders in inner-city residents is nearly twice that of suburbanites." *Id.* at 1649.

²⁶ See *infra* part V. and text accompanying note 183 (describing Catherine O'Neill's presentation at the Symposium).

²⁷ See *infra* note 183 and accompanying text. Ms. O'Neill noted that her organization had fought for and won important legal provisions that protect persons with drug abuse problems and AIDS from discriminatory treatment in health care. Notwithstanding these provisions, the access to health care for these people and their families is "lousy."

²⁸ See Watson, *supra* note 14, at 1658; see also Susan Chira, *Study Confirms Some Fears on U.S. Children*, N.Y. TIMES, Apr. 12, 1994, at A1, A13 (reporting on Carnegie Corporation panel's conclusion that millions of infants and toddlers in the United States "are so deprived of medical care, loving supervision and intellectual stimulation that their growth into healthy and responsible adults is threatened"); Clymer, *supra* note 11, at B8 (noting that people without insurance delay receiving care, come into the hospitals more severely ill and "may be hospitalized more frequently [than persons with health insurance] for conditions that could have been treated on an ambulatory basis" (quoting JOEL S. WEISSMAN & ARNOLD M. EPSTEIN, *FALLING THROUGH THE SAFETY NET* (forthcoming 1994))).

B. *The Symposium's Objective: To Begin a Dialogue Toward Change*

On December 3 and 4, 1993, the Edward V. Sparer Public Interest Law Fellowship Program, in conjunction with the *Brooklyn Law Review*, sponsored a symposium entitled "Ensuring (E)qual(ity) Health Care for Poor Americans." In early Fall 1992, when the Symposium's initial planning began, the committee decided to honor Ed Sparer's significant accomplishments in the health care field on the tenth anniversary of his death. But the committee wanted the Symposium to be more than a memorial to Ed Sparer. Having been his research assistant at the University of Pennsylvania Law School, I believed we could best honor Ed Sparer by initiating a dialogue about how to remedy the health care problems of the poor and disadvantaged. Thus, the committee chose to examine the theoretical and practical aspects of health care reform, focusing on how lawyers and health professionals could work to ensure equal and quality health care for the poor and other disadvantaged groups. Because the audience and Symposium participants worked and lived predominantly in urban areas, the committee decided to narrow the discussion to the needs of the urban poor and underserved.

Although in the Fall of 1992 the Committee could not predict what would happen on the national scene, it was obvious that health care reform had become an important issue to Americans. The Pennsylvania voters had recently elected Harris Wofford to the United States Senate on the single issue of health care reform. The media had prominently publicized the rising costs of health care; it focused on workers' Hobson's choice of remaining in jobs that did not fulfill their career goals or of risking the loss of their health insurance.²⁹ A presidential campaign was proceeding at breakneck speed, and health care reform had become a campaign issue.³⁰

²⁹ Moreover, estimates of national expenditures on health care for the future were staggering. Although health care costs accounted for approximately 14% of the gross domestic product in 1993, the Health Care Financing Administration estimated that health care would represent 32% of the gross domestic product by the year 2030. See Raymond G. Davis, *Health Care Reform and the Probabilities of Change*, 3 KAN. J.L. & PUB. POL'Y 25, 27 (1993).

³⁰ Once elected, President Clinton promised that health care reform would be a

It seemed that health care reform had become a priority precisely because the middle class was suffering from rising costs and unavailability of insurance.³¹ Although the poor had suffered from insufficient health care for years, it was only when the middle class felt the economic pinch that health care reform moved to the top of the national agenda.³² This situation reminded me of one of Ed Sparer's themes. Ed Sparer believed that where their interests converge, disadvantaged persons should align with the middle class to produce change that would benefit both groups. In this way, the poor, a group with little political power, could benefit from the enormous political power of the middle class.³³ In the Fall of 1992, it appeared that it was time for the poor to consider building a coalition with the middle class to work for universal coverage and improved quality of care.

Yet, many questions remained about whether a coalition would benefit the poor and, if so, how it should advocate health care reform. Exactly what type of reform would benefit the poor and underserved? Was this reform the same as or substantially different from that needed by the middle class? To what extent was there a national consensus that health care had to be reformed? Should advocates for the poor strive for universal health insurance, or should they work for broader based changes that would alter the delivery and quality of care? What type of reform, if any, would be politically feasible? Is politically feasible reform worth fighting for or would it

key issue in his administration. He appointed Hillary Rodham Clinton to lead the health care reform task force and promised to submit proposed legislation to Congress within 100 days of his inauguration.

³¹ The Kaiser Family Foundation, an organization that does health-based research, estimates that about 50 million Americans lack insurance at some time during a year. The Kaiser Foundation concludes that the United States spends about 14% of its gross domestic product on health care, a share that many believe will reach 19 or 20% by the end of the century. Companies have cut back benefits and employees' payments have increased. The cost of family coverage under an average group insurance plan increased from \$235 to \$436 monthly from 1988 to 1992. The numbers are even worse for persons who have to buy individual insurance plans. See Clymer, *supra* note 11.

³² Of course, the pressures on business and government from the rising costs of health care also contributed a great deal to the political moment.

³³ This is the argument for rejecting "means testing" for persons receiving Social Security retirement benefits. To the extent that "means testing" would eliminate Social Security for the politically powerful middle class, the Social Security program would lose its support and become just another "entitlement" of the poor.

actually harm the poor and disadvantaged? Should those representing the poor compromise in order to build a coalition with the middle class? If so, to what extent? If not, what course of action should advocates for the poor take?

Although there are no definitive answers to these questions, these and other issues surfaced repeatedly at the Symposium. The Symposium comprised five sessions. On Friday morning, December 3, the panel addressed, "The National Agenda of Health Care Reform: What Does It Mean For Poor Americans?" At lunch on Friday, the speakers addressed, "Current Legislative Prospects for Health Care Reform," and "Health Care Reform in the 103rd Congress." That afternoon, two panels entitled "Practical Problems of the Poor and Underserved in Attaining (E)qual(ity) Health Care" and "Seeking Solutions" discussed the problems of the poor and underserved in attaining equal and quality health care and potential solutions to these problems. Finally, on Saturday morning, a panel entitled "The Lawyer's Role: Advocacy Strategies and Other Alternatives" discussed how lawyers could improve the quality of health care available to the poor and underserved.

Many of the speakers at the Symposium have submitted articles for publication in this issue of the *Brooklyn Law Review*. But many others, who made valuable contributions to the discussion, were unable to submit articles because of their extremely busy positions serving the health care and other needs of poor and disadvantaged persons. These important contributions, as well as the ideas presented by an extremely active and thoughtful audience, should be preserved.

Therefore, while this Article will summarize the articles contained in this Symposium edition, it will describe in even greater detail the dialogue that took place at the Symposium that is not memorialized in any of the articles. It will attempt to draw together the main themes, suggestions and concerns voiced by the speakers and members of the audience.

Before embarking on a summary of the Symposium itself, and because so much of the health care debate at the Symposium centered around the national proposals for health care reform, Part II of this Article will briefly describe President

Clinton's Health Security Act ("Act" or "HSA")³⁴ and the other major health care reform proposals that are under consideration as this symposium edition goes to print. Parts III through VI describe the speakers' presentations. Part III focuses on the political choices of advocates for the poor in the national debate over health care reform; Part IV describes the state's role and its effect upon ensuring the poor's access to (e)qual(ity) health care; Part V discusses the types of health care systems that poor people need; and Part VI suggests how lawyers can change the health status of the poor.³⁵ This Article concludes with Part VII, a synthesis of the main themes, questions and ideas raised by participants in the Symposium and an attempt to reconcile the apparent contradictions.

II. NATIONAL MEASURES FOR LEGISLATIVE REFORM

A. *The Clinton American Health Security Act*³⁶

The Clinton plan is based on the "managed competition" model. As envisaged by the Clinton plan, "managed competition" allows for competition among health plans in a given geographical area under heavy regulation by the state and federal governments. The ethical notions underlying the plan include universal access to quality health care, a guaranteed comprehensive benefits package, consumer choice of plans and the wise allocation of resources.³⁷ The Clinton plan creates a National Health Board, which consists of seven members appointed by the President with the advice and consent of the Senate. The National Health Board will set national standards and oversee "the establishment and administration of the new health system by the states."³⁸

States will have primary responsibility for ensuring that

³⁴ H.R. 3600, 103d Cong., 1st Sess. (1993) [hereinafter HSA].

³⁵ To the extent that these different themes overlap, I apologize. Many of the speakers addressed more than one theme in their presentations and the categories selected are rough approximations of where the speakers' presentations fit.

³⁶ For a more detailed description of the Act, see Randall, *supra* note 15.

³⁷ THE WHITE HOUSE DOMESTIC POLICY COUNCIL, THE PRESIDENT'S HEALTH SECURITY PLAN: THE CLINTON BLUEPRINT 11-13 (1993) [hereinafter CLINTON BLUEPRINT].

³⁸ *Id.* at 44-46; HSA § 1501.

their citizens have access to a health plan offering the comprehensive benefits package as defined by the Act. Each state will submit to the National Health Board a plan for implementing health care reform that demonstrates the plan's compliance with federal law.³⁹ Each state must create either a health alliance system or a single-payer system.⁴⁰

The Act contemplates that most states will choose the health alliance system. Under this system, the state must create one or more regional health alliances. Health alliances will be responsible for: "[r]epresenting the interests of consumers and purchasers of health care services;"⁴¹ "[s]tructuring the market for health care to encourage the delivery of high quality care and the control of costs;"⁴² and assuring that the residents within their geographical boundaries enroll in health plans which grant the federally guaranteed benefits package.⁴³ As a result, health alliances will: negotiate with health plans to provide the comprehensive benefits package required by the HSA; control marketing materials distributed to the public by the health plans; publish informative materials concerning purchasers' different plan options including cost and quality information; and draft uniform contracts with the plans.⁴⁴

Consumers who are residents of states with health alliance systems will have the option of choosing among three basic types of plans, each with different prices.⁴⁵ The least expensive option is the "low cost-sharing" plan. In this plan, the consumer belongs to an HMO⁴⁶ and must use affiliated doc-

³⁹ CLINTON BLUEPRINT, *supra* note 37, at 52; HSA §§ 1201-1202.

⁴⁰ CLINTON BLUEPRINT, *supra* note 37, at 53, 58; HSA §§ 1202, 1221-1224.

⁴¹ CLINTON BLUEPRINT, *supra* note 37, at 60.

⁴² CLINTON BLUEPRINT, *supra* note 37, at 60.

⁴³ CLINTON BLUEPRINT, *supra* note 37, at 60.

⁴⁴ CLINTON BLUEPRINT, *supra* note 37, at 60-65; HSA §§ 1321, 1325.

Senator Edward Kennedy, in consultation with Senator George J. Mitchell, the majority leader, has proposed changes to the President's plan which require all states to establish insurance purchasing cooperatives, but permit employers to purchase insurance from private insurers instead of joining the cooperatives. Senator Kennedy's amendment would also allow individuals to purchase their insurance through the cooperatives or directly from an insurance agent. See Adam Clymer, *Kennedy Proposes Expanded Choices for Health Plan*, N.Y. TIMES, May 10, 1994, at A1, A21.

⁴⁵ See Erik Eckholm, *Introduction* to CLINTON BLUEPRINT, *supra* note 37, at vii, xiii.

⁴⁶ An "HMO" is a "health maintenance organization." It is a group of providers

tors and hospitals that receive preset per capita fees. Patients enrolled in these plans will pay \$10 per office visit.⁴⁷ The most expensive option is a "high cost-sharing" plan. This plan allows consumers to visit any doctor or facility. Doctors are paid on a fee-for-service basis. Families must pay the first \$400, and 20% of all subsequent bills up to a maximum family spending amount of \$3000 per year.⁴⁸ The intermediate option, a "combination" plan, allows patients to pay little for affiliated doctors but requires them to pay more for other doctors.⁴⁹

Although any patient may choose any plan, the HSA creates economic incentives to encourage most people to use the most cost-effective option—HMOs.⁵⁰ The plan is financed through employer contributions,⁵¹ representing 80% of the average-priced plan in the alliance.⁵² Families and individuals

who join together to supply health care to consumers whose health services are prepaid. The providers are usually employees of the HMO and receive a salary from the corporation.

⁴⁷ Eckholm, *supra* note 45, at xiii; HSA § 1135(a).

⁴⁸ HSA §§ 1131, 1133, 1135(a).

⁴⁹ *Id.* §§ 1131, 1134, 1135(a).

⁵⁰ Eckholm, *supra* note 45, at xiii.

⁵¹ This method of financing, requiring employers to pay for the bulk of their employees' insurance, is known as the "employer mandate." The Clinton plan has faced considerable opposition from small and large corporations. To some extent this opposition is attributable to the cost of the employer mandate. The corporate opposition results also from the sentiment that government is intruding upon the corporations' purely private interests. See Louis Uchitelle, *Executives Balking at Clinton Health Plan*, N.Y. TIMES, May 10, 1994, at D1, D8; see also Raymond G. Davis, *Health Care Reform and the Probabilities of Change*, 3 KAN. J.L. & PUB. POL'Y 25, 28 (1993). Some believe that corporations should look toward Hawaii, a state in which employers, regardless of their size, must purchase health insurance for their employees. As a result of this system, approximately 95% of Hawaii's population has health insurance, the premiums are about 30% cheaper than those on the mainland, and the health status of the people has improved. Moreover, although businesses in Hawaii are frustrated over expanding benefits, they have continued to thrive. See Adam Clymer, *Hawaii is a Health Care Lab as Employers Buy Insurance*, N.Y. TIMES, May 6, 1994, at A1, A18.

In an effort to work a compromise between small businesses and the Clinton Administration, Senator Edward Kennedy has proposed changing the President's bill to exempt employers with five or fewer workers from paying for their employees' health insurance. Instead, employers of 5 or fewer employees would pay a 2% payroll tax. The workers would be required to purchase insurance themselves with subsidies for those with lower incomes. See Clymer, *supra* note 44, at A21.

⁵² CLINTON BLUEPRINT, *supra* note 37, at 257. To an extent, the Administration has already stepped back from this position. One of the original three compromise

pay the difference between the 80% of the average-priced premium and the actual cost of the plan they select.⁵³ Families whose incomes fall below 150% of the poverty level may apply to their regional alliance for help in paying the premiums. The health alliance will grant subsidies to these low-income families based upon family income and the average premium in the alliance.⁵⁴ The federal government will bear the cost of the subsidies.⁵⁵

Persons under 65 years old who are Medicaid recipients and do not receive Aid to Families with Dependent Children ("AFDC") or Supplemental Security Income ("SSI") cash payments will no longer receive insurance through Medicaid.⁵⁶ Those persons will enter regional health alliances based on their employment status.⁵⁷ For AFDC and SSI cash recipients, Medicaid will make payments to the regional health alliances rather than directly to providers. Like other members of the health alliances, cash assistance recipients can choose among a variety of plans participating in the alliance.⁵⁸ Medicaid patients can choose a plan at or below the weighted average premium for the alliance without making any payment.⁵⁹

The HSA contemplates that universal coverage and a comprehensive benefits package may not be sufficient to provide equal and quality care to poor and underserved groups. Thus, it requires the alliances to adjust premium payments to health plans to reflect the level of risk assumed for patients enrolled, in comparison to the level of risk of the average population in

plans offered by Senator George Mitchell of Maine (with White House support) requires employers to pay only 50% of the cost of the average premiums charged to their workers. This plan also reduces the benefits package by 5%. See Adam Clymer, *Senator Outlines Cheaper Versions of Health Plan*, N.Y. TIMES, Apr. 18, 1994, at A1, A11 [hereinafter Clymer, *Cheaper Versions*]. The most recent Mitchell plan would not require employers to pay until the year 2002, if at all. See Adam Clymer, *Senate's Leader Unveils His Plan for Health Care*, N.Y. TIMES, Aug. 3, 1994, at A1 [hereinafter Clymer, *Leader Unveils Plan*].

⁵³ CLINTON BLUEPRINT, *supra* note 37, at 257.

⁵⁴ CLINTON BLUEPRINT, *supra* note 37, at 257-58; HSA §§ 1371-1375.

⁵⁵ CLINTON BLUEPRINT, *supra* note 37, at 257-58.

⁵⁶ CLINTON BLUEPRINT, *supra* note 37, at 229.

⁵⁷ Undocumented workers will continue to receive Medicaid for emergencies because they are not covered by the plan. CLINTON BLUEPRINT, *supra* note 37, at 229.

⁵⁸ CLINTON BLUEPRINT, *supra* note 37, at 229-30.

⁵⁹ CLINTON BLUEPRINT, *supra* note 37, at 230.

the area.⁶⁰ This mechanism permits the alliances to take into account such risk factors as age, gender, health status and services to disadvantaged populations.⁶¹ The HSA also permits the states to use financial incentives for plans enrolling disadvantaged groups of the population.⁶²

As an alternative to the health alliance model, states may choose to operate a single-payer system.⁶³ Under a single-payer system, the state or its designated agency makes all payments directly to health care providers without intermediaries, health plans or other entities assuming the financial risk.⁶⁴ Groups of providers, however, may establish HMOs or other networks under single-payer plans that assume the risk by accepting capitated payments⁶⁵ to cover their patients' health needs.⁶⁶ The single-payer system must provide, at a minimum, the mandatory comprehensive benefits package.⁶⁷ Moreover, under the single-payer option, any copayments by consumers or deductibles cannot exceed those charged by regional health alliance plans.⁶⁸ Single-payer systems also must comply with the Act's requirements for quality management and the collection of health data imposed on health plans and alliances.⁶⁹

A single-payer system is financed in part by employer contributions. The HSA requires employers in a single-payer system to pay at least the amount they would be required to pay if they were located in a state with an alliance system.⁷⁰ It also permits the state to use any other financing method

⁶⁰ CLINTON BLUEPRINT, *supra* note 37, at 91.

⁶¹ CLINTON BLUEPRINT, *supra* note 37, at 91.

⁶² CLINTON BLUEPRINT, *supra* note 37, at 92.

⁶³ The Act contemplates two types of single-payer plans: a state-wide single payer system, HSA § 1223, and an alliance-specific single-payer system. *Id.* § 1224.

⁶⁴ *Id.* § 1222(4)(A).

⁶⁵ "Capitated payments" are preset amounts paid each year to the HMO for each individual enrolled in the plan, as opposed to the familiar fee-for-service payments, which require payment for each individual service or treatment the provider gives.

⁶⁶ HSA § 1222(4)(B).

⁶⁷ *Id.* § 1222(5)(A).

⁶⁸ *Id.* § 1222(7).

⁶⁹ *Id.*

⁷⁰ *Id.* § 1223(d)(1).

consistent with this section.⁷¹ Presumably, state income taxes would be one financing method. Although a single-payer system may eliminate the requirements that the consumer share in the cost of health care, the state must appropriate revenues from sources other than those established by the HSA to support delivery of a comprehensive benefits package equal to or greater than that required by federal statute.⁷² States choosing the single-payer option are likely to receive most, if not all, of the federal grants allowed for technical assistance.

Finally, several provisions affect the poor's equal access to quality care. For example, the Act includes a number of initiatives to improve access to disadvantaged groups. Among them are: expansion of the National Health Service Corps to reduce the shortage of primary care practitioners in underserved areas; continued grants for specific populations such as the homeless; new grants to provide loans to community-based providers and to encourage capital infrastructure development; new grants to provide for outreach and enabling services to the underserved; and the creation of essential community providers.⁷³

B. Recent Democratic Proposals Modifying the Clinton Plan

On the eve of publication of this Article, in an effort to gain political support for Clinton's health care reform proposals, House and Senate democrats unveiled two plans which modify the Clinton plan.⁷⁴ Like the Clinton plan, both the House and Senate bills would forbid insurance plans from

⁷¹ HSA § 1223(d)(2).

⁷² *Id.* §§ 1223, 1229(1), (2).

⁷³ CLINTON BLUEPRINT, *supra* note 37, at 208-10. The "essential provider" program provides that, during the first five years of reform, health plans contract with and reimburse established community-based providers. HSA §§ 1431-1432. Professor Vernellia R. Randall argues forcefully that these provisions are inadequate. *See* Randall, *supra* note 15, at 195-97.

⁷⁴ Because these plans are extremely long and were largely unavailable at the time that this issue went to print, this description of the plans relies on reporting contained in the following: Marcia Borkowski, *Compare and Contrast: How the House and Senate Bills Stack Up Against the President's Original Proposal*, N.Y. TIMES, Aug. 3, 1994, at A18; Clymer, *Leader Unveils Plan*, *supra* note 53, at A1; Hilary Stoudt & David Rogers, *Mitchell Says Health-Care Plan Aims to Represent 'What is Best' for U.S.*, WALL ST. J., Aug. 4, 1994, at A14; *House Dems Unveil Health Reform Plan*, STAR-LEDGER, July 30, 1994, at 1.

denying coverage or renewal to any eligible individual or group, including persons with pre-existing conditions.

The House bill, proposed on July 29, 1994, by the House majority leader, Richard Gephardt, would guarantee universal health insurance coverage by January 1, 1999. Like the Clinton plan, it also would guarantee a basic package of comprehensive benefits. But it also includes some new benefits, including a long-term care program that provides home and community-based services to persons with severe disabilities. In addition, the federal government would subsidize, on a sliding scale, the purchase of insurance by persons with income levels up to 250% of the federal poverty level, or \$38,444 for a family of four.

The Gephardt bill requires all employers to offer at least one health insurance plan with an unlimited choice of providers and one managed care plan. Like the Clinton bill, it includes an employer mandate, requiring employers to pay 80% of the health care insurance premiums and employees to pay the remaining 20%. The Gephardt employer mandate would apply to large employers in January, 1997, but small firms would have until 1999 to meet this requirement. Under the plan, small employers with low-wage earners would be eligible for federal subsidies that would reduce their costs by half. The Gephardt plan, however, eliminates the Clinton bill's requirement that employers buy their insurance through purchasing cooperatives.

Unlike the Clinton plan, the Gephardt bill would not rely on mandatory price controls to keep health care insurance affordable. Instead, it foresees that increased competition created by the bill would control costs. If, however, increased competition has not worked to control costs in accordance with federal targets within 5 years, the Gephardt bill would require the government to set fee schedules for hospitals and doctors in states that have exceeded federal price-control targets.

The Senate bill, proposed by Senate majority leader George Mitchell on August 2, 1994, differs significantly from the Clinton plan. Instead of ensuring universal coverage, it seeks to cover 95% of Americans (up from 85%) by the year 2000, through voluntary purchasing cooperatives, insurance market reforms and federal subsidies. Contrary to the Clinton plan, the Mitchell bill contains no employer mandate. Instead,

it requires employers to offer, but not pay for, at least three different types of plans, including a traditional fee-for-service plan and a managed care plan. It also permits, but does not require, businesses with fewer than 500 employees to buy coverage through health insurance purchasing cooperatives, which the bill requires the states to establish.

Welfare recipients, self-employed persons and persons working for companies with fewer than 500 employees could buy their coverage through the program that provides health insurance to federal employees. The Mitchell bill would also provide full federal subsidies of health insurance premiums for persons whose income falls below the federal poverty level. It would also pay the full cost of insurance for pregnant women and children with incomes up to 185% of the poverty level.

According to the Mitchell plan, if 95% coverage is not achieved by January 1, 2000, a federal commission would make recommendations to Congress concerning how to achieve that goal. If Congress did not act on the recommendations by December 31, 2000, a system for ensuring coverage would take effect automatically. Employers with more than 25 employees, doing business in states that have not reached the 95% coverage level by January 2002, would be required to pay 50% of the premiums for their employees' insurance. Like the Gephardt bill, the Mitchell plan does not include mandatory price controls. Instead, it would impose a 25% tax on health insurance plans whose costs grow faster than the pace prescribed by a federal commission.

C. Other National Proposals

There are currently a number of other health care proposals before Congress. This section will briefly describe three that represent different places along the political spectrum: H.R. 1200, a single-payer bill sponsored by Democratic Representative Jim McDermott of Washington state;⁷⁵ H.R. 3080, a conservative bill sponsored by Republican Representative Bob

⁷⁵ H.R. 1200, 103d Cong., 1st Sess. (1993) [hereinafter the McDermott bill]. This same bill was introduced into the Senate by Senator Paul Wellstone of Minnesota, as S. 491, 103d Cong., 1st Sess. (1993).

Michel of Illinois;⁷⁶ and H.R. 3222, a somewhat more moderate bill sponsored by Democratic Representative Jim Cooper of Tennessee.⁷⁷

The McDermott bill is a single-payer bill based on the Canadian system. It is federally financed but substantially run by the states. It grants universal coverage, allows for a generous benefits package that covers all inpatient and outpatient medical services, long term care, home care and hospice care.⁷⁸ It neither permits copayments or deductibles, nor allows providers to charge for authorized services.⁷⁹

The McDermott bill requires the states to pay providers directly within a global budget set by a national board.⁸⁰ Its supporters emphasize that although it permits groups of doctors to practice within the HMO model, it preserves the patient's choice of provider by not creating incentives to join HMOs. Furthermore, it operates under global budgets that control costs, but eliminates the insurance companies' role in deciding which services it will cover. Thus, it preserves the integrity of professional medical decisions.

The Michel bill requires employers to offer, but not to pay for, insurance coverage for all of their workers.⁸¹ Employees cannot be excluded from insurance coverage for pre-existing conditions and cannot lose their insurance if they change jobs.⁸² It also permits states to use private insurance for Medicaid beneficiaries and permits the uninsured to buy into the Medicaid program, with graduated subsidies for those persons whose income does not exceed 200% of the poverty line.⁸³ It seeks to contain health care costs through malpractice reform, administrative reform, antitrust reform, anti-fraud provisions

⁷⁶ H.R. 3080, 103d Cong., 1st Sess. (1993) [hereinafter the Michel bill].

⁷⁷ H.R. 3222, 103d Cong., 1st Sess. (1993) [hereinafter the Cooper bill]. Although the Cooper bill is considered to be a moderate bill, it does not grant universal coverage like the Clinton plan and its benefits package has not been established. See *infra* notes 145-62 and accompanying text for a description of Ron Pollack's speech.

⁷⁸ The McDermott bill § 201.

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ The Michel bill § 1001(a).

⁸² *Id.* § 1011.

⁸³ See *id.* §§ 1601, 1701.

and state Medicaid flexibility.⁸⁴

The third proposal, the Cooper bill, takes a market-based, "managed competition" approach that differs substantially from the Clinton bill.⁸⁵ Like the Michel bill, the Cooper bill does not require employers to pay for their employees' health insurance and does not impose global budgets or price controls.⁸⁷ Instead, the bill uses tax incentives to encourage providers and insurance companies to form health partnerships.⁸⁸ It provides for regional purchasing cooperatives to give individuals and small businesses greater purchasing power.⁸⁹ And rather than specifying basic benefits, it establishes a national commission to write a uniform set of health benefits.⁹⁰

Moreover, the Cooper bill provides that the federal government will pay health plan premiums for all persons below 100% of the poverty level and grants sliding scale subsidies to persons whose income falls between 100% and 200% of the poverty level.⁹¹ It eliminates state obligations to finance Medicaid but requires states gradually to assume responsibility for long-term care for the poor.⁹²

⁸⁴ See generally *id.* §§ 2001-2801.

⁸⁵ See *infra* notes 145-62 and accompanying text for a description of Ron Pollack's speech.

⁸⁶ The Cooper bill § 2. The Congressional Budget Office has estimated that not quite 15 million people, or slightly fewer than 40% of those uninsured, could obtain health insurance under the Cooper bill. The bill would still leave approximately 24 million people without coverage. Moreover, according to the Congressional Budget Office, the Cooper bill could conceivably increase the federal budget deficits by a total of \$301 billion, or 14% over 10 years, if all the subsidies it promises to low-income people are paid. See Robert Pear, *A Go-Slow Plan on Health Gains Support in Congress*, N.Y. TIMES, May 5, 1994, at B14.

⁸⁷ The Cooper bill § 2.

⁸⁸ *Id.* §§ 1001-1104.

⁸⁹ *Id.* §§ 1101-1103.

⁹⁰ *Id.* §§ 1301-1303.

⁹¹ *Id.* § 2002.

⁹² The Cooper bill § 2101.

III. POLITICAL CHOICES: THE POSITION OF ADVOCATES FOR THE POOR AND UNDERSERVED IN THE NATIONAL DEBATE OVER HEALTH CARE REFORM

A. *The Clinton Proposal Versus a Single-Payer Plan*

A number of speakers generated substantial audience discussion about whether those representing the poor should refuse to give up their traditional support of a single-payer system⁹³ or compromise by supporting the Clinton plan.⁹⁴ Some angrily called compromise the same old "trickle down effect" which does not work to help the disadvantaged. Others argued that if advocates for the poor worked together for a single-payer bill there may be enough public support to pass such a plan. Others disagreed, arguing that because there is little support for a single-payer plan, advocates for the poor should take advantage of the rare opportunity for substantial reform presented by the Clinton bill. According to this view, advocates should concentrate their efforts on strengthening provisions in the bill and proposing new measures to ensure delivery of quality care to the poor and underserved.

Dr. David Himmelstein of Harvard Medical School argued that only a single-payer, Canadian-style system would meet the needs of poor Americans. Dr. Himmelstein described the staggering economic barriers to care for persons who are poor and disadvantaged in the United States. He noted that a large percentage of persons cannot get care because they are uninsured. He stated that approximately 200,000 people are denied coverage annually in emergency rooms in this country because they cannot pay for treatment.⁹⁵ He further stressed that infant mortality is no longer declining in this country. According to Dr. Himmelstein, the maternal mortality rate of black women is rising and men in Harlem have shorter life expectancies than those living in Bangladesh.⁹⁶

⁹³ See *supra* text accompanying notes 78-80 (describing the McDermott single-payer plan).

⁹⁴ See *supra* text accompanying notes 36-74 (describing the Clinton plan).

⁹⁵ This is apparently in spite of a federal statute prohibiting hospitals from "patient dumping," the practice of turning away persons from emergency rooms because of their lack of insurance. See *supra* text accompanying notes 8-9.

⁹⁶ According to Dr. Himmelstein, South Africa and the United States are the

To solve these problems, Dr. Himmelstein proposed a Canadian-style single-payer system which would be federally mandated and funded, but administered largely at the state and local levels. The Canadian system is a national health insurance program⁹⁷ that provides block grants to provinces.⁹⁸ It requires the provinces to grant universal coverage; it prohibits the provinces from collecting copayments and deductibles;⁹⁹ it guarantees the portability of coverage from one province to another; and it guarantees coverage of all necessary health services without setting up a specific benefits package. Dr. Himmelstein has argued that a similar system if

only two developed nations in the world without universal health insurance coverage. Dr. Himmelstein also explained that race is a proxy for class in discussions about poverty because the United States and South Africa are the only two developed nations that collect health data by race and not by class.

Professor Sidney Watson has noted other shocking statistics:

The poverty rate for Black families is three times the rate for white families. A third of all Black households, and almost half of all Black children, live in poverty. . . . Black infants are twice as likely to die before their first birthday than are white infants. Babies born in America's inner cities are more likely to die than babies in Costa Rica and Jamaica. . . . [N]ineteen developed countries have lower infant mortality rates than the United States.

See Watson, *supra* note 14, at 1648-49.

⁹⁷ Canadians call their single-payer plan "Medicare." Although British Columbia established a Commission to study the possibility of providing a "Provincial System of Health Insurance" in 1936, it was not until the late 1950s that all provinces had universal hospital insurance, and early 1971 when all provinces provided medical insurance. See Peter D. Seaton, *A Canadian Answer*, 3 KAN. J.L. & PUB. POL'Y 15, 16-17 (1993).

In addition to hospital and medical insurance, the Canadian government contributes to, and all provinces have programs providing for, nursing home care. Other services, such as home nursing care, homemaker care, public health nursing and ambulance services, vary from province to province. Most provinces contribute to the cost of drug prescriptions as well. *Id.* at 17.

⁹⁸ According to the Canadian Constitution, health care is a provincial responsibility. Because the provinces have limited taxing authority and some are more prosperous than others, the Canadian government has devised two systems of procuring money for the provinces to provide health care. First, the Canadian government taxes on a federal level and distributes grants to the provinces, usually favoring the less prosperous provinces. Second, the Canadian government pays a share of the costs of certain health services provided by the provinces. See *id.* at 15.

⁹⁹ Although there has been pressure from some groups to institute user fees—for example a \$10 fee for each visit to the doctor—Canada has resisted the pressure because the health care system is used most heavily by the wealthy who would not be deterred by a modest fee, whereas a user fee may create a barrier to access for the poor. See *id.* at 18.

adopted in this country would "eliminate economic barriers to care, minimize economic incentives for both excessive and insufficient care, discourage administrative interference and expense, improve the distribution of health facilities, and control costs by curtailing bureaucracy and fostering health planning."¹⁰⁰ According to Dr. Himmelstein, a single-payer system would eliminate the insurance companies and their profit motive from the health care field.

Dr. Himmelstein further argued that the Canadian system offers better care for less money. He noted that although the Canadians' health care costs rose at a comparable rate to those of the United States before Canada implemented the single-payer system, Canada's health costs have flattened out since adopting the system while costs in this country have skyrocketed.¹⁰¹ He attributed half of Canada's savings to its system's lack of bureaucracy. For every dollar Americans pay in, according to Dr. Himmelstein, 14 cents goes to the private insurance industry, whereas Canadians pay only 0.7 cents per dollar for administration of their program.¹⁰²

Dr. Himmelstein also noted that the Clinton plan encourages, if not requires, "managed care,"¹⁰³ even though patients prefer to go to their individual doctors rather than an HMO doctor and the costs of managed care are as high as those for traditional insurers.¹⁰⁴

Dr. Himmelstein specifically attacked the employer mandate included in the Clinton plan as failing to address the

¹⁰⁰ See David U. Himmelstein et al., *A National Health Program for the United States*, 320 NEW ENG. J. MED. 102 (1989).

¹⁰¹ Canada now spends approximately 20% less than the United States per capita on health care. See Seaton, *supra* note 97, at 18.

¹⁰² Doctors in Canada are paid in a similar fashion to doctors whose patients have private insurance here. For example, in British Columbia, there is a Medical Services Commission. The Medical Services Commission negotiates with the Medical Association for a fee schedule. After rendering services, doctors bill the Commission through a computer network. See Seaton, *supra* note 97, at 19.

¹⁰³ "Managed care," as many of the speakers at the Symposium noted, is capable of many definitions, but Dr. Himmelstein appeared to define it as that care given by a group of providers joining together to give care in an HMO-type setting.

¹⁰⁴ To demonstrate the bureaucratic inefficiencies of a "managed care" plan, Dr. Himmelstein cited Prudential's Managed Care Plan in New Jersey, which enrolls 110,000 people. This plan employs 18 nurse reviewers, 5 physicians, 8 provider recruiters, 15 sales representative, 27 service representatives and 100 clerks to administer coverage.

health care needs of the poor and disadvantaged. Under the Clinton plan, the employer pays for its employees' health insurance. According to Dr. Himmelstein, such a requirement is regressive because it effectively deducts the amount of insurance from an employee's wages.¹⁰⁵ A well-paid Chief Executive Officer of a company pays the same amount for insurance as does the CEO's relatively low paid secretary, Himmelstein noted. Dr. Himmelstein argued that financing through a progressive income tax would be more equitable.

Dr. Himmelstein vigorously rejected the possibility of compromise with Clinton plan supporters. He deeply disagreed with Professor Theodore Marmor who argued that representatives of the poor should debate for a compromise between those supporting a single-payer plan and those supporting the Clinton plan.¹⁰⁶ The Clinton plan, according to Dr. Himmelstein, is the wrong starting point for the debate. He argued that it would be an enormous mistake for advocates of a single-payer system to orient their work around the legislative process in Washington, D.C., and to assume that a single-payer system is not politically feasible. He suggested that the vast majority of Americans would support a single-payer bill, and argued that through grassroots organization, Americans should make their preferences known. Dr. Himmelstein stressed that it is important to identify a liberal critique explaining why the Clinton bill fails dramatically.

In response to Professor Marmor's suggestion that advocates support the portion of the Clinton plan allowing for state experimentation with a single-payer option,¹⁰⁷ Dr. Himmelstein argued that some states will have terrible health care systems if allowed to experiment. These systems, according to Dr. Himmelstein, will be extremely harmful to the poor

¹⁰⁵ The current health care system is financed in a regressive fashion. For example, the poorest 10% of Americans, receiving 1.3% of the nation's total income, pay 3.9% of the nation's health care costs. By contrast, the wealthiest 10%, receiving 33.8% of the nation's income, pay only 21.7% of health costs. In Great Britain, the roles are reversed. The bottom 10% earn 2.3% of the income, but pay only 1.7% of health care costs. The top 10% earn 24.9% of income and pay 25.6% of health care costs. See Richard D. Lamm, *The Good News & the Bad News About Access*, 3 KAN. J.L. & PUB. POL'Y 5, 7-8 (1993).

¹⁰⁶ See *infra* text accompanying notes 109-17 for a description of Professor Marmor's comments.

¹⁰⁷ HSA §§ 1221-1224; see also *infra* text accompanying notes 109-17.

and underserved in these areas. Finally, Dr. Himmelstein argued that the Clinton bill is worse than the status quo because it accelerates economic pressures on the health care system and will lead to increased corporatization of care.¹⁰⁸ Under the Clinton plan, Dr. Himmelstein believes, the insurance industry will consolidate to increase its control over the system. The ultimate question, Dr. Himmelstein asked, is whether a democratically controlled single-payer system is preferable to a private entrepreneurial system. His answer was an emphatic "yes."

Professor Theodore R. Marmor, from the Yale School of Organization and Management, disagreed. He argued that the political moment has arrived for health care reform. Although he, too, would prefer a single-payer plan, he advocated seizing the moment and working to change the unacceptable portions of the Clinton plan. Professor Marmor noted that the Clinton proposal is a starting point and no one, including the President himself, expects that the plan will be adopted as is. He argued that reform that is good for the middle class is also good for the poor.¹⁰⁹

Professor Marmor emphasized that there is no national consensus for imminent health care reform.¹¹⁰ Health care

¹⁰⁸ This is exactly the trend that Professor James F. Bresnahan, Co-Director of the Ethics and Human Values in Medicine Program and Professor of Clinical Medicine at Northwestern University Medical School, seeks to avoid in reforming medical care. Professor Bresnahan notes that there is currently a heavy emphasis on controlling the increases in health care costs. Although he acknowledges that costs are important, Professor Bresnahan urges that "the first prerequisite of a concrete proposal to broaden access to health care should be that it preserve, if not enhance, the historic character of health care-giving as a fundamentally personalized, compassionate response to human suffering, especially to the suffering of the most disadvantaged." James F. Bresnahan, *Compassionate Response to Human Suffering: A Neglected Issue in Health Care Reform*, 3 KAN. J.L. & PUB. POL'Y 23 (1993).

¹⁰⁹ Professor Marmor expounds on this notion that reform must be "universalistic" rather than directed at the poor and disadvantaged. See Theodore R. Marmor, *The National Agenda for Health Care Reform: What Does it Mean for Poor Americans?*, 60 BROOK. L. REV. 83 (1994).

¹¹⁰ This national mood seems to contrast with that in Canada at the time of its national health care reform. In Canada, there was, and still is, almost universal support for a government-funded, single-payer program. At the time of the passage of the 1967 Medical Care Act, which provided that if the province had a medical care scheme that met the federal government's criteria, the federal government would pay one-half the cost of the program, all three political parties in Parliament favored the Act. See Seaton, *supra* note 97, at 17.

reform reached the top of the political agenda, according to Professor Marmor, because the issue provided political advantage to Democrats challenging President Bush. Professor Marmor noted that every one of the problems cited by advocates of national health reform has existed for more than a decade. And, according to Professor Marmor, advocates for reform do not have the political alignment in the House and Senate that has existed in the past when major reform legislation has been enacted.¹¹¹ This lack of consensus has confused the debate over reform.

Professor Marmor argued that the debate over health care reform is extremely confusing because the country is debating two issues at the same time: whether there should be reform and, if so, what type of reform is necessary.¹¹² By fusing these two issues, advocates from all sides have the motivation to overemphasize the strengths of their own proposals and the weaknesses of alternative plans. The debate over reform, according to Professor Marmor, is characterized by myths and apprehensions. Labels such as "single-payer," "managed competition," "health alliances" and "managed care" have little or no meaning and are merely a substitute for real thought and discussion about what type of health reform is necessary.¹¹³

According to Professor Marmor, those seeking health care reform are caught between the proverbial rock and hard place. The rock is the perceived inability to pass a single-payer plan, a system advocates for reform know will work. The hard place is the perceived ability to do something health care reformers are not sure will work, a system of managed competition.¹¹⁴

¹¹¹ For example, the Senate and House were overwhelmingly Democratic when the Civil Rights Act of 1964 was enacted.

¹¹² In *Health Care Reform and the Probabilities of Change*, Raymond G. Davis, Associate Professor of Government/Health Services Administration at the University of Kansas, echoes Professor Marmor's point that the debate is misleading. Referring to a term coined by James Morone, Mr. Davis notes that there is a "dulling quality" to the political discussion about health care because policymakers attempt to avoid the complex issues. Davis, *supra* note 51, at 27. Davis further argues that the political system requires simplistic prescriptions, even though comprehensive change requires a much more complex analysis. Thus, political discussion focuses on "limited facets of reform." *Id.*

¹¹³ For an elaboration on the misconceptions caused by these labels see Marmor, *supra* note 109, at 87-93.

¹¹⁴ Professor Davis makes a similar point. He argues that the health care problem requires a substantial, comprehensive new policy approach, but the political

Professor Marmor's solution is to begin to debate the subject seriously and deeply. During the debate, advocates for health reform should insist upon universal coverage, cost controls and state experimentation. Universal coverage must be linked to cost controls because without them, universal coverage would cause staggering inflation of health services costs, eventually causing the system to fail miserably.¹¹⁵

Moreover, in direct contrast to Dr. Himmelstein's opinion, Professor Marmor identifies an important provision of the Clinton plan that, in his opinion, gives states the option of adopting a "single-payer" approach.¹¹⁶ Professor Marmor advocates mobilizing supporters of a single-payer system around the principle that states with political support for this system should be encouraged to adopt it. Because the single-payer model eliminates insurance companies, raising revenues through taxation and paying the providers directly, Professor Marmor noted, it may be the most cost-effective system. But, Marmor opined there are deep ideological divisions in this country about health care reform and, in particular, about a single-payer plan. Thus, according to Professor Marmor, state experimentation is an important part of the Clinton bill because it may not be until the single-payer and managed competition models are tested throughout the country that the electorate will be convinced of the desirability of a single-payer plan.¹¹⁷

process is structurally resistant to fundamental change. See Davis, *supra* note 51, at 29.

¹¹⁵ Professor Davis would agree. In *Health Care Reform and the Probabilities of Change*, *supra* note 51, Professor Davis argues that the incremental reform of the past has only delayed problems. But comprehensive reform is politically risky. He notes that policy initiatives of the past have not only failed to deal with rising costs and decreased access to insurance but have actually exacerbated problems. Medicare and Medicaid, for example, have improved access but have also caused substantial cost increases. *Id.* at 26. These policies have caused the price increases by "insulating providers from the implications of the way they practice and organize medicine." *Id.* at 29. Moreover, according to Professor Davis, because doctors have been paid on a fee-for-service basis, past reimbursement policies have encouraged providers to overtreat patients in order to get more reimbursement. *Id.*

¹¹⁶ HSA §§ 1221-1224. This provision was passed upon the insistence of Senator Paul Wellstone from Minnesota, a state with a long history of progressive health care.

¹¹⁷ Presumably, the corollary is that if managed competition works in certain states, the supporters of a single-payer plan may convert to a belief in the managed competition model. Of course, because of the economic conditions in different

Professor Vernellia Randall took issue with both Dr. Himmelstein's and Dr. Marmor's comments. According to Professor Randall, even a national health insurance plan like Canada's would not solve the problems ethnic Americans face in attaining equal and quality health care. Although national health insurance may break down economic barriers to quality health care, Professor Randall asserted that many non-economic barriers still remain in the way of equal and quality health care: class barriers, inadequate infrastructures, racial barriers, cultural barriers and language¹¹⁸ or communication barriers. Without eliminating these impediments, the HSA defines the need for health reform in "ideological, financial and legalistic terms," and essentially disregards the African American health crisis.¹¹⁹

Professor Randall argued that ethnic Americans need a unitary, national, largely government-run health care system grounded in health-based goals and objectives. The health care system proposed by the Clinton Administration is structurally and ideologically flawed because: its ethical foundations are

states, different models may work better or worse in particular states.

In his article, *The National Agenda for Health Care Reform: What Does it Mean for Poor Americans?*, Professor Marmor expounds on the necessary characteristics of health reform that will benefit the poor as well as the middle-class. According to Professor Marmor, an acceptable "fusion plan," one with both substantive and political merit, must contain: (1) broad-based financing; (2) universal eligibility and broad coverage; (3) tough cost controls limiting medical budgets to the nation's rate of growth; (4) rewards for more efficient group providers; (5) measures simplifying health insurance for patients, payers and providers; (6) provisions which ensure clear accountability for cost, quality and accessibility of care; (7) patients' freedom to choose doctors; and (8) a means of consultation and redress. See Marmor, *supra* note 109, at 94-95.

¹¹⁸ Raphael Metzger agrees that cultural and language barriers create significant barriers to access to care and effective service delivery. See Metzger, *supra* note 10. He notes that culture causes Mexican Americans, for example, to use preventive services less than general populations even where they have access to health insurance. He argues that linguistic accommodations must be made to provide greater access to the Hispanic population to government-funded health care. Although a failure to provide an interpreter and health care information in Spanish may not demonstrate intentional discrimination against Spanish-speaking people in this country, it creates a discriminatory effect on their use of health care services, Metzger argues. *Id.* at 32-35.

¹¹⁹ Randall, *supra* note 15, at 176 (quoting W. Michael Byrd & Linda A. Clayton, *The American Health Dilemma Continues: An Analysis of the Clinton Health Plan from an African American and Disadvantaged Patient Perspective* 4-5 (Oct. 27, 1993)).

incomplete and inadequate; it focuses on state's rights; it continues an employment-based health insurance system; it expands the "private sector" role in health care delivery; and, it does not ensure representation of ethnic Americans and the underserved in policy-level decisions.

Professor Randall believes, as does Dr. Himmelstein, that advocates for poor and ethnic Americans should oppose the Clinton plan. The Clinton plan according to Professor Randall will perpetuate an unequal and fragmented system for the poor. For example, Professor Randall argued that financial incentives to encourage providers to care for ethnic Americans are not new and have never worked. Furthermore, according to Professor Randall, the bill provides only minimum, if any, protection for community providers.

Professor Randall advocated maintaining the status quo because as health care delivery and quality continue to deteriorate there should be more support for more comprehensive and equitable reform. Professor Randall disagreed with those supporting incremental change. According to Professor Randall, the Clinton plan, if passed, may have the undesirable effect of satisfying the middle class. Once this country gets a system that is acceptable to the middle class, she argued, it will be impossible to make the incremental changes needed to ensure equal and quality care for ethnic Americans.¹²⁰

Professor Sara Rosenbaum, Senior Health Advisor to the White House Domestic Policy Council, one of the primary authors of the Clinton plan, defended the bill. In *Setting a Place for Ed Sparer at the National Health Reform Table*,¹²¹ Professor Rosenbaum argued that advocates for the poor should not judge the Act by its method of financing. Instead, she argued, they should support the bill because it contains many

¹²⁰ In her article, *Health Care Reform: Does Clinton's Health Care Reform Proposal Ensure (E)qual(ity) of Health Care for Ethnic Americans and the Poor?*, Professor Randall concludes that although the Act makes an effort to assure equality, it proves inadequate. She specifically criticizes the Act for not requiring that health plans enroll a certain percentage of ethnic Americans, for not requiring care that is culturally competent, for not requiring that ethnic Americans be placed on consumer advisory boards, for continuing a two-tiered system in which the rich will be able to afford to buy more comprehensive services and for inadequate provisions outruling discrimination. See *supra* note 15.

¹²¹ Sara Rosenbaum, *Setting a Place for Ed Sparer at the National Health Reform Table*, 60 BROOK. L. REV. 71, 76 (1994).

provisions that could improve health care delivery to poor people.

According to Professor Rosenbaum, the political climate in the country would not support a single-payer bill. Unlike Dr. Himmelstein, who foresees that the Clinton bill would lead to the domination of the health insurance field by a few non-competitive insurance companies, Professor Rosenbaum believes that groups of doctors will organize themselves and self-insure, fostering competitive prices and ensuring that health care quality decisions remain with providers.¹²² She also noted that the bill gives states the option to operate their health plans on a single-payer basis.¹²³

Professor Rosenbaum also argued that there are a number of provisions in the Clinton proposal that improve the status quo for the poor and underserved. First, universal coverage provides the same benefits package¹²⁴ for all Americans.¹²⁵ Second, because there is a pooling mechanism for all the premium contributions,¹²⁶ everyone is subject to the same financing of health care services. Third, the bill creates Resource Development Funds to provide for both the creation of capital funding for community-based practice networks¹²⁷ and the development of the essential provider program,¹²⁸ which will assure that those community programs have the same standing in their communities that any other provider has in any of the areas served by the plan. Finally, the bill has some strong anti-discrimination provisions to help protect the poor and underserved from unlawful discrimination.¹²⁹

In her speech, "Necessary Moral Foundations for Health

¹²² *Id.* at 79.

¹²³ *Id.* at 74.

¹²⁴ Women, the elderly and the disabled have criticized the benefits package as not entirely meeting their needs. Senator Kennedy's proposed changes would add benefits to these groups by requiring middle and upper income patients to pay somewhat higher out-of-pocket expenses. For example, where the Clinton plan provides mammograms every two years for women over the age of 50, the Kennedy amendment would provide them annually. Moreover, the Kennedy plan would offer greater benefits for mental health, drug and alcohol abuse. See Clymer, *supra* note 44, at A21.

¹²⁵ Rosenbaum, *supra* note 121, at 73.

¹²⁶ Rosenbaum, *supra* note 121, at 73.

¹²⁷ See generally HSA §§ 3401-3484.

¹²⁸ *Id.* §§ 1431-1432.

¹²⁹ *Id.* § 1402(c).

Care Reform," Professor Nancy Neveloff Dubler, Director of the Division of Bioethics, Department of Epidemiology and Social Medicine of Montefiore Medical Center and Professor of Bioethics at the Albert Einstein College of Medicine, echoed the themes raised by Professors Marmor and Rosenbaum, but emphasized certain values which advocates for the poor and underserved should not sacrifice. Professor Dubler, a member of the National Health Center Reform Task Force, argued that the political moment is ripe for health care reform and that advocates for the poor and underserved must take advantage of it. She noted that the American system has a commitment to maintain inequalities and that it would be unrealistic to expect health care reform to bear the burden of curing all of the social inequalities and inefficiencies in the country. According to Professor Dubler, current health care reflects the racist biases of American society and the Clinton plan alone will not change those biases. Professor Dubler argued, however, that the plan creates an opportunity for advocates of the poor and underserved because it struggles to reflect decent values of equality and universal coverage that have not been at the top of the political agenda for more than a decade.

Professor Dubler identified three essential, powerful notions included in the bill that could improve health care for the poor: the notion of caring for all, or universal coverage; the notion of making the system work; and the notion of choice and responsibility. Professor Dubler argued that advocates for the poor and underserved must fight to preserve these three values.

Although the Clinton bill purports to grant universal coverage, Professor Dubler noted that the Clinton bill does not provide universal coverage because it excludes undocumented workers. Huge numbers of undocumented individuals reside in New York, Florida, California and Texas. Professor Dubler argued that representatives of the poor should fight to include undocumented persons for two reasons. First, these workers are in the country because it is useful to the society to have them.¹³⁰ Second, almost all families with undocumented per-

¹³⁰ Emanuel Leventhal, associate director of the New Jersey division of the International Ladies' Garment Workers' Union agrees. He opines that illegal immigrants fill "jobs left by other immigrants who have 'moved up.'" *See* Ivette Mendez,

sons include at least one member, usually a child, who is documented.¹³¹ The society can take care of these children by caring for the adults around them.

The notion of caring for all is reflected in the Clinton plan's comprehensive benefits package. Professor Dubler argued that a guarantee of comprehensive, equal benefits is a very worthy goal given the country's history of exclusion.¹³² She emphasized that this history is not present in Canada and therefore, the benefits package is necessary here while it may not be necessary in Canada. The Clinton plan attempts to guarantee intergenerational equity as well, another significant goal to support as the debate continues. The notion of "Making the System Work" includes the wise allocation of resources, cost containment and effective management. Although these do not sound like moral imperatives, Professor Dubler argued that they are, because if society spends too much on health care, it will not have the resources to spend on other important services, such as education.

Finally, Professor Dubler argued that although the notions of choice and responsibility contained in the bill are important, advocates for the poor must realize that these notions could create problems for the poor. She addressed five elements of

Illegal Aliens Called Burden and Benefit, STAR LEDGER, Apr. 12, 1994, at 1, 12. According to Leventhal, the "economic contributions" of legal and illegal immigrants exceed their "economic liabilities." *Id.* In New Jersey, undocumented workers are eligible for emergency medical services through Medicaid. Medical care is particularly necessary for undocumented workers because many of them are working in highly dangerous positions such as asbestos abatement. According to Leonard Katz of the New Jersey Department of Labor, many employers of illegal aliens who work in asbestos abatement do not observe health and safety standards because they know that the immigrants will not report the violations to the authorities. *Id.*

¹³¹ Medical care for children of asbestos abatement workers is particularly crucial because, if the worker does not remove his or her contaminated clothing before entering the home, children's lungs can become infected with asbestos fibers.

¹³² Richard D. Lamm, former governor of Colorado and Director of the Center for Public Policy & Contemporary Issues at the University of Denver, argues that American health care is "technically brilliant, but morally lacking." *See* Lamm, *supra* note 105, at 10. According to Lamm, society must admit that it cannot pay for everything. He criticizes the current model of health care in which "providers . . . have been trained to focus monomaniacally only on the patient." *Id.* Instead of doing everything for the patient, he argues that the physician must consider whether doing so will interfere with the abilities of other patients to obtain basic services. *Id.* So too, he argues, American hospitals must consider their responsibility to the community rather than focusing on individual patients. *Id.*

choice and responsibility that advocates for the poor and underserved must ensure do not operate to ignore the health care needs of the poor: state experimentation with different types of programs; the use of copayments to increase consumers' responsible behavior; the location of clinics; consumers' choice of plans; and discrimination provisions.

The most important aspect of the bill regarding choice, according to Professor Dubler, is that it permits states to experiment with different types of plans so long as they provide universal coverage. Although state experimentation can produce positive results,¹³³ Professor Dubler noted that the bill must provide for close monitoring to assure that states will not be able to use their freedom to experiment as a ruse to offer less care.¹³⁴

Professor Dubler further noted that although some evidence shows that copayments lead to more responsible behavior, they can also provide a barrier to care.¹³⁵ Similarly, advocates must address the issue of how to locate clinics so as to serve the poor and disadvantaged in the best possible way. She questioned whether it is better to locate the clinics for convenience in the inner city, thereby excluding the middle-class population, or to place clinics on the perimeter of the inner city in a less convenient location for the poor in order to serve a more diverse population.

Professor Dubler also noted the difference between healthy consumers of health care and vulnerable, sick patients. While creating reform, society must consider how it can ensure that the decisions that consumers make regarding health care will protect them if they become helpless patients.

Finally, Professor Dubler argued that the bill must assure that there are no patterns of discrimination in treatment. Advocates for the poor must insist on fair procedures for resolving disputes over whether the plans have illegally discriminated against an individual or group of individuals. Furthermore, there must be fair procedures for deciding whether the plan's location has created a pattern of discrimination and exclusion.

¹³³ See *supra* notes 109-13 and accompanying text.

¹³⁴ For more developed arguments on how the state experimentation should work, see the description of Professor Sparer's comments, *infra* text accompanying notes 163-75.

¹³⁵ See also Watson, *supra* note 14.

She argued that the poor must have access to different types of plans of different prices. Professor Dubler advised against recreating Medicaid, a system that excludes poor people from mainstream health care and groups them together for inferior treatment.

Professor Rand Rosenblatt, of Rutgers University Law School—Camden, discussed the role of “rights” as established by the Clinton Act.¹³⁶ He noted that historically the executive and legislative branches have resisted egalitarianism in health care. The same forces that make it difficult to pass legislation have caused serious implementation problems once the programs have become law. There is a large gap between the promise of equal health care and reality and advocates have tried to narrow that gap by litigation. Indeed, before the Reagan and Bush administrations, the federal courts had begun to fashion new rights to health care, but since the influx of Reagan and Bush appointees to the federal bench the courts have stepped back from this role.¹³⁷ Particularly because of the change in the federal bench, Professor Rosenblatt argued it is crucial that health care reform contain very clear remedies for discrimination. Professor Rosenblatt noted that Title V¹³⁸ of the Clinton plan contains very strong remedies and grievance procedures.¹³⁹ But Title V is under serious threat by opponents who argue that the federal courts are already overloaded and that health insurers will face uncertainty if their patients have rights.¹⁴⁰

¹³⁶ See Rand E. Rosenblatt, *Equality, Entitlement, and National Health Care Reform: The Challenge of Managed Competition and Managed Care*, 60 BROOK. L. REV. 105 (1994).

¹³⁷ Rand E. Rosenblatt, *The Courts, Health Care Reform, and the Reconstruction of American Social Legislation*, 18 J. HEALTH POL. POL'Y & LAW 439 (1993).

¹³⁸ HSA § 5201.

¹³⁹ Professor Rosenblatt noted that section 1402(a), which forbids discrimination based on health status and occupation, may not be enforceable. Although health alliances have a duty not to engage in practices causing discriminatory effects, it is unclear whether providers have a similar duty. Professor Rosenblatt raised a variety of other legal questions concerning the rights created by the HSA: What standards would apply under Title VI? Why are there no private rights of actions created against alliance officials? Will the language of the law provide sufficient protection given the Supreme Court's curtailment of rights under 42 U.S.C. § 1983? See Rosenblatt, *supra* note 136.

¹⁴⁰ Professor Rosenblatt, as Co-Chair of the Society of American Law Teachers' Committee on Access to Justice in Health Care Reform, testified before the Health and Environment Subcommittee of the Energy and Commerce Committee of the

Professor Rosenblatt argued that establishing rights for the poor alone can be perceived as a vicious scramble for limited resources.¹⁴¹ Concentrating only on the rights of the poor is a "trap." Professor Rosenblatt noted that Ed Sparer had understood that establishing cross-class coalitions was essential to building political power for the poor and underserved. Rosenblatt suggested building coalitions with the middle class in order to protect the rights of the poor. One way of doing this, Professor Rosenblatt noted, is to mobilize around issues that the middle class supports. He believes that middle class taxpayers would be more willing to participate in a program like the Bronx Health Plan described by Maura Bluestone¹⁴² because they will see that their taxes are used well and not thrown away to a corrupt and wasteful system.

Professor Rosenblatt also advocated building coalitions with the middle class by working on rights provisions of the Clinton bill that affect the middle class as well as the poor. For example, he urged advocates for the poor to join with the middle class to improve the general discrimination provisions located in § 1402(a) of the HSA.¹⁴³ These provisions prohibit health alliances from discriminating against persons because of health status and occupation. Finally, Professor Rosenblatt suggested that advocates for the poor need to take more creative measures to organize around and advocate for the equal treatment of the poor.

United States House of Representatives on January 31, 1994. This testimony addressed specific recommended changes to the Clinton bill to strengthen the rights provided to the poor. See Rand E. Rosenblatt, On Access to Justice, Discrimination and Health Care Reform (Jan. 31, 1994) (testimony before the Health & Env't Subcomm. of the U.S. House of Reps.) (revised text for the record Feb. 14, 1994) (on file with the *Brooklyn Law Review*).

¹⁴¹ Professor Rosenblatt also noted that Ed Sparer was committed to entitlements for poor people. Sparer saw entitlements as contributing to the dignity of poor people and a way of getting services and resources to the poor. He recognized, however, the tension between meeting the special needs of the poor and poor people's lack of political power to acquire and defend their own rights. See Rosenblatt, *supra* note 136, at 113.

¹⁴² See *infra* note 181 and accompanying text for a discussion of Maura Bluestone's presentation.

¹⁴³ See Rosenblatt, *supra* note 136, at 116.

B. *The Clinton Proposal Versus Other Legislative Proposals*

Ron Pollack, Executive Director of Families USA in Washington, D.C., a national consumer advocacy organization for health care reform, compared the various House and Senate proposals for health care reform. Mr. Pollack agreed with Professor Marmor that the legislative process of health care reform will be extraordinarily dynamic. He predicted that there would not be a "yes" or "no" vote on the Clinton plan or on any other plan. Instead, Congress ultimately would adopt an "amalgam of a variety of [the] different proposals." He noted that the division between the single-payer advocates and the Clinton bill advocates that he had witnessed in the Symposium audience does not exist in Washington. Rather, single-payer advocates in Washington have joined with those favoring the Clinton Plan to work on strengthening and adopting the Clinton proposal. According to Mr. Pollack, the extraordinary cooperation between these two groups is due to three key factors: (1) President Clinton made it clear that he would not sign a bill unless it includes universal coverage and a comprehensive benefits package for all; (2) The "Wellstone" provision in the Clinton bill allows the states to opt into a single-payer plan;¹⁴⁴ and (3) the single-payer and Clinton plan advocates have been drawn together by the threat of an alternative, much more conservative, less comprehensive reform.

Mr. Pollack noted that during his travels nationwide he had seen that the debate is much broader than the question of whether one should support a single-payer bill or the Clinton proposal. The debate in Washington reflects the national mood, which lies on the political spectrum between the Clinton bill and the more conservative bills offered by Republicans and conservative Democrats.¹⁴⁵ Although there are a number of bills in Congress that fit into this category, including the Cooper bill,¹⁴⁶ the Graham bill¹⁴⁷ and the Michel bill,¹⁴⁸ Mr. Pollack focused on the Cooper bill because it is viewed as a

¹⁴⁴ See *supra* text accompanying notes 75, 78-80.

¹⁴⁵ This perception is directly contrary to that of Dr. Himmelstein. See *supra* notes 96, 100, 103, 108 and 113 and accompanying text.

¹⁴⁶ See *supra* note 77 and accompanying text.

¹⁴⁷ S. 1757, 103d Cong., 1st Sess. (1993).

¹⁴⁸ See *supra* note 77 and accompanying text.

mid-range proposal.¹⁴⁹

According to Mr. Pollack, the Cooper bill is a dangerous conservative proposal that is "light years" away from the plan offered by President Clinton. For example, the Cooper bill does not provide a guarantee of coverage for everybody; it offers "universal access,"¹⁵⁰ rather than "universal coverage."¹⁵¹ This provision leaves millions of dollars out of the system and hurts the poor and the underserved. Furthermore, the Cooper bill does not guarantee a comprehensive benefits package. That is, it does not specify what benefits it will cover. Instead, the Cooper bill would create a new commission to decide which benefits to provide.¹⁵² The legislation, according to Mr. Pollack, provides little assurance that the commission will establish a serious comprehensive benefits package, like that in the Clinton plan.

Mr. Pollack also argued that the Clinton plan attempts to eliminate the segregation of the poor by using health alliances to integrate Medicaid beneficiaries through the health alliances into plans where middle-class people are treated.¹⁵³ It also reduces the financial disincentives to serving the poor by eliminating the different payment levels for the middle class and the poor.¹⁵⁴ In contrast, the Cooper bill makes no such effort. Instead, it exacerbates the disincentive to treating the poor by reducing the amounts paid for care given to Medicare and Medicaid patients without placing caps on the amounts private insurance will pay for treatment.¹⁵⁵ Mr. Pollack argued that this policy will create a larger gap, decrease access to care for

¹⁴⁹ Representative Cooper calls his bill "Clinton Lite," leaving the impression that it does not differ substantially from President Clinton's proposal. See Richard Berke, *Health Debate is Filling Campaign Coffers*, N.Y. TIMES, Apr. 19, 1994, at A14.

¹⁵⁰ The Cooper bill § 2.

¹⁵¹ Mr. Pollack likened the "universal access" offered by the Cooper bill to everyone's access to a Mercedes-Benz: we all have access but we can't pay for it.

¹⁵² The Cooper bill § 1301-1302.

¹⁵³ HSA § 4001.

¹⁵⁴ Mr. Pollack noted that under the current system doctors treating medicare patients get about two-thirds of the payment they can receive from privately insured people. For Medicaid patients, doctors receive only about 50% of what they would get for treating patients with private insurance. The Cooper bill would exacerbate this discrepancy, creating even greater incentives for doctors to refuse to care for the poor.

¹⁵⁵ The Cooper bill § 2101.

low-income people and senior citizens, and increase the cost shifting to the private system.

Moreover, the Cooper bill provides no coverage for long-term care, while the Clinton bill encourages home and community-based care.¹⁵⁶ Similarly, the Cooper bill, unlike the Clinton Plan, does not expand prescription drug coverage.¹⁵⁷ Although the Clinton bill moves, over time, toward parity between mental health and physical health care coverage,¹⁵⁸ the Cooper bill does not. Finally, the Clinton bill provides caps for premiums, an essential check on managed competition,¹⁵⁹ where the Cooper bill does not provide for any meaningful cost containment.¹⁶⁰

Mr. Pollack urged advocates for the poor to accentuate the damage the Cooper bill could do to the interests of the poor. According to Mr. Pollack, advocates should educate the American public to the substantial differences between these bills because the media has not made a significant effort to do a serious analysis of the alternative proposals.¹⁶¹ He argued that representatives of the poor must "extract the political pound of flesh" from those supporting the Cooper bill. He noted that the bill's proponents in Congress are politically vulnerable¹⁶² and should be challenged in their own districts.

Addressing some of these vulnerabilities, Andreas Schneider, counsel to the United States House of Representatives Subcommittee on Health and the Environment, spoke on "Health Care Reform in the 103d Congress." Mr. Schneider

¹⁵⁶ See *id.*; HSA § 2101.

¹⁵⁷ See the Cooper bill § 2004; HSA § 2001.

¹⁵⁸ HSA § 3501.

¹⁵⁹ HSA §§ 6000-6041.

¹⁶⁰ According to one news article, the Cooper bill is the one most favored by business "because it neither requires employers to provide coverage nor limits insurance premiums." See Berke, *supra* note 149, at A1.

¹⁶¹ Since Mr. Pollack's speech, at least one member of the press has written an article demonstrating the enormous political gain to Congressman Cooper as a result of his promotion of the Cooper bill. See Berke, *supra* note 149, at A1. According to this article, Representative Cooper has admitted that 19% of the \$2.4 million he has raised for the campaign came from health care interests. A more liberal group would count the share at about 33%. *Id.* at A14.

¹⁶² Mr. Pollack noted that Congressman Cooper has announced that he is running for Vice President Gore's former Senate seat in Tennessee. The second strongest proponent of the bill, Congressman Mike Andrews of Texas, has decided to run for the Senate seat of Kay Bailey Hutchinson and, according to Mr. Pollack, faces a very tough primary race.

stated that the fight in the Congress over health care reform is inextricably related to the deficit. In Mr. Schneider's opinion, the struggle is not necessarily among various health proposals; rather, it is a fight between the deficit hawks and those who want universal coverage. Mr. Schneider argued that the deficit hawks had won so far and he opined that they could defeat any bill providing for universal coverage.

IV. STATE EXPERIMENTATION: THE STATES' ROLE AND ITS EFFECT ON ACCESS BY THE POOR AND UNDERSERVED TO (E)QUAL(ITY) HEALTH CARE

Symposium participants also discussed how state experimentation could affect health care services for the poor. Professor Michael Sparer, of the Columbia University School of Public Health, Division of Health Policy and Management, spoke eloquently on state experimentation. Professor Sparer, Ed Sparer's son, is a national expert on Medicaid and its implementation at the state level. He explained that there are five points important to understanding the states' roles in health care reform.

Professor Sparer first noted that states are already key players under the current health care system. The Medicaid program delegates responsibility to states for determining who receives benefits, what benefits they receive, and the amounts of payments to providers.¹⁶³ States also regulate much of the private health insurance industry.

Second, because states have such wide discretion in the current health care system, state programs vary enormously. This variation occurs even between what would be considered similarly-situated states. For example, although both states are poor and rural and share a history stemming from their location in the South, Mississippi has a much more generous Medicaid program than Alabama.

Third, the Clinton plan and other proposals delegate significant responsibility to the states. Professor Sparer argued that the reasons for delegating the responsibility to the states are threefold. First, because states are such key players in the system right now, it would be difficult to imagine a system

¹⁶³ See 42 U.S.C. § 1396a (1988 & Supp. IV 1992).

where the federal government takes over tasks that the states are now performing. Second, many people believe that health care reform should build on some of the initiatives of the more progressive states such as Minnesota, Vermont, Washington and Oregon, which are already experimenting with health care reform. Finally, Americans assume that if the states and local decision-makers have discretion, the program is more democratic; local autonomy encourages innovation and allows the society to test different approaches.

Professor Sparer's fourth point was that the tasks delegated by the Clinton plan to states are critical to poor people. For example, states decide: how many regional health alliances they will have;¹⁶⁴ whether these alliances will be non-profit organizations, existing state agencies or new state agencies;¹⁶⁵ and, most importantly, the jurisdictional boundaries of the alliances.¹⁶⁶ The boundary issue is crucial because well-to-do communities will resist alignment with poor communities. How these disputes are resolved will have a tremendous impact on the poor. Boundary drawing creates the problem of risk segmentation which the reform process is trying to avoid. It also creates implementation nightmares, such as the recruiting of experienced and competent staff. For example, Professor Sparer noted that in the state of Texas, there are currently only three people who set rates. If the state has 12 health alliances, as is planned, there is a question as to who will be hired to set the rates. If the persons working for the alliances are not strong and well-prepared for their positions, the alliances could be very weak regulators, who are ultimately captives of large insurance plans.

Another role of the states, according to Professor Sparer, is to ensure that poor people have adequate access to a range of health plans. The Clinton plan may provide for access by permitting the alliances to offer financial incentives to health plans to expand into medically underserved areas.¹⁶⁷ How well states perform this task will greatly affect how the poor fare under the program.

¹⁶⁴ HSA § 1201(1).

¹⁶⁵ *Id.* § 1301.

¹⁶⁶ *Id.* § 1202(b).

¹⁶⁷ *Id.* § 1203(e)(3).

Professor Sparer noted that risk adjustment problems also complicate the access issue. The Clinton bill operates on the assumption that the alliances easily will figure out a system whereby they give greater funding to health plans that take poor and high-risk people. But risk adjustment as a science is still in its infancy and there is serious concern over whether the states will be capable of making the adjustments effectively. The losers may be the poor and underserved.

The Clinton bill also calls for the alliances to perform a variety of other tasks. The tasks include requiring the alliances to: certify that health plans meet minimum standards of quality of care, fiscal soundness and capacity to provide benefits;¹⁶⁸ implement the subsidy program to consumers and small businesses;¹⁶⁹ offer a new home care program for the disabled;¹⁷⁰ create consumer report cards;¹⁷¹ integrate special populations, such as drug abusers or the mentally ill, into the larger system;¹⁷² continue to run the Medicaid programs;¹⁷³ and devise systems permitting current Medicaid recipients to continue to receive benefits.¹⁷⁴ Whether the alliances will have the capability of performing these tasks is questionable.

Finally, Professor Sparer pointed out that the states' capacity and willingness to perform these tasks fluctuate wildly. According to Professor Sparer, states fall into at least three general classes. Some states, such as Minnesota and Washington, have already begun health care reform and are fairly far along. These states have both the capacity and the will to implement reform, but are concerned that the federal government will hinder them from going forward. They want federal money but also the freedom to implement their plans. Other states, such as Mississippi, lack both the capacity and the will to implement the reform program.¹⁷⁵ Finally, a whole range

¹⁶⁸ *Id.* § 1402.

¹⁶⁹ HSA §§ 1343, 1390.

¹⁷⁰ *Id.* § 4213.

¹⁷¹ *Id.* §§ 1325, 1386.

¹⁷² *Id.* § 1115.

¹⁷³ *Id.* § 4201.

¹⁷⁴ HSA § 4201.

¹⁷⁵ Professor Sparer mentioned that he had recently spoken to a Mississippi official who told him that she doubts that Mississippi would do anything under the Clinton plan if it were not for the provision that allows the federal government to

of states have mixed levels of capacity and will. These states will "muddle along" in different ways. The way they conduct the reform will have a tremendous effect on poor people's health care.

Professor Sparer seemed to agree that a single-payer system would be preferable to the Clinton bill because it would eliminate a state's broad discretion. He argued, however, that if a single-payer plan is not politically feasible right now, any health care reform bill that Congress passes should give the states three options: managed competition with health alliances and very tight federal government regulation; a single-payer plan; or a multiple-payer system with rate setting under clear and strong federal guidelines. Professor Sparer argued that it is crucial that the federal government tightly control how the options are played out. Any other scenario would delegate too much authority to state and local officials and will result in tremendous interstate variation, to the ultimate detriment of poor people.

A closer look at the potential problems described by Professor Sparer was provided by Richard Weishaupt, Project Head of the Health and Human Services Unit at Community Legal Services in Philadelphia. In 1989, Pennsylvania began a managed care waiver program with ten percent of its Medicaid population. Instead of having the poor join an existing HMO, Pennsylvania created a Health Insuring Organization ("HIO") to serve them.¹⁷⁶ Mr. Weishaupt believes that, although Pennsylvania argues that caring for the poor as a separate group allows the state to concentrate on their needs, serving the poor separately is a mistake because the segregation leads to worse care.

Mr. Weishaupt described the problems that Pennsylvania's managed care system has faced in covering Medicaid patients. He noted that the private organizations running the managed care programs were making outrageous profits. For instance, one organization made \$9,000,000 on its managed care Medic-

take over inadequate state plans and imposes a 15% penalty on the state as a cost of requiring federal administration. *See id.* § 1523(a).

¹⁷⁶ An HIO was created because Pennsylvania HMO patients who receive Medicare and Medicaid cannot comprise more than 25% of the HMOs' patient population. In addition, at the time the managed-care system was established, there was no existing HMO willing to join the effort.

aid program only to use the profits to build a hospital in the suburbs. Mr. Weishaupt also noted that there are few, if any, regulations governing quality of care. Additionally, patients with questions about their care cannot speak to the doctors when they need to consult with them. No provision is made for ancillary services such as child care and transportation for patients. Mr. Weishaupt argued that for managed care to work for poor people, there must be powerful Medicaid advisory committees. Consumers must sit in powerful positions on these committees so they can communicate consumers' problems with the delivery of and access to quality health care. In short, there must be enormous regulation and democratization of the process.

V. HEALTH CARE PROGRAMS POOR PEOPLE NEED: SERVICES BEYOND TRADITIONAL "MEDICINE"

The focus of the Symposium shifted from the political agenda of national health reform to the needs of the poor, with remarks by direct-services providers Sylvia Drew Ivie and Maura Bluestone, and lawyer Catherine O'Neill. They echoed much of what Professor Vernellia Randall had said earlier, adding personal stories to illustrate Professor Randall's point that many non-economic barriers deny adequate health care to the poor and underserved.¹⁷⁷ But they also demonstrated that good health care can be provided to the poor.

Sylvia Drew Ivie is the Executive Director of T.H.E. Clinic for Women, a comprehensive community clinic serving low-income African Americans, Latinas and Asian/Pacific Islanders. Like Professor Randall, Ms. Ivie explained that a health care system or plan can be judged only by whether it improves the quality of health care received by the poor. Ms. Ivie focused on the dichotomy between the fight to include poor people in the existing medical system, with all its faults, and the desire to create a new and different medical system for the poor to meet the community's special needs. She concluded that both struggles must take place simultaneously: while advocates for the poor continue to attain access for the poor to the private health care system, they must also consider the particular

¹⁷⁷ See *supra* notes 121-23 and accompanying text; Randall, *supra* note 15.

needs of the poor when improving their health care. Ms. Ivie stressed that for 25 years community health clinics have worked to create an ideal system for the poor. This system is not merely a health care system; it is a community system that includes health care. Ms. Ivie noted that poor people need a broad spectrum of services, including child care, transportation, health care personnel who can communicate to them in their native languages, and peer support for teens, persons infected with HIV and the elderly. The community clinics have all of these support services.

Ms. Ivie criticized the bills currently in Congress for focusing on medical care only. Like Professor Randall, she argued that a bill that provides only insurance will not guarantee the broad range of services that poor people need. Although the various proposals include some money for some of the services that are already provided by the community clinics, Ms. Ivie noted that it remains unclear how much money will be available and how broad a range of services will be covered under the Clinton bill.

Moreover, Ms. Ivie emphasized, it is unclear whether existing successful services will survive health reform. As an example, she pointed out that much of the funding for her clinic comes from the federal government but, because about 50% of those served by her clinic are undocumented immigrants, it is likely that her clinic will lose the funding for those persons.¹⁷⁸ She noted that if so many of her patients lose their funding, there is a serious question as to whether her clinic will survive if the Clinton plan passes. The irony, Ms. Ivie noted, is that the massive effort toward health care reform may ultimately destroy the community health care clinics that for 25 years have offered the types of services needed by the community.¹⁷⁹

¹⁷⁸ Undocumented persons are not covered by the HSA. They will retain Medicaid for emergencies only. HSA § 4201.

¹⁷⁹ There is an interesting parallel between what Ms. Ivie fears may result from health care reform and the result, as many African Americans see it, of integration. Although integration obviously has had beneficial effects, according to some African Americans one of its negative effects has been to destroy stable African American communities. According to Ms. Ivie, health care reform that would integrate the poor into the general public of health care consumers may destroy the community clinics that have proven successful in dealing with many of the special needs of poor women.

Ms. Ivie suggested that the reform effort should build on the systems that are already flourishing, rather than allow for their destruction. Especially for her patients, the strictly medical model of health care reform will not work. Patients need to be brought into the system and to be communicated with and listened to by health care workers. If medical professionals do not listen to their patients and allow them to share in the decisions concerning their own health, people will abandon the system. For example, Ms. Ivie noted that a medical system cannot effectively address the issues currently confronting women, such as breast cancer and HIV infection. Women need self-help, peer education and support groups to give them control over their lives. Ms. Ivie urged advocates for the poor to lobby Congress to pass a bill that will retain the good aspects of community clinics already in place and expand on a model that works.

Catherine O'Neill, Vice President and HIV/AIDS Projects Director at the Legal Action Center, a nonprofit law and policy organization in New York City, agreed with Ms. Ivie that strictly "medical" services do not adequately deal with the problems of the poor. Ms. O'Neill noted that the number of persons with interrelated HIV and drug abuse problems is rising exponentially: 30% of all the AIDS cases reported nationally are linked to drug abuse and, in New York and New Jersey, 50% of AIDS cases are associated with drug abuse. The costs associated with AIDS and drug abuse are, to a large extent, driving the increase in the cost of health care. Persons suffering from AIDS and drug addiction have poor access to health care. Moreover, these persons, in addition to dealing with severe medical problems, suffer from a fragmented health care system that is biased against them because of their illnesses.

According to Ms. O'Neill, this fragmentation threatens to continue under the Clinton plan. For example, the Clinton plan does not provide for coverage of medical care for persons with drug addiction problems who need long term intensive care.¹⁸⁰ Moreover, the Clinton bill does not provide for ancillary services, such as childcare, and support services. Advocates for this population fight against enormous barriers, in-

¹⁸⁰ HSA § 115(c)(2).

cluding the perception of those who do not particularly want to care for people who are poor and have drug abuse problems or communicable diseases. Even though the legal protections may be in place, these people are not getting the health care they need.

Echoing many of the themes presented by Sylvia Drew Ivie and Catherine O'Neill, Maura Bluestone discussed the Bronx Health Plan, of which she is Executive Director. The managed care program Ms. Bluestone runs for the poor contrasts sharply with the managed care program in Pennsylvania as described by Mr. Weishaupt. The Bronx Health Plan, which has been in operation for seven years, is a prepaid health services plan that bases its health centers in the community it serves. It is designed to serve Medicaid recipients and other low-income residents of the Bronx. Ms. Bluestone emphasized that her plan provides one type of "managed care." She believes that for "managed care" to treat poor people successfully, a health plan must have a clear mission. The Bronx Health Plan started with, and implemented, such a mission. It changed the service delivery system to deliver better quality care to Medicaid recipients and other persons with low incomes. The Bronx Health Plan is not just an insurance plan, but rather a comprehensive HMO designed specifically to serve the needs of its clientele. The HMO assumes the risk and grants comprehensive benefits to its clientele.

Ms. Bluestone explained that the Bronx Health Plan sought to alter the nature of the relationship between the consumer and the provider by establishing a personal service relationship which took responsibility for continuity of care. This new relationship requires the providers as well as consumers to change their expectations. For example, Ms. Bluestone noted that many consumers did not expect to be treated fairly, to be able to reach a physician during the night, to see the same doctor more than once, or to understand the medical procedures they received. The providers had similar "very sad" expectations as to how they must serve their patients.

Ms. Bluestone offered a number of requirements for success in treating a poor clientele. First, there must be a clear sense of mission, which, she opined, many of the commercial insurers may lack. Second, the provider network must be dedi-

cated to serving the population and must be accessible. Providers who live and work in the community are essential. Third, there must be personal service. The plan must reach out to provide service by use of a customer relations staff who will help the consumers solve their problems. Fourth, the plan must go beyond the conventional model and provide services such as transportation and outreach education to its clientele. Ms. Bluestone emphasized that poor people are not just middle-class people without money. They are persons with very little discretion and control over their lives who need a whole range of services that differ completely from those needed by middle-class Americans.¹⁸¹ Finally, the plan must work closely with consumer advisory groups who communicate the needs of the clientele to the plan. The providers and administrators must constantly test their own perceptions as they work with these advisory groups.

Like Professor Randall, Ms. Ivie and Ms. O'Neill, Ms. Bluestone stressed that giving poor persons a health security card will do nothing to improve their health care. A health security card alone is not access to services. Rather, it is nothing more than a statement saying that the person is entitled to services. But there are significant barriers to overcome to receive those services. A managed care system that takes a comprehensive view of what is needed and includes enabling services can function very effectively. It appears that the Clinton plan does not contemplate this type of system, leaving advocates with much work to do to ensure quality health care for the poor.

¹⁸¹ As an example, Ms. Bluestone spoke of a little boy with a terrible speech defect whom the Plan referred to speech therapy three times a week. The Plan covered the cost of unlimited visits to the speech therapist, but this service was not enough. The speech therapist was located two bus zones away and the therapy was scheduled to take place after school. The child's mother, who had other children, found it very difficult, logistically and financially, to get her son to speech therapy. As a result, the Plan provided round trip taxi fare for the child to go to the therapist three times a week. Ms. Bluestone emphasized that it is important to include these types of services in the Plan's budget. In fact, the amount of money spent on these types of services is minimal considering the overall budget.

VI. THE LAWYER'S ROLE IN ENSURING (E)QUAL(ITY) HEALTH CARE FOR THE POOR AND UNDERSERVED: ADVOCACY STRATEGIES AND OTHER ALTERNATIVES

Shifting from an analysis of actual reform proposals and the health care needs of the poor, several speakers focused on the role lawyers can play in effecting change to bring about equal and quality health care for the poor and underserved. Marianne Engelman Lado, a staff attorney for the NAACP Legal Defense Fund, Inc., whose work relates to issues of equity in education and health care, argued that although litigation may not be the only strategy available to lawyers, it can play a major role in attaining equal and quality health care. She demonstrated through potent examples¹⁸² that African Americans and other underserved and economically depressed groups are denied access to equal and quality care. For example, Ms. Lado spoke of a meeting at which tenants in a New York City public housing complex told her that the local non-profit hospital segregated persons into different wings in the hospital on the basis of the patients' race and economic status. The tenants provided graphic examples of the inferior treatment that patients received in the poor wing.¹⁸³

Ms. Lado argued that while litigation can be an effective means to overcome these differences, it has made little improvement in the past. Ms. Lado believes that there are sufficient statutes on the books that are designed to protect against these inequities.¹⁸⁴ Yet courts have taken an unconsciously racist approach to interpreting and applying the statutes and have not given credence to the barriers of access to quality care described by the litigants. Because the stories told by individual litigants are not credited or weighed heavily enough by the courts, Ms. Lado believes that lawyers must find new ways of presenting evidence to prove the denial of access to equal and quality care by the poor and underserved. She suggested that lawyers should use experts from other fields, such as social

¹⁸² See Marianne Engelman Lado, *Breaking the Barriers of Access to Health Care: A Discussion of the Role of Civil Rights Litigation and the Relationship Between Burdens of Proof and the Experience of Denial*, 60 BROOK. L. REV. 239 (1994).

¹⁸³ *Id.* at 246.

¹⁸⁴ See, e.g., Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d (1982).

scientists, demographers and medical specialists to develop a record of discrimination.¹⁸⁵

Ellen Yacknin, Health and Litigation Specialist at the Greater Upstate Law Project in Rochester, New York, argued that lawyers must make the faces of the poor real to the public. Only through personal connection will advocates for the poor influence the process of health care reform.

In addition, in her article entitled *Helping the Voices of Poverty To Be Heard in the Health Care Reform Debate*, Ms. Yacknin argues that poor people need to be part of a "seamless system" that does not distinguish between rich and poor. The system, to serve the poor's needs, must give everyone, rich and poor, the same health care coverage card;¹⁸⁶ have truly affordable copayments or deductibles; and grant comprehensive benefits. She notes that lawyers who advocate for the poor are in a good position to work to improve the health care system because they have developed an expertise in the Medicaid system and they know how to advocate effectively for their clients. Lawyers who represent the poor also have the power of their clients' stories; they have credibility because they lack a financial stake in the outcome and, now, for the first time in more than a decade, they have connections to persons in the federal government working on health care reform.

According to Ms. Yacknin there are three services these health care advocates can perform: they can help the poor speak for themselves by accompanying them to testify before Congress; they can use the collective power of the Legal Services Corporation to amass their clients' stories and distribute them to legislators, the local community and the public; and they can analyze proposed provisions for health care reform and suggest new ones.

Louise Trubek, a Professor from the University of Wisconsin Law School and health care advocate for the Center for Public Representation in Madison, spoke of her experience in Wisconsin and how it can inform advocates for the poor. During the early 1980s, the Wisconsin legislature decided to pur-

¹⁸⁵ See Lado, *supra* note 183, at 273.

¹⁸⁶ Ms. Yacknin notes the humiliation suffered by holders of food stamps and welfare cards. See Ellen M. Yacknin, *Helping the Voices of Poverty to be Heard in the Health Care Reform Debate*, 60 BROOK. L. REV. 143 (1994).

sue "a strategy of cost containment through the encouragement of managed competition."¹⁸⁷

Although initially there was "considerable confusion and dissatisfaction," the Wisconsin managed care systems have adapted and the programs are now fairly effective, according to Professor Trubek.¹⁸⁸ The state selects its health care providers by setting up a bidding process for contracts. Advocates for the poor became aware that if they wished to influence how the "(e)qual(ity)" issues would be handled it was necessary for them to participate in the bidding process. Advocates met with state administrators to convince them of the problems and influenced them to require prospective providers to demonstrate that they would meet equal access and care requirements before their bids would be accepted. They also convinced state administrators to add bid requirements that would increase minority providers and encourage community development. Finally, advocates worked to encourage the state to collect consumer data for publication to consumers so that they can make informed choices in selecting their HMOs.¹⁸⁹

The conference concluded with a model presented by David Chavkin for training lawyers to be the next generation of health care advocates. He presented the Clinical Seminar Model, a hybrid between a clinical course and a purely theoretical substantive course. The Clinical Seminar Model uses real cases to help students learn the course syllabus. The Clinical Seminar includes simulation, real client representation, case supervision meetings with the clinician and student attorney, and "grand rounds" where the student attorneys present their problems to the entire class for discussion and resolution. This

¹⁸⁷ See Louise G. Trubek, *Making Managed Competition a Social Arena: Strategies for Action*, 60 BROOK. L. REV. 275 (1994).

¹⁸⁸ A number of quality and equal access issues surfaced early in the experiment, including grievance procedures for persons who believed that they had not received equal treatment, usable consumer information or quality mental health services, alcohol and drug abuse treatment, and obstetrical and gynecological care.

¹⁸⁹ In her article in this Symposium, Professor Trubek suggests a number of strategies: developing new institutions; encouraging representation of disadvantaged groups on governing boards and through consumer activism; writing statutory language that would permit public inspection of the documents in the bid process and that would encourage input from outside groups; and training advocates to counsel organizations, educate clients and lobby legislative and administrative bodies. Trubek, *supra* note 187, at 295-300.

model provides a number of benefits over traditional substantive courses and traditional clinics. Unlike students in a traditional substantive course, students in a Clinical Seminar have a personal stake in the outcome of their clients' cases. This interest creates a greater incentive to learn the material. Because the Clinical Seminar deals with fewer cases than a traditional clinic does, the student-faculty ratio can be somewhat higher in the Clinical Seminar. Finally, the Clinical Seminar avoids the split between practice and theory that is prevalent in law school. It teaches skills and theory in the same setting while bringing clinicians into the law school and avoiding marginalization of the clinical program. Professor Chavkin hopes that the clinical experience will inspire students to become tomorrow's Ed Sparers.

VII. CONCLUSION: CREATING A YARDSTICK TO MEASURE REFORM PROPOSALS

President Clinton initially embraced health care reform in response to political pressures from other Democrats during the primary campaign.¹⁹⁰ The Democrats campaigned on the issue of health care reform because they perceived public anxiety over out-of-control health care costs and an emerging attitude that the middle class should have a right to health insurance coverage.¹⁹¹ It is obvious, therefore, that politics required the Administration to focus on the needs of the middle class rather than on those of the poor when it undertook to reform the health care system. Because the President's proposal grew out of a political movement that sought to protect the middle class from a loss of health insurance, the plan, when viewed from the perspective of an advocate for the poor, may seem odd and even menacing.

If the interests of the poor and underserved were at the core of the Administration's concern for health care reform, the Administration would have built its plan from the bottom up. That is, it would have examined programs that have succeeded

¹⁹⁰ For example, during the primary campaign Senator Bob Kerry of Nebraska and Senator Tom Harkin of Iowa offered well-developed health care proposals guaranteeing universal coverage.

¹⁹¹ See Robin Toner, *The Health Care Debate: Washington at Work*, N.Y. TIMES, July 17, 1994, at A1.

and failed in treating the poor and it would have created a reform that expanded on the programs that worked—the community clinics as described by Sylvia Drew Ivie and Maura Bluestone.¹⁹²

Instead, the Administration constructed its plan from the top down. It put on the roof and then layer upon layer of complex ornamentation before building the rest of the building. Possibly, this structure, although burdensome, will stand to protect the middle class from a loss of insurance. It is potentially the most palatable structure for those living in the heartland of America. But even this point is debatable. More likely, the President feared taking on the powerful insurance lobby. As he travels around the country attempting to sell his program, President Clinton faces tough questions and many obstacles from the very people it is designed to serve.¹⁹³

Although the President's initial reason for supporting health care reform may have been political, he has shown a desire to improve medical services to the poor by selecting Hillary Rodham Clinton and a task force to develop the legislation. The task force included many members who want to improve health care delivery to the poor. Many of these persons, if given a clean slate, would likely support a single-payer system similar to Canada's. But the President had already put the

¹⁹² See *supra* part V.

¹⁹³ For example, to what extent will the President's proposal reduce the patient's choice of physician? To what extent will the cost-containment provisions affect the quality of care provided to patients? Dennis Rivera, President of Local 1199 of the National Health and Human Services Employees Union, the nation's largest health care employees' organization, argued at the Symposium that the Clinton plan should be defeated because it will lower the quality of health care and harm health care workers. Under the Clinton plan, the providers will compete with one another to provide less care, thereby eliminating jobs in the health care industry. The foremost goal of the Clinton Plan is cost control.

Mr. Rivera noted that the profile of his union members is that of a single woman who is a member of a minority group. Because of the union, these workers have enjoyed good salaries and very good health care benefits. If the Clinton plan is passed, the union members will lose many of the health care benefits on which they now rely. Moreover, approximately 15,000-20,000 health care workers in New York will lose their jobs. The loss of the health benefits and jobs will affect the delivery of quality health care to patients. For those employees who will lose their jobs, the bill provides for very little training and education to assist them in making a transition to a new career. The plan, according to Mr. Rivera, requires working-class people to make sacrifices. He argued that instead of asking hospital workers to sacrifice, the doctors themselves, who take home very substantial salaries, should bear the brunt of the plan.

roof on the building by announcing during his campaign that he favored "managed competition" and the advisors on the Task Force were left to add the floors to hold up the roof. Many of those committed to (e)qual(ity) health care for the poor successfully fought long and hard for provisions that would satisfy their concerns.¹⁹⁴

Since the Symposium, support for the Clinton plan has dwindled for various reasons: the cost of health care reform;¹⁹⁵ business' opposition to the "employer mandate"; conservative opposition to price controls; uncertainty of the public regarding the plan's benefits; and the fragmentation of congressional Democratic Party leaders.¹⁹⁶ This result was not unexpected. President Clinton made clear from the start that he would entertain modifications to the plan¹⁹⁷ so long as they did not compromise universal coverage and a comprehensive benefits plan. In fact, his support for the Mitchell plan that was unveiled on August 3 indicates that he is willing to compromise on universal coverage as well.

In considering whether to support the Clinton plan, one of the democratic alternatives, or a single-payer plan, advocates for the poor must resolve several political and practical questions. To what extent would the Clinton plan, an alternative democratic plan, or a Canadian-style single-payer system improve health care services delivered to the poor? Even under a single-payer system the poor could be isolated by inferior care as is the case for many now under the Medicaid system. Should advocates for the poor settle for insurance reform alone

¹⁹⁴ An example is the "blended rate," which is intended to eliminate the economic discrepancies between treating the poor and the middle class. See Yacknin, *supra* note 186, at 165.

¹⁹⁵ See description of Andreas Schneider's speech, *supra* part III.B.

¹⁹⁶ See *supra* discussion in part III. There also has been fragmentation to the right of the Clinton plan. Conservative democrats in early May supported more conservative bills, see Pear, *supra* note 86, at B14, but by the end of May, the Republican opposition appeared to have united conservative and liberal democrats—at least those on the Senate Finance Committee—behind one of the most controversial aspects of the President's plan, the employer mandate. See Adam Clymer, *Some Opponents of Health Plan Give Some Ground*, N.Y. TIMES, May 23, 1994, at A1, B6. Given Senator Mitchell's latest proposal, however, the future of an employer mandate looks bleak.

¹⁹⁷ As Ron Pollack predicted at the Symposium, it looks as though the plan is going to be rewritten in a more conservative fashion. See Clymer, *supra* note 52, at A1.

or should they demand a total reform of the delivery of health care to the poor? Is the total reform of health care services possible? If so, can it be achieved at once or should representatives of the poor work incrementally? Should the poor be members of health plans specifically designed for their needs and located in places that are more convenient for them, or should they be integrated into health plans covering middle-class people?¹⁹⁸

In determining how to answer some of these questions, consider the case of Rosa Rivera, described in the Introduction to this Article. Although the opinion in Rivera's case contained no information concerning why she did not receive prenatal care, her deposition testimony reveals that she tried to get care but could not afford it. Because her story is somewhat sketchy, let us examine a number of possible hypothetical situations to flesh it out. Different variables may have affected her ability and/or willingness to obtain prenatal care. These include: her marital and employment status; whether she was in the country legally or illegally; her cultural biases or linguistic limitations; and the presence or absence of clinics at locations that were convenient to her.

First, assume that Rosa Rivera was married and that both she and her husband were employed, but did not receive health benefits from their employers. As a childless couple they did not qualify for Medicaid, but were unable to afford health insurance on their income. They were also unable to pay the high cost of prenatal doctor visits and for the prescription drugs to control Ms. Rivera's hypertension. This hypothetical may be the easiest case because Ms. Rivera's reason for not getting prenatal care is purely economic. If the Clinton plan

¹⁹⁸ Both positions were represented at the Symposium. Richard Weishaupt argued that the poor should not be segregated. If they are, they lose their political power. But Maura Bluestone and Sylvia Drew Ivie argued effectively that because the poor's needs are different, they should get more services provided by plans that have a clear mission and a desire to accommodate them. Given the demographic realities of urban America, this argument implies that the poor will be segregated from middle-class persons. This debate mirrors that which is going on generally in the African American community concerning the value of desegregation. Some believe that a supportive multi-class African American urban community has been lost due to integration because many of the middle-class African Americans have moved out of the inner city. See Charisse Jones, *Years on Integration Road: New Views of an Old Goal*, N.Y. TIMES, Apr. 10, 1994, at A1, A40.

had been the law at the time, Ms. Rivera's employer would have been required to buy health insurance for her. The insurance would have covered prenatal care,¹⁹⁹ and Ms. Rivera would have been treated for her hypertension as soon as it was discovered, well before she went into labor. The treatment presumably would have eliminated Ms. Rivera's arrival at DeTar Hospital in an extremely hazardous condition. Ms. Rivera would have had her own private doctor to treat her and, most likely, he or she would have made decisions about Ms. Rivera's treatment that were consistent with good care and not motivated by fear of malpractice suits. Ms. Rivera's insurance would have covered her hospital bills as well, eliminating the hospital's incentive in the current health care system to treat her differently from its "paying" patients.²⁰⁰ If a Canadian-style single-payer system had been in effect during Ms. Rivera's pregnancy, the result for Ms. Rivera would be the same under this hypothetical. She would have received prenatal and hospital care. Her doctors and the hospital would have billed the state insurance organization directly for their services, and the state organization would have received federal grants to cover Ms. Rivera's costs.²⁰¹

If the Gephardt bill had been the law, Ms. Rivera and her husband's employer would have covered 80% of the family's health insurance costs, as under the Clinton plan. She and her husband would have been liable for 20% of the coverage. Moreover, if their family income level fell below 250% of the federal poverty level, the Gephardt plan would have provided federal subsidies for their health insurance premiums. This bill may be more beneficial to the poor than the Clinton plan because the Clinton plan would subsidize families who earn only up to 150% of the poverty level.

If the Cooper bill had been law, however, Ms. Rivera may not have been covered by insurance for her prenatal and hospital care. Because the Cooper bill does not require employers to pay for insurance benefits for their employees, Ms. Rivera and her husband's employers could have opted not to cover their

¹⁹⁹ HSA § 1116.

²⁰⁰ This result would not be the same if Ms. Rivera were an undocumented worker. If she were undocumented, she would not be covered by the Clinton bill, except that Medicaid would pay for emergency hospital care. See *supra* note 179.

²⁰¹ See Seaton, *supra* note 97.

insurance benefits. Assuming that the Riveras' employers chose not to pay the insurance premiums for their employees, the Riveras might still have been eligible for federal subsidies of their insurance premiums, but the subsidies would depend on their income. Under the Cooper bill, if the family income fell below 100% of the poverty level, the federal government would pay the premiums for Ms. Rivera's coverage.²⁰² If the family income fell between 100% and 200% of the poverty level, the federal government would grant sliding scale subsidies for health plan premiums. If their family income fell above 200% of the poverty level, however, the Riveras would receive no aid from the government for premium payments. Thus, if the Rivera family income was between 100% and 200% of the poverty level and, even with sliding scale subsidies, the Riveras could not afford to pay the insurance premiums, under the Cooper bill, Ms. Rivera would not have health or hospital insurance. The same is true if their income exceeded 200% of the poverty level and the Riveras could not afford to pay.

It is unclear whether the Riveras would have fared better under the Mitchell or the Cooper plans. Under the Mitchell bill, just like the Cooper plan, the Riveras' employers would not have been required to pay for their health insurance. After the year 2002, however, the Mitchell bill may require the Riveras' employers to pay 50% of their health insurance costs. If the Rivera family income fell below 100% of the poverty level, the Mitchell plan, like the Clinton and Cooper plans, would cover the entire cost of the Riveras' insurance coverage. If their income fell below 185% of the federal poverty level, the federal government would pay the *full cost* of Rosa Rivera's insurance premiums while she was pregnant, but it would not pay for Mr. Rivera's insurance premiums, nor would it pay for Ms. Rivera's premiums after she gave birth, because it does not provide for any subsidies for health insurance premiums of non-pregnant adults who are members of a family earning income above the poverty level. It would pay, however, for all of the insurance costs of their newborn child until he reached age 19. While the Cooper bill provides for subsidies on a *slid-*

²⁰² This is at least an improvement over the current Medicaid system, which excludes 58% of persons living under the poverty level. See *supra* note 14 and accompanying text.

ing scale basis for persons whose income falls between 100% and 200% of the poverty level, it does not distinguish between adults, pregnant or not, and children. Thus, it remains unclear whether the family would have fared better under the Mitchell plan. The answer to this question depends on the family income, how generous the sliding scale subsidies of the Cooper bill are, the cost of insuring Ms. Rivera, the cost of insuring her husband, and the future costs of insuring their child.

One other difference between the Cooper and Mitchell bills could have been crucial in this case. The Mitchell bill grants comprehensive coverage, including the costs of prescription drugs used to control Ms. Rivera's hypertension. It is unclear, however, whether the Cooper bill would cover these costs.

Next, assume that Ms. Rivera was married and that she and her husband had part-time work. Their employers did not pay for their health insurance and they could not afford to buy their own insurance. Once again, they would not qualify for Medicaid. If the Clinton bill had been in place, it would not have required the Riveras' employers to pay for their health insurance because they are part-time workers. The Riveras would get subsidies from their regional alliance if their family income fell below 150% of the poverty level. If, however, their income exceeded 150% of the federal poverty level, and the Riveras could not afford to pay for benefits, they would have no insurance under the Clinton plan.

The result under the Cooper bill would be almost the same as under the Clinton plan.²⁰³ Under the Cooper bill, the Riveras' employers could refuse to pay for health insurance. If the Riveras' income exceeded 200% of the poverty level, they would get no aid in paying insurance premiums. If their income fell below 100% of the poverty level, the government would cover their premiums, and if their income fell between 100% and 200% of the poverty level, they could get sliding scale subsidies for their insurance premiums. Thus, for part-time workers, the Cooper bill is slightly more favorable than the Clinton plan because it gives subsidies up to 200% of the poverty level, whereas the Clinton plan subsidizes insurance premiums for families earning up to 150% of the poverty level.

Under the Mitchell and Gephardt bills, the results would

²⁰³ It is the same result for part-time as for full-time workers.

be much the same as those under the Clinton and Cooper bills. Neither would require the employer to pay the employees' health insurance premiums, but the Gephardt bill would provide a subsidy for the Riveras if their income did not exceed 250% of the poverty level. This bill would subsidize insurance premiums of persons whose income exceeds those subsidized by the Clinton plan—150% of the poverty level—and the Cooper plan—200% of the poverty level. Once again, the Mitchell plan would pay for all of Ms. Rivera's care, assuming that the family income falls below 185% of the poverty line, but it would not pay for her husband's or child's insurance benefits unless the family income were below the poverty level.

If a Canadian-style single-payer plan had been in effect at the time of Ms. Rivera's pregnancy, she would have gotten prenatal and hospital care, thereby eliminating her danger. Because payment is not linked to employment status in such a system, the Riveras would have been entitled to coverage even though she and her husband were part-time workers.

Finally, assume that Ms. Rivera had a number of children, was unmarried and unemployed. Further assume that Ms. Rivera qualified for Medicaid and possessed a Medicaid card. Ms. Rivera did not receive prenatal care because the closest clinic to her home was five miles away—two bus zones and a subway ride. There were no doctors in her area that would treat Medicaid patients. She found it extremely difficult financially and, especially in her condition, physically, to travel with her small children to the clinic where she could see a doctor. Moreover, once she reached the clinic, she could not understand the doctors or the clinic staff because her English was very limited and they did not speak Spanish.²⁰⁴

It is unclear whether the Clinton plan, a single-payer plan, or any of the other proposals considered by the Congress today would solve Ms. Rivera's problems. These problems are not only medical problems; a purely medical system that does not account for cultural differences and logistical problems will fail

²⁰⁴ Ms. Rivera would have been fortunate to be a member of the Bronx Health Plan, described by Maura Bluestone, or T.H.E. Clinic for Women, described by Sylvia Drew Ivie at the Symposium. *See supra* part V. Had she been linked to a community clinic providing culturally competent care, transportation and other enabling services, she may have avoided the hazardous condition she was in when she arrived at DeTar Hospital.

to deliver adequate health care. Certainly, the bills themselves do not provide for, nor even define, culturally competent care. Nor do they require that the clinics pay for transportation of a patient whose situation is as difficult as Ms. Rivera's. The Clinton plan makes some attempts to preserve community clinics by granting some benefits to "essential providers."²⁰⁵ But it is unclear whether these provisions will be sufficient to take care of Ms. Rivera's needs.²⁰⁶ Moreover, the Clinton plan would grant some money for outreach and enabling services²⁰⁷ and for an expansion of the National Health Service Corps to encourage more practitioners to go into underserved areas.²⁰⁸ But whether these grants would be sufficient to maintain the clinics that are already providing good care and encourage the growth of more clinics is doubtful.²⁰⁹ Thus, if the third hypothetical were true, Ms. Rivera would suffer just as much under the health care reform proposals under consideration as she did before the reform took place.

In conclusion, contrary to public perception, the poor need health care reform at least as much as and probably more than the middle class. Professor Marmor correctly argued that without health care reform that benefits the middle class, the poor will be left with nothing. But the converse may not be true. Health care reform that improves the delivery of health care to the middle class may not be adequate to serve the needs of Rosa Rivera or of other poor people.

The poor need a reform with a focus that differs from that of the middle class. While middle-class Americans fear the loss of health insurance if they change jobs, their primary focus is on insurance coverage. To a great degree, granting the middle class the right to universal coverage with a generous benefits package will meet its needs.²¹⁰ In contrast, the poor, even

²⁰⁵ See *supra* note 73.

²⁰⁶ HSA §§ 1431-1432 provide grants to essential providers for 5 years. Professor Randall criticizes this provision as inadequate. See Randall, *supra* note 15, at 195-97.

²⁰⁷ See *supra* part II.A.

²⁰⁸ See *supra* part II.A.

²⁰⁹ See *supra* part V.; Randall, *supra* note 15, at 196-97.

²¹⁰ Of course, there will be substantial debate over how the "managed competition" scheme offered by the President will affect the quality of care. Because cost containment will be a focus of that plan, many middle-class persons may be denied "experimental," potentially life-saving treatments such as bone marrow trans-

when they are covered by Medicaid, historically have had great difficulty acquiring quality health care.²¹¹ At this point, the interests of the poor and the middle class diverge. Although "universal coverage" and access to a "comprehensive benefits package" are crucial to ensuring quality health care for the poor and underserved, these provisions alone may not improve the health status of the poor and underserved.

The poor and underserved need broad-based reform that also includes well-drafted discrimination provisions prohibiting states, health alliances, health plans and individual providers from intentionally discriminating against them because of their race, gender, sexual preference, national origin, age, health,²¹² occupation, language or economic status. They also need provisions that prohibit discrimination that disparately affects them, but which does not satisfy an intent requirement.²¹³ All of these provisions must be enforceable in dual fashion. The representatives of the poor and underserved should be permitted to bring class or individual actions in federal or state court to redress wrongs. These provisions should be supported by attorneys' fees provisions entitling prevailing plaintiffs to collect their attorneys' fees from the defendants.²¹⁴ At the same time, however, there must also be fair, inexpensive, quick procedures for resolving disputes concerning discrimination.²¹⁵

An effective reform bill must provide for feedback from

plants.

²¹¹ See Randall, *supra* note 15, at 192.

²¹² The provision that prohibits discrimination based on health status is applicable not only to the poor, but also to the public at large and, as noted by Professor Rosenblatt, *supra* note 136, could be a basis for a coalition between the poor and the middle class.

²¹³ See Randall, *supra* note 15, at 226-31.

²¹⁴ Given the vast difference in resources between the parties, the defendant should not have the same opportunity. Moreover, such a provision would deter plaintiffs from bringing their discrimination claims.

²¹⁵ For example, arbitration before arbitrators who have had experience working in the discrimination law field could yield quick and fair results. The statute could provide funding for training these arbitrators as well as for lay advocates who could represent the clients' interests. For a description of the use of lay advocates, see Rosenblatt, *supra* note 136; Trubek, *supra* note 187. For a description of current provisions under Title VI of the Civil Rights Act of 1964, Pub. L. No 88-352, 78 Stat. 252 (codified at 42 U.S.C. §§ 2000d to 2000d-4 (1982)), and its failure to end health care discrimination, see Watson, *supra* note 14, at 1668-69.

poor and other underserved consumers.²¹⁶ It should specifically require a diverse group to serve on the National Board of Health, the Regional Alliances and on other consumer groups from which the Board, the Alliances and the Health Plans will get feedback.

The HSA should provide funding for research efforts that delve into the health problems of the poor, of women,²¹⁷ of minorities and other underserved people, rather than permit the customary reliance on the white male as the standard upon which most research takes place.²¹⁸

For the poor and underserved to enjoy better health, this society must also build new community-based infrastructures that provide services that poor people need.²¹⁹ The bill should provide capital funding for revitalization of the inner-city health services. By providing funding for medical school education, it must work to attract minority and non-minority providers who have the specific and clear mission of serving the poor. The bill should provide funding for medical schools, hospitals²²⁰ and clinics to be established in the poor communities.²²¹ It must assure that its provisions will provide grants to persons who truly intend to serve the community, rather

²¹⁶ See Randall, *supra* note 15, at 190-92.

²¹⁷ Although they constitute a majority of the population, women have been virtually ignored by the scientific community when conducting medical research. See generally Lillian Gonzalez-Pardo, *Women's Health Care: Limited Access Despite Majority Status*, 3 KAN. J.L. & PUB. POL'Y 57 (1993).

²¹⁸ *Id.*

²¹⁹ See *supra* part V. (describing comments of Maura Bluestone, Sylvia Drew Ivie and Catherine O'Neill). See generally Watson, *supra* note 14.

²²⁰ Senator Kennedy's proposed amendment would put \$2.5 billion more than the Clinton plan into a program aiding hospitals that serve the poor. See Clymer, *supra* note 51, at A21.

²²¹ See Watson, *supra* note 14, for an elaboration of the other types of programs needed to serve poor people in the inner city. There is some question as to whether these programs will work. Certainly, as Professor Dubler emphasized at the Symposium, a reform of the health care system cannot by itself eliminate the class and race-based biases that have such profound roots in this country. Health care reform cannot, by itself, bring back urban communities that are besieged by problems. But some programs could help to contribute to the community. Dr. Phillip R. Lee, Assistant Secretary for Health in the Department of Health and Human Services, may disagree. He has been quoted as saying that it would be unrealistic to expect many doctors to open up practices in the inner city because "the environment is just too difficult." He advocates the formation of networks like that established by Montefiore Hospital in the South Bronx. See Clymer, *supra* note 11, at B8.

than those who want to exploit it. It must ensure the continued existence of medical schools that train primarily minority physicians who will return to their communities to provide care.²²²

This model of community-based care is not necessarily inconsistent with a model that would encourage health plans to serve a more diverse economic group. The bill could permit experimentation with a variety of models. If it does, however, it must support the community-based clinics well, permitting them to include in their budgets the necessary ancillary services Maura Bluestone describes. The bill should also permit choice, allowing poor consumers like Rosa Rivera to select either a community-based clinic or one that will draw from a more diverse community, without creating an economic incentive for choosing one over the other. To ensure that this choice is real, the Act should provide for the necessary ancillary services for poor persons to participate in a clinic that is not located in their community. It should also require that, to avoid discrimination, all health plans provide culturally competent care, including linguistic services, if necessary, by sensitive health professionals.

Only by including these changes will the health plan represent true reform, not just to serve the needs of the middle class, but also to provide equal and quality health care for Rosa Rivera and other poor and underserved persons.

²²² See Randall, *supra* note 15, at 202-03.

