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# SYMPOSIUM

## SETTING A PLACE FOR ED SPARER AT THE NATIONAL HEALTH REFORM TABLE

*Sara Rosenbaum\**

### INTRODUCTION

I had the great fortune to know Ed Sparer. His interest and involvement in all aspects of health reform—both as law and as the embodiment of the nation's commitment to health care for all—would have been limitless. In speaking with Professor Nan Hunter earlier this fall, I had thought that perhaps I would discuss the actual drafting of the legislation. But while the policy basis and the construction of complex law are matters that would have held Ed's intellectual interest, what would have held his attention is an assessment of what the plan will do for medically underserved communities.

Therefore, I will begin with an overview of the President's bill and its legal structure. I will then turn to the issue on which Ed would have focused his energies: the ways in which the bill would actually bring equity in health care to all communities.

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## THE HEALTH SECURITY ACT

The Health Security Act ("the Act" or "HSA")<sup>1</sup> may be the single largest piece of social welfare reform legislation ever considered by Congress, both in length and scope. Contained in its 1300-plus pages are hundreds of pages of new law and several hundred pages of revisions to a host of existing federal health laws. The drafting effort took approximately eleven months and involved about ten attorneys, including Professor Hunter. It began with countless meetings with the President's Health Reform Task Force and with the President and First Lady, from which emerged a set of broad legislative specifications. The development of this outline was followed by four months of intensive legislative drafting and consultation in order to convert the specifications into legislation.

Some critics have challenged the measure as unduly lengthy and specific. Indeed, the bill leaves little to the imagination and, as a result, portions of the measure that are opposed by the health industry may prove easier to challenge. Yet it is the bill's very specificity that will make it amenable to reasonably accurate cost projections—essential to passage—and more importantly perhaps, clear in its policy and legal intent. With the exception of the McDermott/Wellstone measure—the single-payer bill—other legislative proposals offered during this past Congressional session have left policymakers in the dark about the benefits that will be guaranteed, the financial assistance in paying for health coverage that will be assured, or how coverage will be assured, regardless of any change in family, health or economic status.

From a lawyering point of view, the experience of preparing the HSA was a once-in-a-lifetime event. Nearly all of us had done extensive legislative drafting over the years, but the types of questions that arose in constructing this bill were ones that generally are considered only in a law school setting. Few lawyers ever have the opportunity to bring into being a piece of legislation that changes the course of national social policy and demands consideration of whether Congress has the constitutional authority to enact law that, in many respects, represents

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<sup>1</sup> H.R. 3600, 103d Cong., 1st Sess. (1993), S. 1757, 103d Cong., 1st Sess. (1993) [hereinafter HSA].

a fundamental shift in one-seventh of the U.S. economy.

The bill that emerged from this effort will change significantly as it moves through Congress. Yet, vast portions of the measure, particularly its fundamental legal form, probably will remain unchanged. Therefore, the fact that this bill is likely to be the real thing, as opposed to just another piece of introduced legislation, made it very important to address many "first order" constitutional matters that never have been considered in health reform bills of this nature.

The President's bill constitutes a unique legal structure. It requires all citizens and most legal residents to purchase private health insurance coverage through large purchasing groups known as health alliances. It also ensures that individuals subject to this new obligation will be entitled to receive sufficient premium contributions through employers and the government so that coverage is affordable. Moreover, the Act provides a specified benefits package and requires accessible health services. The bill thus constitutes a legal amalgam unparalleled in current law. All Americans not yet eligible for Medicare are guaranteed health coverage but have a concomitant duty to purchase private health insurance. The guarantee of coverage is federal, the program design is federal, and the same entitlement exists regardless of the state of residence. The program, however, is to be administered by the states.

Unlike Medicare, which authorizes a federally administered, public-insurance program financed through general revenues and dedicated taxes, and whose basis lies squarely within the Commerce and Taxing Clauses of the Constitution, the President's measure does not depend on taxing powers.<sup>2</sup> Instead, it is a Commerce Clause measure which authorizes a complex set of federal duties on individuals and employers and requires all obligated parties to purchase private health insurance.

Thus, the bill seeks to regulate the conduct of both businesses and individuals within the marketplace. The question of whether, in the absence of some specific limitation, Congress

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<sup>2</sup> Subsequent rulings by the Congressional Budget Office, the arm of Congress which estimates the cost of legislation, have classified the law's premium contribution requirements as revenue raising measures. As a result, Congress's taxing powers may also form a constitutional basis for the measure.

can reach individual conduct and regulate the purchase of health insurance as part of its authority to regulate interstate commerce, would appear to be settled, even in situations in which the regulation imposes financial requirements on individuals.<sup>3</sup> Because the measure has no historical precedent, however, the determination of whether Congress has the power to require Americans to purchase private insurance was reached only after careful debate which led to the inclusion of certain limitations on congressional powers. These limitations include the right of individuals to purchase any additional health services they choose, and the right of individual health professionals who oppose the provision of certain types of health care on moral or religious grounds not to be compelled to furnish covered medical services.<sup>4</sup>

Similarly unprecedented is the manner in which the Act is to be administered. Unlike Medicare, which is federally administered, the HSA contemplates state administration of a federal program. Under programs enacted pursuant to Congress's spending powers, there is ample precedent for state administration of federally guaranteed benefits. The principal example of such a health program is, of course, Medicaid. Yet, as with all Spending Clause programs, whether a state administers Medicaid is voluntary. That is, only if a state elects to accept federal funding and administer the program is it bound by federal requirements.<sup>5</sup>

Under the HSA, all U.S. citizens and most legal U.S. residents are guaranteed coverage,<sup>6</sup> regardless of their place of residence. Yet, under the Constitution, the States may not be compelled to carry out a federal duty (in this case, the assistance of affordable coverage). Therefore, to assure that the federal guarantee will be enforced, regardless of whether one or more states elect not to administer the program, the bill contains a federal "default" provision under which the Secretary of Health and Human Services would administer the plan in non-participating states and would impose a direct premium levy on employers and individuals.<sup>7</sup>

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<sup>3</sup> See *Wickard v. Filburn*, 317 U.S. 111 (1942).

<sup>4</sup> HSA §§ 1003, 1162.

<sup>5</sup> *Virginia Hosp. Ass'n v. Wilder*, 496 U.S. 498, 510 (1990).

<sup>6</sup> HSA § 1001.

<sup>7</sup> *Id.* §§ 1522-1523.

Beyond these "first order" constitutional matters lie dozens of other issues with enormous legal and policy implications. What individual remedies should be included in a new health care program to enforce legal guarantees? How should the bill relate to other existing laws protecting the rights of individuals, particularly the civil rights laws, where, as here, the programs at issue (i.e., private insurance plans) are not "federally assisted" entities in the traditional sense? What due process will be required for individuals with grievances against health plans? I believe that the Act answers these and related questions involving the protection of individual rights in a fair and just fashion.<sup>8</sup> Indeed, no other measure currently under consideration contains such extensive provisions relating to the fair treatment of all eligible persons.

Thus, the President's bill represents an unprecedented effort to build on the private health insurance system that has existed for a half century, while at the same time using the power of the federal government to eliminate the many aspects of the system that have made it unfair, excessively costly and unworkable. Ed Sparer, while one of the most idealistic of persons, also was a pragmatist. Regardless of whether Ed would have considered himself a "single-payer" advocate, a "pay-or-play" aficionado, or a true disciple of a National Health Service, I believe that he would have appreciated the milieu in which social policy in late twentieth-century America has developed. He also would have understood the enormous political difficulties inevitably entailed in passing national health reform legislation in the face of a highly developed, essentially unregulated and enormously wealthy private health insurance market. Of all people, Ed would have looked for a way to advance to the next level, even if that level ultimately was not the end point.

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<sup>8</sup> The bill prohibits discrimination by states, health alliances—the state-created entities that collect premiums, select qualified health plans for alliance residents and assure enrollment and the continuation of coverage—and health plans on the basis of race, national origin, religion, sex, disability, perceived health status and socioeconomic status. In the case of health plans, these non-discrimination provisions are a direct federal contractual requirement and, thus, are not dependent on a finding of federal financial assistance. HSA §§ 1200-1591.

## ACCESS TO SERVICES

Notwithstanding different models of health *insurance* reform, Ed surely would have placed utmost importance on those elements of health reform that are particularly critical to poor communities. There are specific aspects of any national health reform measure that take on heightened prominence in communities that have a high proportion of low income and minority residents and, thus, are unable to attract and sustain a sufficient level of health services. Even if insured, these communities risk losing out in the fight for decent health care. Few practitioners, even in the face of a more lucrative market, willingly choose to settle and work in impoverished inner-city and rural areas of the nation. Even insured families cannot make the out-of-pocket payments, in the form of coinsurance, deductibles and uncovered benefits, that may be integral to even a generous health reform plan. Moreover, they are unable to buy the types of services such as food, shelter and other basics of life that, while essential to health, are not medical in nature and, therefore, are not covered by even the broadest form of health insurance. Thus, practicing medicine in these communities presents an enormous challenge to which an insufficient number of health professionals have risen over the years.

I believe that, in measuring equality and universality in health reform, Ed would have looked for far more than insurance coverage. He would have cared most deeply about whether the health reform plan before him contained provisions designed to ensure care of equal accessibility and quality. In a seminal article written over a decade ago,<sup>9</sup> Ed explored the limits of Medicaid as both a health insurance plan restricted to the poor and as a means in-and-of-itself for bringing about equal access to health care and, perhaps even more importantly, dignity in health care. In a country with as much poverty and residential segregation as this one, increasing market purchasing power surely will have some impact, but alone its long-term effect may be quite limited. Reforms beyond health insurance are needed.

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<sup>9</sup> Edward V. Sparer, *Gordian Knots: The Situation of Health Care Advocacy for the Poor Today*, 15 CLEARINGHOUSE REV. 1 (1981).

Ed cared passionately about the dignity of his clients and saw firsthand what it means in poor communities when the choices are only those of substandard care or no care at all. His writings concerning his work on the quality of care and the ultimate closure of the Sarah Allen Nursing Home,<sup>10</sup> which consumed much of his time, are some of the best I have read about the true Hobson's choices that plague low-income communities when, as bad as conditions in a facility are, the consequences of facility closure are far worse. The amount of time Ed invested in creating family medical centers,<sup>11</sup> and in trying to preserve a birthing center for low-income and underserved women so that they could have a dignified child-birth experience,<sup>12</sup> are a testament to his paramount concern with the outcome of health policy, not on the abstract policy itself, on care for the poor.

Ed was someone who strove to take what life dealt out for his clients and make better of it, and he did so tirelessly on behalf of the communities and families he represented. He worked with a great sense of idealism and pragmatism and in a constructive, rather than destructive, manner. He was always looking for the next progressive step. Andy Schneider described Ed wonderfully: he was a creative incrementalist.

To the naked eye, Ed's writings may seem inconsistent. On the one hand, he ended his life deeply troubled by a poverty health insurance program such as Medicaid, which, despite the best efforts of many advocates, appeared to him to "dead end" into a world of inadequate financing and unfair decision-making by officials. On the other hand, Ed championed the creation and survival of facilities that, by their very location and service missions, were almost exclusively sources of health care for the poor. Even when they were substandard, Ed devoted an immense amount of time to making them work better, rather

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<sup>10</sup> Edward V. Sparer, *The Case of the Sarah Allen Nursing Home: Personal Reactions, Speculations, and Proposals Concerning the Plight of the Aged in Philadelphia*, 4 HEALTH L. PROJECT LIBR. BULL. 343 (1979).

<sup>11</sup> Edward V. Sparer, *The Family Medical Centers of Philadelphia: What They Are, What Their Promise Is, and How the Citizens of Philadelphia Can Help*, 3 HEALTH L. PROJECT LIBR. BULL. (1978).

<sup>12</sup> Edward V. Sparer, *Health Planning For—or Against—Innovative and Improved Maternity Care: The Case of the Closing of Obstetrical Services at Presbyterian Medical Center in Philadelphia*, 5 HEALTH L. PROJECT LIBR. BULL. 291 (1980).

than taking the easy way out by espousing their closure.

My own career, which has involved work on both health-care financing and service delivery issues for the poor, has led me to the same point Ed reached, and I find his conclusions eminently easy to understand and reconcile. Like Ed, I view insurance as a means to an end. It is a way of paying for something and no more. It is the "what" that health insurance purchases, not the "how" that matters. I think that Ed probably would have cared little about whether health reform produced a private or public health insurance purchasing system. In the end he would have cared most about whether the "what" that is purchased for communities is responsive to them. He opposed Medicaid not because of technical flaws in the program but because of the sheer impossibility of keeping such a segregated financing system adequately funded. At the same time, he would have championed any health reform effort that applied an equitable funding base to the creation of community-based sources of health care because of his abiding belief in the need for community-responsive services to foster the dignity of patients and neighborhoods.

The question for Ed, then, would not have been whether reform was packaged as a single- or multi-payer bill, but whether it would lead to a just health care system, rather than merely to more insurance coverage.

The President's bill attempts to deal with access to health care for the poor in several ways. First, the legislation contains a number of provisions designed to promote health services of good quality in underserved communities. Funds are authorized for a significant expansion of federally funded community and migrant health centers.<sup>13</sup> The bill also authorizes increased funding for the National Health Service Corps<sup>14</sup> and provides additional financial support for hospitals that furnish health services to high numbers of low-income persons.<sup>15</sup> The measure also authorizes expanded funding for population-based public health activities designed to plan, promote and monitor the public's health and to measure the quality of

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<sup>13</sup> HSA §§ 3401.

<sup>14</sup> *Id.* §§ 3471-3484.

<sup>15</sup> *Id.* §§ 3411-3462.

health services furnished by health plans.<sup>16</sup>

Most significantly, perhaps, the bill contains substantial, authorized funding for the development of community-based practice networks and health plans comprised of providers who have dedicated their careers and programs to the practice of health care in underserved areas.<sup>17</sup> Groups of health providers would have the choice of joining large commercial plans or coming together to form health plans designed to further the mission of individual participating providers or both. These community plans and networks, as well as other providers working in low income areas, also would be eligible to receive grants for "enabling services," including translation, transportation and other patient case management services necessary to achieve access to health care among underserved populations.<sup>18</sup>

Perhaps most far-reaching in the President's bill are those provisions that prohibit discriminatory practices by health plans and require plans to include within their networks certain "essential community providers." These provisions are unparalleled in any other measure introduced to date, including the McDermott/Wellstone bill.

## DISCRIMINATORY PRACTICES

For the first time, the health insurance industry would be prohibited from medically underwriting individuals or groups.<sup>19</sup> Building on this medical underwriting prohibition, health plans would also be prohibited from engaging in any practice, including the selection of marketing and service areas and, in the case of HMO-type network plans, the selection of participating providers, which has the effect of discriminating on the basis of race, national origin, religion, sex, socioeconomic status, disability or the anticipated need for health services. Only where a plan could make a showing that a particular action complained of arose out of a business necessity would discriminatory actions be permissible.<sup>20</sup> More significantly,

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<sup>16</sup> *Id.* §§ 1301-1334.

<sup>17</sup> *Id.* §§ 3401-3484.

<sup>18</sup> HSA §§ 3401-3484.

<sup>19</sup> *Id.* §§ 1400-1591.

<sup>20</sup> *Id.*

the prohibition is not based on the plan's receipt of federal financial assistance in the case of subsidized individuals; instead, it is included as a basic condition of participation as an alliance health plan.

#### TREATMENT OF ESSENTIAL COMMUNITY PROVIDERS

Beyond the prohibition against discrimination, plans affirmatively would be required to include essential community providers within their networks.<sup>21</sup> These providers include several classes of publicly funded general and special purpose health providers which, by law, are located in and furnish care to medically underserved areas and populations. Their services range from general family practices—in the case of community and migrant health centers, federally qualified health centers and rural health clinics—to special programs for homeless persons, publicly supported maternal and child health and family planning clinics and school health clinics.<sup>22</sup> All of these programs have developed a special expertise in the care of poor, high-risk and medically underserved populations, and are designed to enhance access to health care for hard-to-reach patients. Decades of litigation in the area of civil rights and health care have underscored that one of the most effective tools used by the private health system for reducing access to and utilization of health services by "undesirable" populations is to deny their providers access to necessary medical resources, such as staff privileges,<sup>23</sup> thereby forcing patients to rely on providers (for what care they receive) who are unfamiliar with them and who may be unwilling to serve them. Out of concern that health plans, denied the right to medically underwrite, would engage in risk avoidance through patient discrimination, the President's bill denies to plans one of the most potent discriminatory tools, namely, the isolation of quality providers who treat poor patients.

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<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

<sup>23</sup> Sara Rosenbaum & Marilyn Sager, *Unlocking the Hospital Doors: Medical Staff Membership and Physicians Who Serve the Poor*, 9 YALE L. & POL'Y REV. 46 (1991).

## CONCLUSION

No bill will come out of Congress in its original form. As the deliberative process unfolds, we will witness vast changes in the Health Security Act. It is past the time when abstract ideological discussions about which insurance models should be pursued have any real meaning. Ed Sparer set the standard for all of us. He rose above ideological discussions and instead forced us to focus on what would really help people. I only wish that federal policymakers always could be guided by Ed's approach to life and its challenges and his insistence on separating the real from the philosophical for the sake of the people he represented. Under these circumstances, the American public would be virtually guaranteed an end product that always attempts to do what is good and just.

