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Does Clinton's Health Care Reform Proposal Ensure Equality of Health Care for Ethnic Americans and the Poor?

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DOES CLINTON'S HEALTH CARE REFORM PROPOSAL ENSURE (E)QUAL(ITY)* OF HEALTH CARE FOR ETHNIC AMERICANS AND THE POOR?

*Vernellia R. Randall***

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* The term (e)qual(ity) means equal and quality. It was coined by Professor Ann C. McGinley of Brooklyn Law School.

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INTRODUCTION

On September 22, 1993, President Clinton appeared before the American people to discuss his plans to reform the health care system. On November 20, 1993, the Health Security Act

(the "Act" or "HSA") was introduced into Congress.¹ The Act responded to concerns about the uninsured and underinsured, about uncompensated care and about cost containment.² An implicit assumption has been that economic access is the most significant barrier to health care; and, in fact, it may be. However, there are many other barriers to access.³

If equitable access means, or is defined as, the actual receipt of the quality and quantity of services needed, then access in America has been inequitable.⁴ Many individuals receive different health care (both quantity and quality) based on characteristics other than medical need. The care received by the wealthy is different than the care received by the poor; the care received by European Americans⁵ is different than the care received by ethnic Americans;⁶ and the care received by

¹ The Health Security Act was introduced into the House as H.R. 3600, 103d Cong., 1st Sess. (1993), and into the Senate as S. 1757, 103d Cong., 1st Sess. (1993) [hereinafter the HSA].

² See e.g., 139 Cong. Rec. S12.288-01 (daily ed. Sept. 23, 1993) (statement of Senator Moseley-Braun, D-Ill., reciting the need for the HSA, based on the thirty-eight million uninsured, the millions inadequately insured, the escalating cost of health insurance, and the escalating expenditures on health care).

³ The barriers to (e)qual(ity) health care for ethnic Americans include: inability to afford quality health care (economic barriers); lack of providers and facilities from which to obtain health care (infrastructure barriers); provision of services in a middle-class form (class barriers); inability to obtain care because of racism (racial barriers); provision of culturally incompetent care (cultural barriers); and inability to obtain health care because of communication problems (language barriers). See *infra* notes 113-19, 175-84, and accompanying text.

⁴ America has had a "long tradition of inadequately-funded, inferior, and segregated services for low-income and minority patients . . . entrenched by widespread racial, gender, ethnic, and class bias in many parts of the system." Rand E. Rosenblatt, *On Access to Justice, Discrimination and Health Care Reform 3* (Feb. 14, 1994) (testimony before the Health and Environment Subcommittee of the House of Representatives) (on file with the *Brooklyn Law Review*).

⁵ "European American" denotes individuals usually called "white." Historically, ethnic Americans have been designated with a hyphenated name: "African-Americans," "Asian-Americans," "Native-Americans," "Hispanic-Americans." The hyphenation implies that a second person would not recognize these individuals as Americans unless designated as such. On the other hand, "white" persons need no designation because they are presumed to be Americans. Consequently, even linguistically, "whites" maintain a position of power. See Charles P. Freund, *Rhetorical Questions: The Power of, and Behind, a Name*, WASH. POST, Feb. 7, 1989, at A23. It would be "nice" if no designations were needed, but the reality of the situation requires us to discuss the needs of specific ethnic groups. The term "European," rather than "Anglo-Saxon," provides balance with the other designations; that is, it offers a designation which loosely identifies the geographic region from which the original ancestors migrated.

⁶ I reject the designation of "minorities" because it connotes subordination. The

men is different than the care received by women.

Has the HSA designed a system that removes or minimizes inequities? Or will it provide the wealthy with one level of care and the poor with another? Does the HSA fashion a system that distributes health care resources so that ethnic Americans receive the same quantity and quality of care as European Americans? Will the system envisioned result in improved health status for ethnic Americans?

It is important that ethnic Americans do not accept an inadequate solution as a compromise. Once a significant reform package passes Congress and becomes law, the issue of "major" health care reform probably will not be addressed again for quite some time. Furthermore, as ethnic Americans begin to point out problems with the "reformed" system, European Americans, particularly those with upper-middle income, are likely to feel resentful toward ethnic Americans. European Americans, having expended a significant amount of energy, time and political capital on reforming the health care system, are likely to consider ethnic American concerns as undocumented complaints.

Consequently, despite the rhetoric of economics, ethnic Americans must ultimately evaluate health care reform on the potential to improve health status. Improving health status depends on improving access to both equal and quality health care. Ultimately, then, health care reform must be evaluated on how effectively it removes (or at least, significantly reduces) barriers to (e)qual(ity) health care.

Using the Health Security Act⁷ as a bases for analysis, this article analyzes the potential for health care reform, in its current form, to improve access to health care for ethnic Americans.⁸ Unfortunately, the article concludes that health

phrase "ethnic Americans" is used to refer to African Americans, Asian/Pacific Islander Americans, Indian/Native/Eskimo Americans and Hispanic/Latino Americans. Ethnic Americans constitute a significant portion of the American population—24.36%. 1990 U.S. CENSUS. Even within each ethnic group, however, there is significant diversity. For instance, Asian/Pacific Islanders speak over 100 different languages and dialects. ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS, at 2 (unpublished manuscript, on file with author). They have a varied history of settlement in America, and represent 47 different ethnicities. *Id.* at 3. Such diversity exists to some extent among all ethnic Americans. Consequently, the categorizations in this paper are, at best, generalizations.

⁷ See *infra* part I.

⁸ This evaluation is based on the contents of the HSA, as submitted to Con-

care reform will fail ethnic Americans and the poor because it maintains a structurally and ideologically flawed system;⁹ it perpetuates a fragmented system with inadequate infrastructure;¹⁰ it maintains a culturally incompetent system based on illness care;¹¹ it rations health care through a tiered system based on private interests;¹² and it inadequately protects against health care discrimination.¹³

I. DESCRIPTION OF THE HEALTH SECURITY ACT

Of the industrialized nations, only two, the United States and South Africa, do not have a national system of health care for their citizens.¹⁴ The Health Security Act sets the framework for a national health care system. It is a complex bill, over 1500 pages long. This description is intended to provide only a brief overview of the structure, coverage and benefits proposed by the Act.

A. Structure

According to the HSA, the federal government sets the basic framework for the system, including national standards on benefits, quality and access to care.¹⁵ States are given flexibility to implement health care reform within the federal framework, including designing and monitoring the system.¹⁶ That flexibility extends to designing a single-payer plan if a state desires.¹⁷

The Act, however, clearly lays out each player's responsibilities under the health care plan. States must identify one or

gress on November 20, 1993, and technically corrected on December 15, 1993. It does not attempt to evaluate the multiple changes (both major and minor) made to the HSA after that date.

⁹ See *infra* part II.

¹⁰ See *infra* part III.

¹¹ See *infra* part IV.

¹² See *infra* part V.

¹³ See *infra* part VI.

¹⁴ See Allyn Lise Taylor, *Making the World Health Organization Work: A Legal Framework for Universal Access to the Conditions for Health*, 18 AM. J. L. & MED. 301, 306 (1992).

¹⁵ HSA § 1151 (definition of benefits).

¹⁶ *Id.* §§ 1200-1205.

¹⁷ *Id.* §§ 1221-1224.

more regional alliances to serve as purchasing agents for health care insurance.¹⁸ The board of each regional alliance consists of employers and consumers, but providers are specifically prohibited from sitting on a regional alliance.¹⁹ Employers with more than 5000 employees may opt out of the regional alliance and develop their own corporate alliance.²⁰ Those that do not are required to pay 80% of the average premium of a full-time employee's health care premium. Health plans that are selected by the alliances may market their product in the alliance. But, ultimately health plans are responsible for guaranteeing coverage for a basic comprehensive benefits package by contracting with providers to provide services.²¹ Providers may choose to participate in as many or as few health plans as they desire. Consumers are required to enroll in a health care plan, to obtain a health care card, and to make premium payments, co-payments and deductible payments.²² No eligible individual can be disenrolled from a health plan until that individual is enrolled in another health plan or becomes Medicare-eligible.²³

The Act offers three basic cost-sharing schedules—the lower, higher and combination types—for health plans, and each individual may sign up for only one of the schedules.²⁴ Each of these schemes represents a different type of health care plan. The lower cost-sharing schedule represents a health maintenance organization ("HMO").²⁵ The higher cost-sharing

¹⁸ *Id.* §§ 1301-1303, 1321-1330.

¹⁹ *Id.* §§ 1301-1302.

²⁰ *Id.* §§ 1311-1313, 1381-1397.

²¹ *Id.* §§ 1400-1414.

²² *Id.* § 1002(a).

²³ *Id.* § 1002(b).

²⁴ *Id.* § 1131.

²⁵ *Id.* § 1132. The lower cost-sharing plan may limit the number and type of health care providers who participate in the plan; require enrollees to obtain health services (other than emergency services) from participating providers or from providers authorized by the plan; require enrollees to obtain a referral for treatment by a specialized physician or health institution; establish different payment rates for participating providers and providers outside the plan; create incentives to encourage the use of participating providers; or require the use of single-source suppliers for pharmacy, medical equipment and other health products and services. *Cf. Id.* § 1407 (providing that "no State law shall apply to any services provided under a health plan that is not a fee-for-service plan [or a fee-for-service component of a plan] if such law has the effect of prohibiting or otherwise restricting plans" from engaging in the above behavior).

schedule represents a fee-for-services plan.²⁶ The combination cost sharing represents a preferred provider organization ("PPO") without network options.²⁷ Even though each of these plans assures basic coverage, consumers are free to purchase any health care services not covered by the health plan or purchase supplemental insurance to cover health care services not included within the basic benefit package.²⁸

In addition to the difference in cost sharing, the higher cost-sharing fee-for-service option and the combination options charge a higher premium.²⁹ Premiums are based on family type.³⁰ The general family share of the premium is computed

The lower cost sharing does not include a deductible, and it has an annual individual out-of-pocket limit on cost-sharing of \$1500 and an annual family out-of-pocket limit on cost sharing of \$3000. *Id.* § 1132(a)(1), (2). Except for out-of-network care, payment of any coinsurance is prohibited. *Id.* § 1132(a)(3)(A), (a)(4). However, a co-payment is required for most services. *Id.* §§ 1132(a)(3)(A), 1135.

²⁶ *Id.* §§ 1131, 1133. The higher cost-sharing plan has an annual individual general deductible of \$200 and an annual general family deductible of \$400. *Id.* § 1133(1). The higher cost-sharing plan shall have an annual individual out-of-pocket limit on cost sharing of \$1500 and an annual family out-of-pocket limit on cost sharing of \$3000. *Id.* § 1133(9). Furthermore, the higher cost-sharing plan may not have co-payments but shall require payment of the coinsurance for most items or services. *Id.* § 1133(10), (11). In addition, the lower cost-sharing schedule requires an individual to incur expenses: during each episode of inpatient and residential mental illness and substance abuse treatment; during each episode of intensive non-residential mental illness and substance abuse; for one year for outpatient prescription drugs, biologicals and for dental care. *Id.* § 1133(2)-(5). However, the plan may not require any deductible for clinical preventive services, for prenatal care, for prevention and diagnosis of dental disease. *Id.* § 1133(6)-(8).

²⁷ *Id.* § 1131. The combination plan will have both the lower cost (managed care) option and the higher cost (fee-for-service) option. *Id.* §§ 1131(a)(3), 1134. Like the other plans, the combination plan has an annual individual out-of-pocket limit on cost sharing of \$1500 and an annual family out-of-pocket limit on cost sharing of \$3000. *Id.* § 1134(a)(1). The combination plan requires different cost sharing for in-network items and services than for out-of-network items and services. *Id.* § 1134(a)(2), (b). The combination cost-sharing plan may not apply to the deductible. Furthermore, coinsurance is prohibited, and the combination cost-sharing plan requires an individual and a family to incur expenses before the plan provides benefits for the item or service. *Id.* § 1134(c).

²⁸ *Id.* §§ 1003, 1421-1423 (describing requirements relating to supplemental insurance).

²⁹ *Cf. Id.* § 1423(d)(1)(B) ("the price of any cost-sharing policy shall . . . take into account any expected increase in utilization resulting from the purchase of the policy by individuals").

³⁰ All members of the same family are enrolled in the same health plan. "Family" means an individual who is not a child, the individual's spouse, the individual's children and, if applicable, the children of the individual's spouse. *Id.* § 1011(b). There are separate classes of family enrollment: individual, married

based on the following components: the plan premium, alliance credit, excess premium credit and corporate alliance opt-in credit.³¹ The amount a family is required to pay is based on

couple without children (couple-only), and unmarried individual and one or more children (single parent), and married couple and one or more children (dual parent). *Id.* § 1011(c). The terms "spouse" and "married" are limited to persons married under state law. "Child" means an eligible individual who is under 18 years of age (or under 24 years of age in the case of a full-time student), who is a dependent of an eligible individual. A child includes a stepchild or foster child, and an unmarried disabled individual, regardless of age, who is incapable of self-support. Emancipated minors and married individuals are not children. *Id.* § 1011(e).

Examples of health insurance premiums under the health care reform plan are as follows:

	Low-cost Sharing	Combination Plan B	Combination Plan C	Higher Cost Sharing
Dual Parent Family	\$3700	\$4000	\$4200	\$4900
Single Parent Family	\$2100	\$2200	\$2400	\$2900
Childless Married Couple	\$3000	\$3400	\$3600	\$4400
Single Individual	\$1500	\$1700	\$1800	\$2200

See Appendix A: President Clinton's Health Care Reform Proposal—Preliminary Working Group Draft of Sept. 7, 1993, at *114-*117 (available in WESTLAW BNA-DER) [hereinafter Description].

³¹ HSA § 1342(a)(1). In 1994, a preliminary estimate of monthly premiums based on the Act are:

Monthly Premium under Health Care Reform in 1994

Family Type	Range	Average
Dual Parent Family with children	\$0-\$91	\$73
Single Parent Family with children	\$0-\$80	\$64
Childless Married Couple	\$0-\$80	\$64
Single Person	\$0-\$40	\$32

THE WHITE HOUSE DOMESTIC POLICY COUNCIL, HEALTH SECURITY: THE PRESIDENT'S REPORT TO THE AMERICAN PEOPLE 29 (1993) [hereinafter THE PRESIDENT'S REPORT].

the general family share of the premium for the class of family, any income-related discount for the family, and whether the family receives Supplemental Security Income ("SSI") or Aid to Families with Dependent Children ("AFDC").³²

Full-time employees pay a maximum of 20% of the premium. Employers may pay 100% of the premium if they desire or provide additional benefits.³³ In contrast, a part-time employee's premium is not limited to a certain percentage. It is based on the number of hours worked. For instance, if the employee works half-time, then the worker pays 60% of the premium—the employee's share (20%) plus half of the employer's share (40%). Unemployed individuals and self-employed individuals pay 100% of the premium. Individuals with incomes less than 150% of poverty, however, can obtain discounts or reductions in cost-sharing.³⁴ Self-employed individuals obtain the same discounts as a small employer. Failure to pay amounts owed will not result in loss of coverage,³⁵ however, regional alliances may use credit and collection procedures, including interest charges and late fees, to collect amounts owed.³⁶

B. Coverage

Eligible individuals include citizens or nationals of the United States; an alien permanently residing in the United States under color of law; or a long-term nonimmigrant.³⁷ A Medicare-eligible individual is entitled to health benefits under the Medicare program.³⁸ Military personnel and families, veterans and Indians have a choice of health plan coverage.³⁹ Prisoners⁴⁰ and undocumented aliens,⁴¹ however, are ineligible for benefits through enrollment in a health plan.

³² HSA § 1343(b).

³³ *Id.* § 1003(b)(4).

³⁴ *Id.* §§ 1371-1375.

³⁵ *Id.* § 1344(d).

³⁶ *Id.* § 1345(a).

³⁷ HSA § 1001(c).

³⁸ *Id.* § 1001(d).

³⁹ *Id.* § 1004(b).

⁴⁰ *Id.* § 1001(e).

⁴¹ *Id.* § 1005(a).

C. *Benefits*

The Health Security Act proposes to reform the health care system so that all Americans are guaranteed comprehensive health coverage. Subject to cost-sharing requirements, exclusions, and the National Health Board, the benefits package consists of the following items and services: hospital services, services of health professionals, emergency and ambulatory medical and surgical services, clinical preventive services, mental health and substance abuse services, family planning services and services for pregnant women, hospice care, home health care, extended care services, ambulance services, outpatient laboratory, radiology, and diagnostic services, outpatient prescription drugs and biologicals, outpatient rehabilitation services, durable medical equipment and prosthetic and orthotic devices, vision care, dental care, health education classes, and investigational treatments.⁴² The items and services in the comprehensive benefit package are not subject to "any duration or scope limitation or any deductible, co-payment, or coinsurance amount that is not required or authorized under" the HSA.⁴³ However, each of the services or items is limited by the Act in some manner. For instance, routine screening for cancer of the cervix (pap smears) are authorized only every three years for women between the ages of 20 and 39.⁴⁴ The comprehensive benefit package does not include: custodial care, cosmetic surgery, hearing aids, eyeglasses and contact lenses for individuals at least 18 years of age, in vitro fertilization services, sex change surgery and related services, private duty nursing, personal comfort items, or any dental procedures.⁴⁵ Furthermore, the comprehensive benefits package does not include any item or service that is not medically necessary or appropriate.⁴⁶

⁴² HSA §§ 1101-1128.

⁴³ *Id.* § 1101(b).

⁴⁴ *Id.* § 1114(e).

⁴⁵ *Id.* § 1141(b).

⁴⁶ *Id.* § 1141(a).

II. THE HEALTH SECURITY ACT MAINTAINS A STRUCTURALLY AND IDEOLOGICALLY FLAWED SYSTEM

Unfortunately, for ethnic Americans and the poor, the ethical foundations of health reform are "ideological, financial and legalistic terms."⁴⁷ By framing the need for health care reform in terms designed to appeal to middle-class European Americans, the Clinton administration denies the existence of the health crisis among ethnic Americans and the poor. In particular, it fails to place the issues of race, class or culture at the forefront of health care reform.

Ethnic Americans need a health system that is structurally and ideologically focused on improving health status. Thus, for ethnic Americans, the reformed health care system proposed by the Act is structurally and ideologically flawed because its ethical foundations are incomplete and inadequate;⁴⁸ it focuses on states' rights;⁴⁹ it continues an employment-based health insurance system;⁵⁰ it expands the "private sector" role in health care delivery;⁵¹ and it does not insure representation of ethnic Americans in policy-level decisions.⁵²

A. *Incomplete and Inadequate Ethical Foundations*

As articulated by President Clinton's administration, "[t]he values and principles that shape the new health care system reflect fundamental national beliefs about community, equality, justice and liberty."⁵³ The Administration articulates several principles forming the basis of its proposal.⁵⁴ It is these

⁴⁷ 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) (unpublished manuscript on file with author).

⁴⁸ See *infra* part II.A.

⁴⁹ See *infra* part II.B.

⁵⁰ See *infra* part II.C.

⁵¹ See *infra* part II.D.

⁵² See *infra* part II.E.

⁵³ Description, *supra* note 30, at *5.

⁵⁴ Description, *supra* note 30, at *5-*6. The principles were universal access, comprehensive benefits, choice, equality of care, fair distribution of costs, personal responsibility, inter-generational justice, wise allocation of resources, effectiveness, quality, effective management, professional integrity and responsibility, fair proce-

principles that will direct the ongoing development of the reformed health care system. Two principles of particular significance to ethnic Americans are universal access and equality of care.⁵⁵

The HSA acknowledges that delivery of health care under the current system lacks equality. When it discusses the issue of equality, however, it does so in vague terms that indicate that the magnitude of barriers to health care for ethnic Americans were not adequately contemplated.⁵⁶ Furthermore, the Act, itself, does not recognize equality as an essential component.⁵⁷ Rather, essential foundations articulated in the Act clearly center on autonomy,⁵⁸ regional independence⁵⁹ and competition.⁶⁰

Unfortunately, rather than facilitate effective health reform for ethnic Americans, the foundations could actually serve to erect or maintain barriers. This will be particularly true when the needs of ethnic Americans can be met only by some restriction on either autonomy, regional independence or com-

dures, and local responsibility. *Id.*

⁵⁵ Essentially, "[e]very American citizen and legal resident should have access to health care without financial or other barriers." Description, *supra* note 30, at *5.

⁵⁶ For instance, the Description acknowledges that "[m]any Americans cannot obtain quality care," however, it limits its discussion of barriers to the shortages of doctors, clinics and hospitals. Description, *supra* note 30, at *2.

⁵⁷ The articulated purposes of the HSA are: to guarantee comprehensive health care coverage, to simplify the health care system, to control the cost of health care, to protect individual choice of health plans and health care providers, to ensure the quality of health care, and to encourage responsibility. See HSA § 3(1)-(6) (emphases added).

⁵⁸ It stresses individual autonomy by emphasizing the need to assure that consumers have "the opportunity to exercise effective choice about providers, plans and treatments." Description, *supra* note 30, at *5.

⁵⁹ Regional independence is specifically stressed by maintaining that "states and local communities [should be allowed] to design effective, high-quality systems of care that serve each of their citizens." Description, *supra* note 30, at *6.

⁶⁰ The HSA believes that competition will ensure that "health plans and health care providers are efficient and charge reasonable prices." The HSA § 2(2)(G). See generally *id.* §§ 1300-1303, 1321-1330 (establishing regional health alliances to contract competitively with health care plans to service their identified area); see also *id.* § 1551(c)(2) (allowing the Board to require additional capital of health care plan for factors likely to affect their financial stability including market share and strength of competition); *Id.* § 4118 (allowing "competitive acquisition areas for the purpose of awarding a contract or contracts for furnishing . . . items and services" under Part B of Title XVIII of the Social Security Act. 42 U.S.C. § 1395w-4 (1988 & Supp. IV 1992)).

petition.

For instance, if providers are unwilling to practice in underserved communities, that service may need to be mandated. Such a requirement would certainly conflict with an essential Act element—autonomy. Similarly, regional independence may be restricted if states are required to do more than provide financial incentives to assure health services to ethnic Americans. Such requirements would necessarily restrict a state's option in designing and implementing a health care system.

In an effort to promote competition in the health care system, the HSA relies on the principles of managed competition.⁶¹ Although supported by many organizations and groups, the idea of managed competition has never been tested.⁶² Presumably, managed competition controls health care expenditures because consumers become more cost-conscious. Managed competition assumes large enrollment in managed care products, such as HMOs and PPOs. Since these organizational forms limit the number of participant providers, providers will compete for selection by charging less or providing services in a cost-effective manner or both.⁶³ But, in reality, managed competition will not succeed in controlling U.S. health care expenditures.⁶⁴

⁶¹ Managed competition was coined by the Jackson Hole Group and is synonymous with market-oriented health care reform. Paul Ellwood et al., *The Jackson Hole Initiatives for a Twenty-First Century American Health Care System*, 1 J. HEALTH ECON. 149 (1992). Managed competition requires three major changes in the U.S. health insurance system. First, regional health insurance purchasing cooperatives ("HIPC's") need to be formed to manage the marketplace for health care coverage. Second, employers must contribute the same amount of money for coverage regardless of which plan a consumer chooses. Third, new rules are needed to make it more difficult for plans to avoid enrolling high-risk individuals. Thomas Rice et al., *Holes in the Jackson Hole Approach to Health Care Reform*, 270 JAMA 1357, 1357 (1993). See generally Sandra J. Greenblatt & Michael J. Cherniga, *New Florida Health Reform Plan is First Large Scale Test of Clinton's Managed Competition Theory*, 10 HEALTHSPAN 7 (1993).

⁶² Groups supporting managed competition include major insurance companies, the American Medical Association, the Pharmaceutical Manufacturers Association, and large health maintenance organizations (HMOs). Rice et al., *supra* note 61, at 1357. Consumer organizations are the only significant interest group not supporting managed competition. *Id.*

⁶³ Rice et al., *supra* note 61, at 1357.

⁶⁴ See generally U.S. CONGRESS, CONGRESSIONAL BUDGET OFFICE, *THE EFFECTS OF MANAGED CARE ON USE AND COST OF HEALTH SERVICES* (1992) (little evidence of savings); J. Zwanziger & Rebecca R. Auerbach, *Evaluating PPO Performance*

A number of factors will contribute to its failure. First, many consumers "will continue to purchase expensive health plans."⁶⁵ Second, the "greater enrollment in HMOs will provide few savings."⁶⁶ At present, managed care organizations have not been successful in controlling the rate of increase in health care expenditures.⁶⁷ Third, some "providers will continue to have considerable bargaining power in their dealings with health plans."⁶⁸ Consequently, as one commentator has noted, managed competition "may be this decade's intellectual and moral equivalent of the Laffer Curve, the construct which purported to demonstrate that cutting federal taxes would increase federal revenues, inspiring George Bush to coin the phrase 'voodoo economics'."⁶⁹

Moreover, in an effort to be effective, the HSA may in fact promote behavior in the system that might be harmful to the interests of ethnic Americans and the poor. For instance, since fee-for-service plans lack the gatekeeping aspects of managed competition necessary for cost control, the Act must discourage enrollment in higher cost-sharing plans (fee-for-service plans) and encourage enrollment in the lower cost-sharing plans (HMOs). The HSA attempts to do this by requiring significantly higher premiums for fee-for-service plans and requiring significant co-insurance.⁷⁰ But, many individuals who want to

Using Prior Expenditure Data, 29 MED. CARE 142 (1991); James A. Hester et al., *Evaluation of a Preferred Provider Organization*, 65 MILBANK Q. 575 (1987); P. Diehr et al., *Use of a Preferred Provider Plan by Employees of the City of Seattle*, 28 MED. CARE 1073 (1990). But see Sheldon Greenfield et al., *Variations in Resource Utilization Among Medical Specialties and Systems of Care: Results from the Medical Outcomes Study*, 267 JAMA 1624 (1992) (reporting some cost savings).

⁶⁵ Rice et al., *supra* note 61, at 1357.

⁶⁶ Rice et al., *supra* note 61, at 1357.

⁶⁷ See generally Harold S. Luft, *Trends in Medical Care Costs: Do HMOs Lower the Rate of Growth?*, 18 MED. CARE 1 (1980); Joseph P. Newhouse et al., *Are Fee-for-Service Costs Increasing Faster Than HMO Costs?*, 23 MED. CARE 960 (1985).

⁶⁸ Rice et al., *supra* note 61, at 1357. See Richard Kronick et al., *The Marketplace in Health Care Reform: The Demographic Limitations of Managed Competition*, 328 NEW ENG. J. MED. 148 (1993) (suggesting that managed competition is not as effective if providers are allowed to contract with multiple plans); Rice et al., *supra* note 61, at 1359 (suggesting that providers will "consolidat[e] into larger practices to obtain countervailing market power").

⁶⁹ W. Michael Byrd & Linda A. Clayton, *Managed Competition: An Analysis of Consumer Concerns*, in A GUIDE FOR HEALTH CARE REFORM (1993) (unpublished manuscript on file with author).

⁷⁰ See *infra* notes 204-14 and accompanying text.

enroll in the lower cost plan may not be able to do so because it may be at capacity and unable to accept new enrollees, or its providers may not be accessible. While the HSA makes provisions for some consumers who cannot enroll in the lower cost-sharing plan to obtain subsidies,⁷¹ what will happen to ethnic Americans who cannot enroll in the lower cost-sharing plan and do not have adequate resources to pay for the other plans?

By defining the foundation for health care as centered on autonomy, regional independence and competition, the HSA becomes grounded in the rhetoric of choice and responsibility rather than the improved health status of Americans. Thus, this installment of health care reform is no more capable of rectifying the extensive race- and class-based health deficits suffered by ethnic Americans than the previous attempts at reform.⁷² The Act's failure to deal specifically with inequality and discrimination in the delivery of health care means that the reformed health care system will continue to place the concerns of ethnic Americans after other considerations.⁷³

B. *Protecting States' Autonomy to the Detriment of Ethnic Americans*

The HSA delegates the responsibility for "ensuring that all eligible individuals have access to a health plan that delivers the nationally guaranteed comprehensive benefit package" to the states.⁷⁴ Although the Act provides states with significant flexibility, there are measures that ensure some structure to the state systems's development, and in the process, protect consumers.⁷⁵ Ultimately, however, the HSA protects a state's

⁷¹ See *infra* notes 218-20 and accompanying text.

⁷² See generally W. Michael Byrd & Linda A. Clayton, *An American Health Dilemma: A History of Blacks in the Health System*, 84 J. NAT'L MED. ASS'N 189 (1992).

⁷³ The sections of the Act which would have been appropriate in demonstrating that equality of health care was an essential ethical foundation of the reform would have been section 2 (Findings) or section 3 (Purposes). See generally Charles J. Dougherty, *Ethical Values at Stake in Health Care Reform*, 268 JAMA 2409 (1992).

⁷⁴ HSA § 1203(e). In fact, in carrying out their responsibility, states have the flexibility to establish either an alliance system offering multiple plans or a single-payer health care system. *Id.* §§ 1221-1224.

⁷⁵ States are required to submit a nationally approved standard health plan to the National Health Board. *Id.* § 1200(b)(1). Each state must create an adminis-

right to develop its system as the state sees fit.

The potential exists that some states will exercise the flexibility in ways that will be counter-productive to the interests of ethnic Americans. In fact, traditionally ethnic Americans have not fared well under "state's rights"-supervised social programs.⁷⁶ The possibility exists that states will fail to design programs that meet the needs of ethnic Americans.

For instance, states ultimately approve health alliance risk adjustments.⁷⁷ In exercising this responsibility, states could provide for an alteration to the risk-adjustment methodology that would encourage (rather than discourage) health care plans to enroll ethnic Americans.⁷⁸ This type of variation is important since, as a group, ethnic American patients are a medically high risk group.⁷⁹ Those who are medically high

trative mechanism to administer the plan. *Id.* § 1201(4). States must administer subsidies for low-income individuals, families and employers. *Id.* §§ 1202(e)(1), 9011(a). They certify health plans, *Id.* §§ 1201(2), 1203(b), and financially regulate the health plans. *Id.* §§ 1204(a)-(d)(1), 1201(3). The states are responsible for administering data collection and quality management programs. *Id.* § 5013(1), § 5004(b). Finally, the states are responsible for the creation and governance of health alliances, including mechanisms for selecting members of their boards of directors and advisory boards. *Id.* §§ 1201(1), 1202(a)(1).

⁷⁶ For example, Medicaid is a state-operated, federally authorized program and Medicaid eligibility varies widely from state to state. John C. Boger, *Race and the American City: The Kerner Commission in Retrospect—An Introduction*, 71 N.C. L. REV. 1289, 1329 (1993); see also Diane Rowland, *Medicaid: Financing Care for Low-Income Americans* 3 (Nov. 1991) (conference paper presented at "An African American Health Care Agenda: Strategies For Reforming an Unjust System," Johns Hopkins University) (discussing Medicaid's role in meeting the health needs of African Americans).

⁷⁷ Cf. Stephen F. Jencks, *Quality Assurance*, 263 JAMA 2679, 2679-81 (1990) (discussing the role of risk adjustment in quality assurance measures); Douglas Sharrot, Note, *Provider-Specific Quality-of-Care Data: A Proposal for Limited Mandatory Disclosure*, 58 BROOK. L. REV. 85, 148 (1992) (discussing providers' tendency to shy away from high-risk patients even if risk adjustment methodologies were extremely accurate).

⁷⁸ HSA §§ 1203(e)(3)(A), 1541(b), 1542.

⁷⁹ See *Allergy Briefs*, 10 PEDIATRIC REP.'S CHILD HEALTH NEWSL. 66 (1993) (discussing high risk of Alaskan natives for contracting hepatitis B); Michael Higgins, *Native People Take on Diabetes: Indigenous Peoples from America to Australia are Fighting Some of the Highest Rates of Diabetes in the World by Returning to Traditional Foods and Practices*, 21 EAST WEST 94 (1991) (discussing the high risk of diabetes among Native Americans); Laurie Jones, *Prevention Seen as Best AIDS Hope*, 37 AM. MED. NEWS 3 (discussing outreach work with high-risk African American men and women); David Marder et al., *Effect of Racial and Socioeconomic Factors on Asthma Mortality in Chicago*, 101 CHEST 426S (1992) (indicating that African Americans with low incomes are at higher risk for asthma deaths);

risk are likely to need more medical services; consequently, ethnic American patients may be the least desirable financially, and health plans may try to avoid the risk posed by their enrollment by avoiding the patients.⁸⁰ States, in exercising their ultimate power over health alliance risk adjustment, could provide inadequate or little adjustment to risk, resulting in health plans that might develop ways to avoid serving ethnic Americans.

More important than how the states might exercise their discretion, however, is that the HSA does not require states to assure that citizens have access to culturally competent care.⁸¹ Rather, the Act permits funding of special programs by the Department of Health and Human Services ("HHS").⁸² These provisions are troubling. Are ethnic Americans a disadvantaged group? Since the Act doesn't define "disadvantaged group," it is possible that regulations will focus, if at all, on income and not necessarily race, culture or language. If plans avoid serving ethnic Americans, and if "disadvantaged" is narrowly defined by income, many ethnic Americans will be hindered in their ability to obtain care. By including permissive provisions, one wonders to what extent the states will provide incentives.

Even without a clear definition, why doesn't the HSA require health care plans to enroll disadvantaged groups?⁸³ Why continue to perpetuate the image that providing for ethnic

National Institute on Drug Abuse, *The Spread of Tuberculosis Among Drug Users*, AIDS WEEKLY 14 (Feb. 1, 1993) (indicating that African Americans and Hispanics are historically at high risk for developing tuberculosis); Vernellia R. Randall, *Racist Health Care: Reforming the Health Care System to Meet the Needs of African Americans*, 3 HEALTH MATRIX: J. OF L. & MED. 127 (1993); *Treating Prostate Cancer*, 5 CONSUMER REP. ON HEALTH 89 (1993) (indicating that African American men are at high risk for contracting prostate cancer).

⁸⁰ Maya Wiley, Statement of the Legal Defense & Educational Fund, Inc. on the Health Security Act of 1993, Before the Subcommittee on Commerce, Consumer Protection and Competitiveness, U.S. House of Representatives 5 (Nov. 16, 1993) (on file with the author).

⁸¹ Cf. HSA §§ 1400-1414 (outlining health plan requirements); *Id.* §§ 1201-1205 (outlining state responsibilities).

⁸² *Id.* §§ 3061-3062(f). These programs will, among other things, train health professionals and administrators to provide culturally sensitive care. *Id.* § 3062(d). In addition, the Act permits states, if they wish, to administer financial incentives to health plans to encourage the plans to enroll "disadvantaged groups" or to remove barriers to access. *Id.* § 1203(e)(3)(B).

⁸³ See *infra* part VII.

Americans is an extra burden—an add-on service? Why must serving ethnic Americans be something that health care plans are enticed to undertake rather than something that they are expected to do? Why not bring ethnic Americans into the mainstream of the reformed health care system by stating flatly that states must assure that health care plans provide culturally competent services to all? Without these requirements, “financial incentives” merely open ethnic Americans and the poor to exploitation, without any assurance that their needs will be integrated into the mainstream of the health care delivery system.

Indeed, because ethnic Americans never fared well under “state’s rights”-supervised social programs,⁸⁴ as compared with the rest of the population, it is not likely that they will fare well under this system either. While providing states with flexibility, the plan lacks the necessary safeguards to assure that all eligible individuals have not only access “to a health plan that delivers the nationally guaranteed comprehensive benefit package” but in fact have access to culturally competent health care.

C. *The Continuation of a Complex Employment-Based Health Insurance System with No Assurance of Cost Containment*

The Act maintains that the health care system should build on the strength of the employment-based coverage arrangements that now exist in the United States.⁸⁵ By expanding the employment-based health insurance system, the HSA perpetuates several problems. First, the distribution of jobs is based on race. Ethnic Americans are systematically excluded from trade and professional employment. By tying a person’s health care insurance to the person’s type of job, the Act imports the racism that exists in the employment system into the health insurance system.⁸⁶ In particular, the HSA does not consider that ethnic Americans’ unemployment and underemployment are at crisis levels.⁸⁷ High unemployment and pov-

⁸⁴ See *supra* note 76 and accompanying text.

⁸⁵ HSA § 2(2)(J).

⁸⁶ Byrd & Clayton, *supra* note 69, at 5.

⁸⁷ For instance, in California, African American men with less than a high school education are twice as likely to be unemployed as European American men

erty levels among ethnic Americans suggest that many will be limited to the basic health care plan. But even when employed, ethnic Americans will continue to be limited to the basic plan in disproportionate numbers. An employment-based insurance system fragments the insurance market based on race and class, resulting in the channeling of a larger percentage of European Americans into the higher cost-sharing plan (fee-for-service) or the combination plan (preferred provider). This difference in plan distribution will result in different services, both in kind and quantity.⁸⁸

Second, an employment-based health care system is unstable for the individual because it does not factor in the likelihood of massive job cutbacks and a national economic recession. Consequently, some individual's type of health insurance could be in constant flux. Third, employees may have to change health care providers every time their provider changes plans, as nothing in the Act prevents the provider from changing plans as often as they wish. This may be particularly problematic if the employee has coverage through a corporate health alliance rather than a regional alliance. Since large employers are allowed to opt out by providing coverage through a corporate alliance, an employee's choice may be limited. Employees of these opt out firms are forced to accept coverage through corporate alliances.

Fourth, employers may reduce their health care coverage to the minimum requirements of the basic benefit package, thereby requiring many to obtain additional coverage through supplemental policies. If many ethnic Americans cannot afford

with the same education. Almost 25% of all African American men in California over 16 years of age have been unemployed for more than two years, compared to about 12% of European American men and 10% of Asian American and Latino American men. Even for those with jobs, African American men are concentrated in lower prestige occupations, are about twice as likely as all other men to work in the public sector, and are half as likely as European American and Asian men to be self-employed. See Kim Clark, *Blacks, Males in MD Hit Hard by Unemployment But Women's Rate Didn't Change in '92*, BALT. MORN. SUN, Aug. 24, 1993 (Financial), at 10C (unemployment rate for blacks jumped nearly 1 1/2 points to 11.2%); Sonia Nazario, *Grim Picture Painted for State's Black Men Study*, L.A. TIMES, Dec. 11, 1993, at A1; Spencer Rich, *While Most Gain, Millions Suffer: Conditions Worsen for Chronically Poor "Underclass"*, WASH. POST, Jan. 20, 1986, at A1 (America's 28.6 million African Americans still lag far behind European Americans in every measure of economic and social well-being).

⁸⁸ See *infra* notes 204-29 and accompanying text.

those supplemental policies, then discrepancy in access to services based on race and class will continue. Fifth, even employees with supplemental, job-based health care coverage could be locked into a job because of insurance benefits. Cost-sharing plans provided by an employer could exceed the basic plan. If those benefits are needed by the individual or family, an individual may be unable to change jobs for fear of losing the necessary health coverage.⁸⁹ Finally, complicated systems will be necessary to deal with the 38 million Americans who work neither full-year nor full-time.

Furthermore, many health economists maintain that an employer-based, market reform-based competitive approach will not achieve the cost savings necessary to provide high quality universal health care for the entire nation.⁹⁰ Thus, an employment-based health insurance system raises many complex problems with no assurance of cost containment. As one observer has noted:

The current system of employer-based health insurance arose through historical events and accidents, rather than through a deliberate and morally thoughtful process. In its wake, patterns of injustice in the distribution of jobs linked to health insurance have compromised justice in health care. . . . [p]roposals that call for mandatory employer insurance and an expanded public system for the poor and unemployed do not eliminate justice concerns. Such proposals fall short because they do not ensure that the most vulnerable members of society receive adequate protection⁹¹

⁸⁹ Health plans may offer standardized supplemental insurance policies to cover cost sharing or health benefits above and beyond the comprehensive benefits package. HSA § 1421(a).

⁹⁰ See generally John B. Crosby & David L. Heidorn, *Achieving Full Access: It's Already Being Done*, 3 KAN. J.L. & PUB. POL'Y 31 (1993) (arguing that managed competition would not be an acceptable way to provide health care to all Americans or to control costs, especially in rural areas); Robert Pear, *Budget Official Sees No Savings in Clinton's Health Care Plans*, N.Y. TIMES, Feb. 3, 1993, at A16.

⁹¹ Nancy S. Jecker, *Can an Employer-based Health Insurance System be Just?*, 18 J. HEALTH POL. POL'Y & L. 657 (1993).

D. *Expanding the Role of the Private Sector Despite Its Past Failure to Provide Adequate Care to Ethnic Americans and the Poor*

"For [Prudential] the best-case scenario for reform—preferable to even the status quo—would be enactment of a managed competition proposal."⁹²

By employing a managed competition approach, the Act attempts to bring the "growth in health care costs in line by increasing competition in health care."⁹³ Under the HSA, regional health alliances are given the authority to entrust the care of ethnic American communities to corporate and institutional giants. The motives and interests of these health conglomerates are driven primarily by profit. The private sector is not committed necessarily to assuring culturally appropriate care to high-risk communities. Consequently, the transfer of the delivery of care to health care conglomerates has the potential for transforming ethnic American communities into a "new generation of substandard medical ghettos at worst and peripheral colonial outpost health subsystems at best."⁹⁴

The HSA is based on the belief that competition will ensure that plans and providers will be efficient and charge reasonable prices.⁹⁵ Both the private sector and major government programs (including Medicare and Medicaid) will operate under a budget restraining the growth of health care spending.⁹⁶ This reliance on "market forces" to generate savings,

⁹² DAVID V. HIMMELSTEIN & STEFFIE WOOLHANDLER, *THE NATIONAL HEALTH PROGRAM BOOK* (1994) (quoting Bill Link, Executive VP, Prudential).

⁹³ Description, *supra* note 30, at *3; See *infra* notes 199-203 and accompanying text.

⁹⁴ Byrd & Clayton, *supra* note 47, at 4-5.

⁹⁵ HSA § 2(2)(G). As articulated by Henry Aaron, director of Economic Studies Program at the Brookings Institution, "A free market rests on the idea that insurance should be cheaper for those who need it least and more expensive for those who need it [more]. It may be good economic policy, but its bad social policy." Byrd & Clayton, *supra* note 69.

⁹⁶ The budget includes premiums paid to cover the guaranteed comprehensive benefit package, whether paid by employers, employees or individuals. Medicare and Medicaid expenditures are included under separate budgets. "Supplemental benefits beyond the comprehensive benefit package, workers' compensation and auto insurance benefits are not included in the budget." Premiums for insurance policies providing coverage for cost sharing are not included. This includes budgets for fee-for-service plans. Description, *supra* note 30, at *45, *64; HSA §§ 1322(d), 2109.

improve quality, and generate efficiency is not based on objective justification but rather on unsupported ideology.⁹⁷ As one author has suggested:

A careful search of employee-benefits experience . . . suggests that competitive markets in America have produced results that do bear out [or even contradict] predictions [that competition would reduce costs, increase efficiency, and increase quality]. . . . These are the American facts But American health policy has long been dominated by ideology, and it remains so. America's destiny is supposed to lie in economic markets, and the market must be made to work successfully in health. If facts deviate, they must be forced to conform; if the facts prove recalcitrant, they can be imagined away, since only the theory is true. Perhaps at some date the facts will prove inescapable.⁹⁸

Thus, this enlargement of the role of the private sector is irrational given its role in creating the existing health care crisis.⁹⁹ The insurance industry will seek to maximize its revenues; if it can't do so by raising premiums, it will do so by restricting access to care.¹⁰⁰ In restricting access to health services, the target will be vulnerable populations: ethnic Americans and the poor.

Furthermore, expanding the private sector's role is irrational since the private insurance industry is not as efficient as a publicly run system. For instance, while private health insurance policies divert an average 14% of their premium dollars to pay for administrative costs, Medicare spends only 4% of reve-

⁹⁷ Byrd and Clayton, *supra* note 47, at 4.

⁹⁸ William A. Glaser, *The Competition Vogue and Its Outcomes*, 341 LANCET 805 (1993).

⁹⁹ Byrd & Clayton, *supra* note 47, at 4; HIMMELSTEIN & WOOLHANDLER, *supra* note 92, at 1; Vernellia R. Randall, *Managed Care, Utilization Review and Financial Risk-shifting: Compensating Patients for Cost Containment Injuries*, 17 U. PUGET SOUND L. REV. 1 (1993).

¹⁰⁰ Insurance companies deny needed care by limiting providers, providing financial disincentives for treatment, or delaying appointments. Another problem with turning the system over to private enterprise is that insurance companies will still engage in marketing practices. Those practices not only will add to health care cost, but they could actually help them to avoid certain consumers. While the HSA forbids certain practices (i.e., marketing to a smaller area than the entire area served, insurance tie-ins and inaccurate information), HSA § 1404(a)(2), health plans may still devise ways to avoid high risk consumers (i.e., ethnic Americans). *But cf.* HSA § 1325(b) (requiring approval by regional alliance of any materials used to market health plans offered through the alliance).

nues for administration.¹⁰¹

It is also irrational to delegate to private health plans the health policy information system (gathering, analyses, and interpretation).¹⁰² The government information system that exists today is considered one of the best. Yet, the HSA turns over the responsibility to "an incomplete, inadequate, and inferior private system."¹⁰³ Furthermore, from an ethnic American's perspective, reliance on the private sector for health data could be dangerous. Often the private sector fails to collect data about the impact of its policies on ethnic Americans,¹⁰⁴ as such data would often reveal its inadequate service. For instance, although other demographic information is collected, the current claims form designed by the private sector for use with Medicare and Medicaid recipients has no field for collecting information about a patient's race.¹⁰⁵

Of course, the Act does require that states ensure that the private sector enroll ethnic Americans.¹⁰⁶ Furthermore, states are allowed to administer financial incentives to achieve such objectives.¹⁰⁷ Unfortunately, financial incentives are not a good substitute for requiring the private sector to serve adequately ethnic Americans. By not requiring the private sector to provide culturally competent health care to all populations, the health care system will maintain a second-class attitude toward serving ethnic Americans.

More importantly, the private sector, whose interests are more financial than service-oriented, may merely exploit ethnic

¹⁰¹ HIMMELSTEIN & WOOLHANDLER, *supra* note 92, at 3.

¹⁰² HSA §§ 1410, 5013.

¹⁰³ Byrd & Clayton, *supra* note 69, at 8-10.

¹⁰⁴ See generally Gordon Bonnyman, Jr., *Unmasking Jim Crow*, 18 J. HEALTH POL. POLY & LAW 872 (1993); David B. Smith, *The Racial Integration of Health Facilities*, 18 J. HEALTH POL. POLY & LAW 851 (1993) (discussing the limited published sources of data on health care discriminations).

¹⁰⁵ Memorandum in Support of Motion to Appear as Amici Curiae, *Hughes v. Shalala*, No. 93-0048 (M.D. Tenn. 1993) (arguing that Department of Health and Human Services should be required to amend claims forms for hospitals and facilities by including spaces for information about race of client).

¹⁰⁶ HSA § 1203(e).

¹⁰⁷ *Id.* § 1203(e)(3). Certainly, these incentives could be used to assure that ethnic Americans have supplementary services such as translation and transportation. Such services would help assure that low-income groups, women, ethnic Americans and the disabled have real choices in the health care system.

American communities—and then leave.¹⁰⁸ Health plans will leave when they no longer have the capacity or financial stability to serve the community. Ordinarily, each health plan must accept for enrollment every eligible individual. Furthermore, the plan may not engage in any practice that has the effect of limiting enrollees on the basis of personal characteristics such as health status, anticipated need for health care, age, occupation, or affiliation with any person or entity.¹⁰⁹ With the state's approval, however, a health plan may limit enrollment because of the plan's capacity to deliver services or to maintain financial stability.¹¹⁰ Given the poor health status of ethnic Americans, it is likely this exception will allow plans to exclude many ethnic Americans. Private insurance has not competed to provide services to "the uninsured, the homeless, the lower income, the ethnic minority populations, and the mentally ill."¹¹¹ It is irrational to expect the reformed system run by the private sector to embrace these populations.¹¹²

E. *Failure to Insure Ethnic American Representation in Policy-Level Decisions*

While the Act creates another bureaucracy and extends the power of the executive branch, there are no mandates or mechanisms to ensure that the historical pattern of the absence or underrepresentation of ethnic Americans in bureaucracy is not repeated. Unless there are specific provisions assuring representation on the National Health Board and the Regional Health Alliance Board, these boards are not only likely to be dominated by European American middle-class males, but will not articulate or advocate the needs of ethnic Americans.¹¹³

Specifically, the HSA creates two new levels of bureaucracy: the National Health Board¹¹⁴ and the Regional Alli-

¹⁰⁸ Byrd & Clayton, *supra* note 69, at 8.

¹⁰⁹ HSA § 1402(a)(1).

¹¹⁰ *Id.* § 1402(a)(2).

¹¹¹ CNN News, *White House Health Care Reform*, #177-10 (CNN television broadcast, Mar. 29, 1993) (transcript on file with author).

¹¹² *Id.*

¹¹³ Byrd & Clayton, *supra* note 69, at 7.

¹¹⁴ HSA § 1501(a). The Board is appointed by the President and confirmed by

ance Board.¹¹⁵ National Health Board members are to be selected on the basis of their experience and expertise in relevant subjects including the "delivery of care to vulnerable populations."¹¹⁶ While the term "vulnerable population" is used in several provisions in the Act, it is not defined.¹¹⁷ Just who is in this category? Who will decide what is meant by a vulnerable population? Does it include all ethnic Americans or just low-income ethnic Americans? Without a definition there is no ongoing assurance that ethnic Americans will be represented on the National Health Board.¹¹⁸

As to the Regional Alliance Board, the HSA requires that it consist of an equal representation of employers and consumers. However, nothing in the HSA requires representation of ethnic Americans or even vulnerable populations.¹¹⁹

If the health care system is to be an evolving entity, it will only evolve into an equitable system if ethnic Americans who understand the needs of ethnic American communities are assured representation at policy-level positions. Appointing individuals who understand the needs of ethnic Americans will be particularly difficult since the Act prohibits the appointment of health care providers to the Regional Alliance Boards.¹²⁰

the Senate. *Id.* § 1501(b).

¹¹⁵ The Regional Alliance consists of employers, including self-employed individuals who purchase such coverage. HSA § 1302. Nothing in the Act assures representation of the Medicaid population, low income population or ethnic Americans.

¹¹⁶ HSA § 1502(b).

¹¹⁷ *Id.* §§ 1502(b), 1513(b)(3).

¹¹⁸ *Cf.* 45 C.F.R. § 46.111(a)(3) (1992) (defining vulnerable populations as "children, prisoners, pregnant women, mentally disabled persons or economically or educationally disadvantaged persons").

¹¹⁹ HSA § 3331(b), (c) (authorizing national prevention initiatives to develop and implement innovative community-based strategies to provide for health promotion and disease prevention activities targeted to the most needy and vulnerable population groups); *Id.* § 3481 (authorizing payment to hospitals serving vulnerable populations); *Id.* § 5004(c) (requiring that survey samples adequately measure populations considered to be at risk of receiving inadequate health care and difficult to reach through consumer-sampling methods, including individuals who are members of a vulnerable population).

¹²⁰ *Id.* § 1302(c) (prohibiting an individual from serving as a member of the Board of Directors if the individual is: a health care provider; derives substantial income from a health care provider, health plan, pharmaceutical company or a supplier of medical equipment, devices or services; derives substantial income from the provision of health care; a member or employee of an association, law firm or other institution or organization that represents the interests of health care providers, health plans or others involved in the health care field; or an individual

From the ethnic American community perspective, this is unfortunate since ethnic American providers are often the most knowledgeable about ethnic American communities' needs.

F. *Summary*

As to ethnic Americans, the reformed health care system proposed by the Act is structurally and ideologically flawed because its ethical foundations are 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 in policy-level decisions. This is more than unfortunate for ethnic Americans. It is tragic. This race and class-based health care system has "serious structural, medical, social and cultural deficits" and it will not "correct itself if left to serendipity."¹²¹

III. THE HEALTH SECURITY ACT PERPETUATES A FRAGMENTED SYSTEM

One of the major problems with the current system is that it is a fragmented system. The current health care system is a puffed-up system providing unnecessary, indulgent services for the privileged, while basic critically needed services for the disadvantaged are rationed and often unavailable.¹²² Unfortunately, the Health Security Act continues the fragmentation of an inadequate infrastructure.¹²³ Such inadequate infrastructure might not be so bad if the Health Security Act delivered on the Clinton administration's promises of universal coverage for comprehensive benefits. However, for ethnic Americans the Act provides less than universal coverage, and the benefits are not comprehensive enough.¹²⁴

who practices as a professional in an area involving health care). The health professionals will be part of a separate Provider Advisory Board to function under the direction of the Board of Directors. *Id.* § 1303.

¹²¹ Byrd & Clayton, *supra* note 47, at 5.

¹²² Byrd & Clayton, *supra* note 69, at 21-22.

¹²³ See *infra* part III.A.

¹²⁴ See *infra* part III.B.

A. Continuation of Inadequate Infrastructure

Despite the apparent importance of economics as a barrier to access to health care, the unavailability of providers and facilities from which to obtain health care is equally as devastating. Even persons with the ability to pay may not have quality health care.¹²⁵ In fact, the more inaccessible the providers and facilities, the more likely the person will, at a minimum, delay seeking care.¹²⁶

Certainly, providers and facilities are not accessible if they are not located near the population they are intended to serve. Moreover, even if they are located in the community, they are unavailable if they refuse to accept patients. Both rural communities¹²⁷ and inner city communities¹²⁸ have significant

¹²⁵ See generally Arnold S. Relman, *Controlling Costs by "Managed Competition"—Would It Work?*, 328 NEW ENG. J. MED. 133 (1993).

¹²⁶ See generally Randall, *supra* note 79, at 146-60; Sidney D. Watson, *Health Care in the Inner City: Asking the Right Question*, 71 N.C. L. REV. 1647 (1993).

¹²⁷ One-quarter of the U.S. population, about 65 million persons, resides in rural areas. Rural Americans face unique health needs which require access to local health care. Charles Marwick, *Educating Farmers, Physicians Who Treat Them, About Rural Life's Potential Health Hazards*, 261 JAMA 343 (1989); Ross M. Mullner et al., *New Report Cites Rural Health Problems, Needs*, 107 PUB. HEALTH REP. 486 (1992); Ross M. Mullner et al., *Rural Community Hospitals and Factors Correlated with Their Risk of Closing*, 104 PUB. HEALTH REP. 315, 316 (1989) [hereinafter Mullner et al., *Rural Community Hospitals*]. However, rural Americans do not have access to as many or as wide a range of health care services as suburban Americans. The health care of rural Americans is restricted both because of the lack of medical providers and the lack of health care facilities. In 1986, rural areas had 44% fewer physicians than cities. C. Neil Bull & Share DeCroix Bane, *Growing Old in Rural America: New Approach Needed in Rural Health Care*, 365 AGING 18, 20 (1993); cf. David A. Kindig & H. Movassaghi, *The Adequacy of Physician Supply in Small Rural Communities*, 8 HEALTH AFF. 63-76 (1989); Joseph P. Newhouse et al., *Where Have All the Doctors Gone?*, 247 JAMA 2392, 2393 (1982); William B. Schwartz et al., *The Changing Geographic Distribution of Board-Certified Physicians*, 303 NEW ENG. J. MED. 1032 (1980). Very small rural counties had 112 fewer physicians per county than the national average. Shawn Tully, *America's Painful Doctor Shortage*, 126 FORTUNE 103 (1992). In fact, in 1992, the Department of Health and Human Services estimated that more than 100 U.S. counties had no physicians. *Id.* The shortage of providers is so severe that in some communities essentially all medical practices are closed to new patients. *Id.* Many communities have no training programs and find it extremely difficult to recruit providers. Stephen J. Pearson, *Health Care for Uninsured and Underinsured Children: Letter to the Editor*, 145 AM. J. DIS. CHILD 1085 (1991). In 1988, there were 2,549 rural community hospitals. David G. Whiteis, *Hospital and Community Characteristics in Closures of Urban Hospitals, 1980-1987*, 107 PUB. HEALTH REP. 409 (1992) (citing AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS, 1989-90 (1990)).

problems with access due to inadequate infrastructure.¹²⁹

The Act does not require states, regional alliances or health plans to strengthen the bare-bones health care infrastructures in the nation's inner-city and rural areas. Rather, the HSA relies on temporary contracting provisions with essential community providers, grants and loans by HHS for public

During a seven year period, estimates of hospital closures ranged from 161 to 200. See Bull & Bane, *supra*, at 20 (reporting 190 rural hospital closing between 1981 and 1988); Tully, *supra*, at 103 (reporting over 200 hospitals closed between 1987 and 1992); Mullner et al., *Rural Community Hospitals*, *supra*, at 318 (reporting 161 hospital closings between 1980 and 1987).

The reasons for rural closings are complex, and include the disproportionate impact of Medicare's prospective payment system on rural hospitals. However, the lack of available physicians is another story. Many rural communities are unable to replace physicians who retire or leave. "You can have a physician without a hospital, but you cannot have a hospital without a physician." Emily Friedman, *Analysts Differ Over Implications of More Hospital Closings Than Opening Since 1987*, 264 JAMA 310, 313 (1990). Other health services are also in short supply, including nursing homes, allied health care professionals, nurses, health technology personnel, dentists, physical therapists, pharmacists and opticians. In fact, inpatient psychiatric services are "virtually nonexistent" in rural communities. Bull & Bane, *supra*, at 21. Thus, a rural person's ability to obtain (e)qual(ity) health care is severely impaired by the serious lack of infrastructure for the delivery of care.

¹²⁹ Ethnic Americans and poor Americans who live in inner cities are similarly affected by the lack of infrastructure. As in rural communities, many hospitals and primary care clinics have been forced to close. Boger, *supra* note 75, at 1330. Many hospitals have abandoned the inner city and moved to more lucrative suburban areas. Between 1980 and 1989, of the 508 general acute care hospitals that closed, 256 were urban. Friedman, *supra* note 127, at 310. Hospital closures left many communities stripped of any available resource. For instance, the "entire north side of St. Louis, parts of Philadelphia, and even sections of New York City are virtually devoid of hospital care." *Id.* at 313. Although surviving hospitals often maintain that patients may find "a safe harbor there," the reality is that disabled individuals and individuals "with linguistic, cultural, geographic, or financial access problems are less able to find substitute care." *Id.* (quoting Alan Sager, Associate Professor at the Boston University School of Public Health).

The inadequate infrastructure also has to do with the lack of physicians practicing in the inner city. This lack of infrastructure is due both to physicians who have moved their practices from inner city communities and to the shortage of physicians trained in primary medicine. See generally Watson, *supra* note 126, at 1649-50. In 1961, 50% of U.S. doctors were primary care providers; by 1990 that figure had dropped to 33%. Marc L. Rivo & David Satcher, *Improving Access to Health Care Through Physician Workforce Reform*, 270 JAMA 1074-78 (1993). In a study performed by the Council on Graduate Medical Education, projections indicate that the number of primary care providers will continue to decline. John M. Eisenberg, *Economics*, 270 JAMA 198-200 (1993). The lack of providers and facilities from which to obtain health care is equally as devastating as economic barriers, and providing universal coverage will not, by itself, remove all infrastructure barriers.

¹²⁹ See *infra* notes 137-51 and accompanying text.

health and rural health initiatives, expansion of responsibility of academic health centers, and training grants for health care professionals. None of these methods will prove adequate.

1. Essential Community Providers

The HSA attempts to provide some continuity of care for ethnic Americans, as well as poor and rural communities, by requiring health care plans to contract with professional and institutional providers that have been the bulwark of the service provision for those communities.¹³⁰ Unfortunately, the requirement for health plans to contract with essential community providers applies only for five years.¹³¹ While the Act contemplates the possible extension of this provision, it is uncertain and subject to the political process.¹³² Consequent-

¹³⁰ Basically, each health plan must enter into a provider participation agreement with essential community providers. HSA § 1431(a). The agreement provides that the plan shall make payment to the provider. *Id.* § 1431(c). The participation agreement between the health plan and an essential community provider shall provide that the health plan agrees to treat the provider at least as favorably as other providers. *Id.* § 1431(b). In particular, the agreement must be similar with respect to the scope of services for which payment is made by the plan to the provider, the rate of payment for covered care and services, the availability of financial incentives, limitations on financial risk provided, assignment of enrollees, and access by the provider's patients to providers in medical specialties or sub-specialties participating in the plan. *Id.* Essential community providers are not merely any providers serving in underserved areas but those that have been certified by HHS. The Act provides that any of the following health care providers or organizations can be certified as an essential community provider: a migrant health center; a community health center; a homeless program provider; a public housing provider; a family planning clinic; an Indian health program; an AIDS provider under the Ryan White Act, 42 U.S.C. § 300ee-3 to -12 (1991); a maternal and child health provider; a federally qualified health center; a rural health clinic; a provider of school health service; or, a community practice network. *Id.* § 1582(a)(1)-(11). Other categories of health care providers and organizations may also be certified as essential community providers. *Id.* § 1583(a). An essential community provider who is aggrieved by the failure of a health plan to fulfill a duty imposed by the HSA may commence a civil action against the plan. *Id.* § 5240(a). If the court finds that the health plan has failed to fulfill its duty, the essential community provider may recover compensatory damages, other appropriate relief, and reasonable attorney's fees, including expert fees. *Id.* § 5240(b), (c).

¹³¹ Specifically, it applies during the five-year period beginning with the first year in which any health plan is offered by an alliance. *Id.* § 1432(a).

¹³² The Act authorizes the preparation of recommendations regarding essential community providers, including studies that assess the definition of essential community providers, the sufficiency of the funding levels for providers, the effects of contracting requirements relating to such providers, the effects of contracting re-

ly, the essential community providers provisions are inadequate precisely because of the temporary nature of the protection. The historical problem of inadequate infrastructure will not be relieved in five years, especially if health care plans have to assure culturally competent care. Health care plans should be required to contract with "essential community providers" so long as there are an inadequate number of culturally appropriate health care providers in the community. Without such provisions, the protection of essential community providers will not be translated into culturally appropriate health care for ethnic Americans.

The HSA does provide some resources for essential community providers to become competitive participants against corporate health insurance.¹³³ Furthermore, it attempts to eliminate the problem of providers who do not want to serve ethnic American communities because of a disparity in reim-

quirements on such providers, health plans, and enrollees, the impact of the payment rules for such providers, and the impact of national health reform on such providers. *Id.* § 1432(b). Congress will decide whether and to what extent to continue requiring the health care plan to contract with essential community providers. *Id.* § 1432(c).

¹³³ The HSA provides for regional alliances to encourage the development of plans to serve areas that have inadequate health services. In particular, a regional alliance may encourage the establishment of new health plans in an area that has inadequate health services. *Id.* § 1329(b). Health alliances may encourage the development of community plans by organizing health providers to create a plan, by providing assistance with setting up and administering such a plan, and by arranging favorable financing for such a plan. *Id.* Furthermore, the Act authorizes the use of federal funds to improve the infrastructure for urban and rural medically underserved populations. *Id.* § 3411. In particular, the funding is to be used to facilitate transition to a system in which medically underserved populations have an adequate choice of community-oriented providers and health plans; to promote the development of community practice networks and community health plans that integrate health professionals and health care organizations supported through public funding with other providers in medically underserved areas; to support linkages between providers of health care for medically underserved populations and regional and corporate alliance health plans; to expand the capacity of community practice networks and community health plans in underserved areas by increasing the number of practice sites and by renovating and converting substandard inpatient and outpatient facilities; to link providers in underserved areas with each other and with regional health care institutions and academic health centers through information systems and telecommunications; and to support activities that enable medically underserved populations to gain access to the health care system and use it effectively. *Id.* Finally, the Act allows HHS to make grants and to enter into contracts with consortia of providers for the development of qualified community health plans and qualified community practice networks. *Id.* § 3421.

bursement rates.¹³⁴ The HSA does so by creating a "blended rate."¹³⁵ To the extent that this "blended rate" will encourage plans and providers not to make distinctions based on reimbursement rates, it is critical to assuring equity in the system.

Nevertheless, regardless of the merit of these provisions, they are inadequate. They attempt to induce health plans by monetary incentive to focus on the provision of services to ethnic Americans, rather than requiring such behavior. Furthermore, there is no language specifying ethnic American inclusion, participation or set-asides in the grants, contracts or loans.¹³⁶ Without such language, it is likely that those best able to serve their communities will be included in only a minimal capacity. With the temporary and waivable protections for essential community providers and the lack of specific affirmative action contracting goals, the Act gives only a superficial effort to protecting the pool of health care providers that traditionally serve ethnic Americans.

2. Public Health and Rural Infrastructure

Nothing in the HSA indicates that the public health structure for delivery of services will be preserved, expanded or revitalized. In fact, health reform shifts the emphasis away from the direct delivery of health services. Instead, it redirects the emphasis of public health to health-related data collection, surveillance and outcomes monitoring,¹³⁷ protection of envi-

¹³⁴ See *infra* notes 144-50 and accompanying text.

¹³⁵ HSA § 1351(a).

¹³⁶ Minority "set-aside" is a term that refers to both public and private sector efforts to reserve a predetermined percentage of benefits and opportunities for racial minorities. Set-asides are most often associated with public construction dollars, where a general contractor working on a public building project must devote a certain percentage of the bid price to minority sub-contractors. See *Richmond v. J.A. Croson Co.*, 488 U.S. 469 (1989) (minority set-asides for municipal contractors); *Fullilove v. Klutznick*, 448 U.S. 448 (1980) (federal minority set-aside program in construction industry); see also *Wygant v. Jackson Bd. of Educ.*, 476 U.S. 267 (1986) (formula for preserving employment for minority teachers during district-wide layoffs); Cliff Hocker, *Richmond Enacts New Set-Aside Law*, BLACK ENTER., Aug. 1993, at 24.

¹³⁷ The health-related data collection, surveillance and outcome monitoring function of public health provides for regular collection and analysis of information on key dimensions to ensure timely awareness, decisions and interventions related to epidemics, emerging patterns of disease and injury, prevalence of risks to health, and outcomes of personal health services. HSA § 3312(b)(1).

ronment, housing, food and water;¹³⁸ investigation and control of diseases and injuries;¹³⁹ public information and education;¹⁴⁰ accountability and quality assurance;¹⁴¹ laboratory services;¹⁴² training and education;¹⁴³ and leadership, policy development and administration.¹⁴⁴

While these are important and necessary functions of public health, so is service delivery. The public health system developed as a result of the failure of the private sector to provide health services to the poor, to the underserved and to ethnic Americans. It is improbable that private corporations and voluntary health care organizations will build health care infrastructures in ethnic American, poor or rural communities. Thus, it is unlikely that private corporations and voluntary

¹³⁸ The public health functions related to enforcement focuses on air pollution, including indoor air, exposure to high lead levels, water contamination, handling and preparation of food, sewage and solid waste disposal, radiation exposure, radon exposure, noise levels and abatement, and consumer protection and safety. *Id.* § 3312(b)(2).

¹³⁹ The public health functions that focus on investigation and control of diseases and injuries include improvements in emergency treatment preparedness, cooperative activities to reduce violence levels in communities, activities to control the outbreak of disease, exposure related conditions and other threats to the health status of individuals. *Id.* § 3312(b)(3).

¹⁴⁰ The public information and education function of public health focuses on mobilizing communities and motivating individuals to reduce risks to health such as tobacco use, abuse of alcohol and other drugs, sexual activity that increases vulnerability to HIV infection and sexually transmitted diseases, inadequate nutrition, physical inactivity and childhood immunization. *Id.* § 3312(b)(4).

¹⁴¹ The accountability and quality assurance focus of public health functions includes monitoring the quality of personal health services furnished by health plans and providers of medical and health services in a manner consistent with the overall quality of care monitoring activities undertaken under Title V of the Health Security Act and monitoring communities' overall access to health services. *Id.* § 3312(b)(5).

¹⁴² Laboratory services include the provision of individual testing and pathology services (including the system of state laboratories that screen for metabolic diseases in newborns), providing toxicology assessments of blood lead levels and other environmental toxins, diagnosing sexually transmitted disease and tuberculosis requiring partner notification, testing for cholera and other infections or food-borne diseases, and monitoring the safety of water and food supplies. HSA § 3312(b)(6).

¹⁴³ The training and education function of public health focuses on ensuring adequate training with special emphasis on public health professionals such as epidemiologist, biostatisticians, health educators, public health administrators, sanitarians and laboratorians. *Id.* § 3312(b)(7).

¹⁴⁴ Leadership, policy development and administration activities focus on defining health goals, standards and policies, and the development of health coalitions. *Id.* § 3312(b)(8).

health care organizations can replace health care provided by the existing public health infrastructure. Apparently, recognizing this, the HSA provides for funding for community and migrant health centers,¹⁴⁵ for initiatives to improve health care access,¹⁴⁶ and for the development of plans and networks.¹⁴⁷ Also, the Act proposes a number of measures to assure health care in medically underserved rural areas.¹⁴⁸

¹⁴⁵ *Id.* §§ 3401, 3402.

¹⁴⁶ *Id.* § 3411. The funding is intended to provide a program of grants, contracts and loans and will "facilitate transition to a system in which medically underserved populations have an adequate choice of community-oriented providers and health plans." *Id.* It will do so by promoting "the development of community practice networks and community health plans that integrate health professionals and health care organizations supported through public funding with other providers in medically underserved areas." *Id.* It is also intended "to support linkages between providers of health care for medically underserved populations and regional and corporate alliance health plans. The funding will be used to expand the capacity of community practice networks and community health plans in underserved areas by increasing the number of practice sites and by renovating and converting substandard inpatient and outpatient facilities." *Id.* It will also "link providers in underserved areas with each other and with regional health care institutions and academic health centers through information systems and telecommunications." *Id.* Finally, it will be used "to support activities that enable medically underserved populations to gain access to the health care system and use it effectively." *Id.*

¹⁴⁷ *Id.* § 3421. The funding is intended to remove barriers to health care and to assist communities that include a substantial number of individuals who have a limited ability to speak English to assure culturally competent care. *Id.* § 3421(d), (e).

¹⁴⁸ The Act attempts to ensure health care for rural Americans by requiring alliance areas to serve rural areas, by providing investment in rural infrastructure, by creating incentives to expand rural community-based networks and plans, by providing investments for the development of the health workforce, and by providing for the expansion of the rural public health system. The Act recognizes rural health clinics as essential community providers. *See supra* note 130. In addition, the HSA allows HHS to make grants to establish rural information and referral systems, and it allows HHS to make grants to carry out activities to provide rural health care. *Id.* § 3132. The Act authorizes funding for projects to train more primary care physicians and physician assistants, including expanding the supply of physicians with special training to serve in rural areas. *Id.* § 3062. Finally, *The Act* amends the Social Security Act's Anti-Fraud and Abuse provisions to allow more favorable provisions for rural providers. The HSA amends § 1877(d)(2) of the Social Security Act, which limits physician self-referrals, 42 U.S.C. § 1395nn(d)(2) (1988 & Supp. V 1993), by allowing exceptions for rural physicians where at least 85% of their services are furnished in rural areas, rather than "substantially all." HSA § 4042(e). Section 1877(e)(4) (relating to physician recruitment) is amended to limit the exception to entities located in rural areas, areas with a shortage of health professionals, or an entity in which 85% of patients are members of medically underserved populations. *Id.* § 4042(f)(4).

Notwithstanding the positive aspects of the public health and rural initiatives, they still present issues of concern. First, the funding of the initiatives requires special federal appropriations after the year 2000.¹⁴⁹ Given political realities, it is unclear whether Congress will continue to fund special appropriations for public health initiatives as the cost of the Act becomes apparent. However, one thing is certain: in five years, the health care infrastructure needed by ethnic Americans will not be in place.

Second, the public health initiatives are just another set of grudgingly given "special programs" for disadvantaged and poor people. They constitute a tacit acknowledgment of the failure of this health reform, since special programs for ethnic Americans and the poor inevitably become programs that the European American middle class resent.¹⁵⁰ Thus, the "special programs" approach preserves a multi-tiered health care system, and such a system necessarily results in an unequal and unjust system. Thus, the Act fails to create a truly universal unitary health system designed to meet the needs of all Americans. Arguably, the HSA restructures and reforms a system without changing the worst aspect of it. That is, the Act proposes a system that is a "complex matrix of stigmatized special programs and categorical grants."¹⁵¹

¹⁴⁹ The Act provides appropriation for the development of qualified community health plans and practice groups, and community and migrant health centers through fiscal year 2000. *Id.* §§ 3412(a), 3401(b).

¹⁵⁰ Byrd & Clayton, *supra* note 69, at 22.

¹⁵¹ Byrd & Clayton, *supra* note 69, at 24-26. As noted by one author:

Arranging care for those who are least well off is a matter of how best to integrate them into a system of universal access. . . . [S]pecial attention should be paid to the impact on the least well off. Will the proposed system work for them? Will it address, for example, the higher rates of disease and disability among those of lower socioeconomic status? Does it recognize and take into account flawed educational and transportation infrastructures, cultural and linguistic barriers, the stigmatization of certain diseases and lifestyles and so forth? Reform in light of the intrinsic value of helping the least well off means starting reconstruction, so to speak, from the bottom up rather than from the top down.

Dougherty, *supra* note 73.

3. Academic Health Centers

The Act appears to be structured around the provisions of services in existing facilities. Although there are some provisions for the development of infrastructure outside of the discretionary grants by HHS, the HSA does not appear to contemplate the building of additional hospitals or clinics. This is unfortunate since prior hospital closure decisions have been made by a "patently imperfect market" and have affected ethnic American and poor communities disproportionately.¹⁵² Rather, the Act contemplates extending health care by requiring academic health centers to extend their programs in primary care to inner city and rural areas.¹⁵³

No doubt, these provisions could improve access to health care in ethnic American communities. But they will do so only if provisions are made for meaningful transportation and provider hours for inner city and rural residents. Furthermore, these linkages will prove beneficial only if the advisory and policymaking levels within the academic health centers are reflective of rural and ethnic American communities, and only if the academic health centers are required to provide culturally competent care.

Unfortunately, while the HSA provides incentives for academic health centers to establish outreach into ethnic American communities, they are under no requirement to provide culturally competent care or community participation. Furthermore, the financial incentives to the academic health centers produces the same stigma of making the provision of services to ethnic American communities outside the "normal" expectation of academic health centers. The Act should mandate that academic health centers include community-based goals that

¹⁵² Friedman, *supra* note 127, at 5 (quoting Robert Van Hook, Executive Director of the National Rural Health Association).

¹⁵³ Regional and corporate health alliances must ensure that health plans enter into sufficient contracts with academic health centers to ensure that enrollees receive the specialized treatment expertise of such centers. HSA § 3131(a). More importantly, HHS has the authority to "make grants to [academic health] centers for the establishment and operation of information and referral systems to provide the services [to rural health plans]." *Id.* § 3132(a). Furthermore, HHS may make grants to academic centers to carry out activities which provide the services to residents of urban communities who otherwise would not have adequate access to such services. *Id.* § 3132(b).

center on health, community participation and education. Furthermore, academic health centers must be forced to have ethnic Americans represented at advisory and policymaking levels within the academic health centers. Finally, academic health centers must be required to provide culturally competent care.

4. Training of Health Care Professionals

The HSA establishes the National Council on Graduate Medical Education to control nationally the number of individuals who can enroll in medical programs.¹⁵⁴ Even though the Act contemplates training participants who are members of racial or ethnic minority,¹⁵⁵ it does nothing to assure the via-

¹⁵⁴ HSA § 3011. The HSA designates the specific composition of the National Council. Unfortunately, nothing in the Act requires the appointment of ethnic Americans. *Id.* § 3001.

In the case of each medical specialty, the National Council shall designate for each academic year the number of individuals nationwide who are authorized to be enrolled in eligible medical programs. *Id.* § 3012(a). Specifically, the Act requires that the percentage of individuals enrolled in primary health care is not less than 55%. *Id.* § 3012(b)(1). Furthermore, for each medical specialty, the National Council is authorized to make annual designations for periods of three academic years. *Id.* §§ 3012(b)(1), 3013. In making the designation, the National Council shall consider the incidence and prevalence of the diseases, disorders or other health conditions with which the specialty is concerned, the number of physicians who will be practicing in the specialty in the academic year, and the number of physicians who will be practicing in the specialty at the end of the five-year period beginning on the first day of the academic year. *Id.* § 3012(d)(1).

¹⁵⁵ Significantly, the HSA requires the National Council to consider the extent to which each program trains members of racial or ethnic minority groups when making allocations for eligible programs. *Id.* § 3013(c)(2)(A). "With respect to a racial or ethnic group represented among the training participants, the extent to which the group is underrepresented in the field of medicine generally and in the various medical specialties," is considered. *Id.* § 3013(c)(2)(B). Furthermore, the Act provides funding for primary care physician and physician assistant training. *Id.* § 3031(b). This includes supporting projects to train additional primary care providers and to increase the number of physicians capable of serving medically underserved rural and inner city areas. *Id.* The Act includes a provision for the training of ethnic Americans. *Id.* The programs include: supporting projects to increase the number of underrepresented minority and disadvantaged persons in medicine, osteopathy, dentistry, nursing, public health and other health professions; financial assistance for underrepresented minority and disadvantaged persons in health professions training programs; and funding for recruitment and retention of underrepresented minority and disadvantaged persons in the health professions. The funding can be used to maintain efforts to foster interest in health careers among such persons at the pre-professional level and to increase the number of

bility of the primary source of black health care professionals—historically black schools. Historically black medical schools provide an irreplaceable means of providing access to culturally appropriate care to African Americans.¹⁵⁶ Even though these institutions are financially and structurally threatened, the HSA makes no specific provision for sustaining or strengthening their roles.¹⁵⁷

Without sufficient measures to assure the development of an adequate infrastructure, ethnic American and poor communities face the disconcerting prospect of depending on private, competitive for-profit health providers for culturally competent health care. Access to health care requires actual services provided by physicians and hospitals. But, many physicians and hospitals are reluctant to serve ethnic Americans.¹⁵⁸ Within a professional culture that is reluctant to serve ethnic Americans and poor communities, universal coverage, by itself, will not “appreciably redistribute the physician supply” in a way that would significantly improve access.¹⁵⁹ In sum, infrastructure barriers, separate and distinct from the issue of financing, are not adequately addressed, and the promise of universal coverage is not a promise of equality of care.¹⁶⁰

minority health professionals in faculty positions. Finally, it includes funds for training providers to supply culturally sensitive care. *Id.*

¹⁵⁶ For instance, by 1980, three-fourths of all of Meharry's graduates had gone on to practice in underserved rural and inner city communities. Marsha F. Goldsmith & Charles Olson, *Minority Physician Training: Critical for Improving Overall Health of Nation*, 261 JAMA 187 (1989).

¹⁵⁷ The HSA authorizes the limitation on the number of individuals who can be enrolled in medical programs. HSA § 3012(a). The Act also provides for the allocation of training spots among medical specialties. *Id.* § 3013(a).

¹⁵⁸ Eli Ginzberg & Miriam Ostow, *Beyond Universal Health Insurance to Effective Health Care*, 265 JAMA 2559 (1991).

¹⁵⁹

New York City has operated a major health and hospital system . . . committed to providing care to everyone, regardless of ability to pay. Accordingly, New Yorkers may be said to have had universal coverage for almost a century. . . . [The Health and Hospitals Corporation of New York] is faced with severely overcrowded conditions stemming from significant increases in AIDS, psychiatric, and drug-abuse patients; a lack of available discharge options for patients occupying acute care beds unnecessarily; and bed closings due to shortages of key staff such as nurses and social workers.

Ginzberg & Ostow, *supra* note 158, at 2559.

¹⁶⁰ Ginzberg & Ostow, *supra* note 158, at 2559. As reported in one newspaper: With President Clinton trying to give all Americans health insurance,

B. *Lack of Universal Coverage*

The plan maintains a fragmented system by excluding large segments of the population, keeping them outside of the main system. Specifically, undocumented aliens,¹⁶¹ Medicare recipients,¹⁶² prison populations,¹⁶³ employees of eligible corporate alliance sponsors,¹⁶⁴ military personnel and families,¹⁶⁵ veterans¹⁶⁶ and Indians¹⁶⁷ are all either excluded or kept outside of the main system.

These exclusions are problematic for several reasons. First, the exclusion of a large number of individuals threatens the financial integrity of the main health system by producing inefficiencies and duplications.¹⁶⁸ Second, the exclusion of some individuals inevitably causes discrimination, because someone must determine who is not covered. Consequently, providers and facilities may use skin color or language as a de facto method of determining eligibility for citizens who do not have health security cards.¹⁶⁹ Finally, a significant portion of ethnic American males will not be in the system since prison

places like the Washington Free Clinic might be expected to be getting ready to go out of business. But the Clinic volunteers who work out of a transformed church choir loft are not planning to pack up anytime soon. Their patients are the ones who often fall through the cracks of the existing health care system. . . . And many of these people, even strong supporters of the Clinton health plan admit, will still be out in the cold after the plan.

Clinics for Poor Expect to Continue Being Needed, N.Y. Times, Sept. 20, 1993, at B6.

¹⁶¹ HSA § 1005(a).

¹⁶² *Id.* § 1001(d).

¹⁶³ *Id.* § 1001(e).

¹⁶⁴ Eligible sponsors of corporate alliances include large employer, multi-employer plan sponsors, rural electric cooperatives and rural telephone cooperative associations. A large employer is one that has more than 5,000 full-time employees in the United States. *Id.* § 1311(b).

¹⁶⁵ The Act allows military personnel and families to elect the Uniformed Services Health Plan rather than a plan through a regional alliance HSA § 1004(b)(1).

¹⁶⁶ Veterans and families may elect a veterans health plan rather than a plan through a regional alliance. *Id.* § 1004(b)(2).

¹⁶⁷ The HSA permits eligible individuals to elect the Indian Health Service rather than a plan through a regional alliance. *Id.* § 1004(b)(3)

¹⁶⁸ Byrd & Clayton, *supra* note 47, at 5.

¹⁶⁹ A health security card is issued to each eligible individual by the alliance in which he or she is enrolled. HSA §§ 1001(b), 1324, 1383.

populations are specifically excluded and military personnel and veterans may opt out. This is particularly troubling because the HSA does not assure that individuals in alternative systems will receive at least the same comprehensive services.

IV. THE HEALTH SECURITY ACT MAINTAINS A CULTURALLY INCOMPETENT SYSTEM BASED ON ILLNESS CARE

A person does not have meaningful access to health care if that person is not provided health care within the context of his or her cultural background.¹⁷⁰ Merely providing a person with a piece of paper (insurance) or a provider does not mean that that person will receive health care that assists in improving the person's health status. For centuries, Americans indulged in the fantasy that all persons (native Americans, immigrants and slaves) blended into one great "melting pot" to become Americans. While it is true that there are unique American cultural similarities that cut across all groups, this country has always had a diverse population of races, ethnic groups, subcultures and religions.

That diverse mix will continue. By the end of this century, 39% of the population will be from foreign-born parents.¹⁷¹ At the same time, 50% of all Americans will be either African American, Hispanic American, Asian American or Native

¹⁷⁰ "Culture" is employed in various manners. It has been defined as an "integrated system of learned patterns of behavior, ideas, and products characteristic of a society." Vernellia R. Randall, *Ethnic Americans, Long Term Health Care Providers and the Patient Self-Determination Act*, in LONG TERM HEALTH CARE PROVIDERS AND THE PATIENT SELF-DETERMINATION ACT (Marshall Kapp ed., forthcoming 1994). See generally Henry S. Perkins, *Cultural Differences and Ethical Issues in the Problem of Autopsy Requests*, 87 TEXAS MEDICINE/THE JOURNAL 1991. It is a body of learned values, beliefs and behaviors that depict a group of people. "Culture provides the basic framework by which individuals interpret their surroundings, the behavior of the people around them, and the events that befall." Randall, *supra*. Many factors determine a person's culture. They include race, nationality, native language, education, occupation, religion, socioeconomic factors and area of origin. See generally Randall, *supra*; Alan Harwood, *Guidelines for Culturally Appropriate Health Care*, in ETHNICITY AND MEDICAL CARE (1981). These factors affect values, beliefs and behaviors. A subculture is defined by values, beliefs and behaviors that are peculiar to a particular subgroup within a culture. See generally Randall, *supra*.

¹⁷¹ WHITE HOUSE COMMISSION ON IMMIGRATION AND REFUGEE POLICY (1982) [hereinafter, IMMIGRATION & REFUGEE POLICY].

American.¹⁷² America is a "micro-world reflecting [the] cultural diversity of the entire world."¹⁷³

A. *The Perpetuation of European American Culture*

The medical care system is a representation of one subculture—the middle-class, middle-aged, European American. The system focuses on individual autonomy rather than family involvement.¹⁷⁴ It assumes a basic trust in the health care system instead of distrust.¹⁷⁵ It relies on a western European

¹⁷² *Id.*

¹⁷³ See generally I. Murillo-Rhode, *Unique Needs of Ethnic Minority Clients in a Multiracial Society: A Socio-Cultural Perspective*, in AFFIRMATIVE ACTION: TOWARD QUALITY NURSING CARE FOR A MULTIRACIAL SOCIETY (1980); MIRIAM ROSS, SOCIETAL/CULTURAL VIEWS REGARDING DEATH AND DYING, TOPICS IN CLINICAL NURSING 5 (1981).

¹⁷⁴ The existing health care system has not sufficiently promoted family involvement. It focuses on the individual and illness care rather than family and wellness care. This is unfortunate since the concept of family has a particular influence on wellness care and health promotion. See Gabriel Smilkstein, *The Cycle of Family Function: A Conceptual Model for Family Medicine*, 11 J. FAM. PR. 223, 224 (1980). Furthermore, "family" has different meanings across cultures and ethnic groups. See Randall, *supra* note 170. Different cultural priorities may modify the degree to which families are involved in treatment decisions including the involvement of the extended family. Particularly offensive in some cultures may be the European American method of personal decision-making that focuses on the individual, instead of the family. For many ethnic Americans illness is a family affair, and family members are involved in the patient's medical decisions and care. See Alan Harwood, *Mainland Puerto Rican*, in ETHNICITY AND MEDICAL CARE *supra* note 170, at 401; Stephen J. Kunitz & Jerrold E. Levy, *Navajos*, in ETHNICITY AND MEDICAL CARE, *supra* note 170, at 337; Michael S. Laguerre, *Haitian Americans*, in ETHNICITY AND MEDICAL CARE, *supra* note 170, at 198; Janet M. Schreiber & John P. Homiak, *Mexican Americans*, in ETHNICITY AND MEDICAL CARE, *supra* note 170, at 301. To provide access to quality health care, providers must appreciate cultural differences in kinship terms, in role expectations and in the role of the family in major decision-making.

¹⁷⁵ The existing health care system supposes that a patient will interpret a provider's behavior to be in his or her best interest. However, many individuals in our society distrust the health care system, in particular ethnic Americans. African Americans' distrust is rooted in slavery, sharecropping, peonage, lynching, Jim Crow laws, disenfranchisement, residential segregation, job discrimination, insufficient health care and inappropriate scientific experimentation. See James Jones, *The Tuskegee Legacy: AIDS and the Black Community (Twenty Years After: The Legacy of the Tuskegee Syphilis Study)*, 22 HASTINGS CTR. REP. 38 (1992); Thomas A. Laveist, *Segregation, Poverty and Empowerment: Health Consequences for African Americans*, 71 MILBANK Q. 41 (1993); Lorene Cary, *Why It's Not Just Paranoia: An American History of 'Plans' for Blacks*, NEWSWEEK, Apr. 6, 1992, at 23. For instance, African Americans may feel that managed care providers will deny

American concept of communications.¹⁷⁶ It is built on a western European concept of wellness, illness and health care.¹⁷⁷

them necessary services. Many Southeast Asian Americans identify the health care system with death. Laura Uba, *Cultural Barriers to Health Care for Southeast Asian Refugees*, 107 PUB. HEALTH REP. 544, 546 (1992). Many Hispanics perceive providers as obstacles to receiving any meaningful help. Wendy Mettger & Vicki S. Freimuth, *Is there a Hard-to-Reach Audience?*, 105 PUB. HEALTH REP. 232 (1990). Consequently, after years of neglect and culturally insensitive care, there is often a deep distrust of the health care system. This is true even when those providing the health care are of the same ethnic community. *Forgotten Americans—Special Report on Medical Care for Blacks*, 9 AMERICAN HEALTH: FITNESS OF BODY AND MIND 52 (1990). Historically, Hispanic Americans, particularly Mexican Americans, have not had access to good housing, schooling or health services. Neglect combined with bigotry and discrimination has encouraged Hispanic Americans to be suspicious of the health care system. Schreiber & Homiak, *supra* note 174, at 301. Obviously, a significant question is how this general distrust will be impacted by a system of health care designed to deny health care rather than to provide services. In particular, utilization review processes may allow providers to make decisions which will adversely impact persons of color more than European Americans. When that happens, some ethnic Americans' distrust in the health care system may be reaffirmed.

¹⁷⁶ Communication is basic to obtaining quality health care. A person may have doctors in the community, a person may have money in his or her pocket, a person may have insurance, but if health care providers cannot communicate with their patients, they cannot provide effective quality health care. See THE ASSOCIATION OF ASIAN PACIFIC COMMUNITY HEALTH ORGANIZATIONS, *supra* note 6, at 6 (maintaining that the lack of linguistically accessible services presents a barrier for many Asian and Pacific Islander Americans in need of health care); *Lifting Barriers to Asian and Pacific Islander Health Care: Issues and Recommendations* (unpublished manuscript, on file with the author).

How different cultures communicate is very important. Different linguistic groups see and conceive reality differently. See Gustavo M. Quesada, *Language and Communication Barriers for Health Delivery to Minority Group*, 10 SOC. SCI. & MED. 323, 324 (1976). Ethnic Americans' views of health care are shaped by the language used. To the extent that a person's primary language is not English, communication and language barriers will exist.

¹⁷⁷ See Donald Gelfand & Barbara W.K. Yee, *Trends & Forces: Influence of Immigration, Migration, and Acculturation on the Fabric of Aging in America*, 15 GENERATIONS 7 (1991) (health care professionals who treat elderly immigrants need to understand cultural beliefs concerning etiology and appropriate treatments for illness; for example, explanations for illness and disease using culturally defined norms about "hot" and "cold" forces are common among Southeast Asians and differ markedly from Western concepts); Susan Pollak, *Melancholia and Depression: From Hippocratic Times to Modern Times*, 22 PSYCH. TODAY 73 (1988) (pointing out that many non-Western cultures do not have an equivalent concept of depression; depression assumes different meanings and consequences depending on the culture in which it occurs); Charles E. Rosenberg, *Disease in History: Frames and Framers*, 67 MILBANK Q. 1 (1989) (discussing the social construction of disease and illness); N.J. Temple & D.P. Burkitt, *Towards a New System of Health: The Challenge of Western Disease*, 18 J. COMM. HEALTH 37 (1993) (pointing out that the concept of Western disease has become well-established).

Consequently, the more a patient differs from the cultural prototype (middle-class, middle-aged, European American) the more likely the person will not have "meaningful access" to health care.

Merely providing financial coverage for health care does nothing to assure that ethnic Americans will have access to care that is culturally competent.¹⁷⁸ One barrier to culturally competent care is physicians' own negative perceptions about ethnic Americans.¹⁷⁹ This barrier exists in part because the health care system is designed around the cultural needs of middle-class European Americans. Ethnic Americans and poor individuals seem less compliant and more difficult to care for because they have differing needs and problems in accessing care.¹⁸⁰ The problem, however, is not poor patients or ethnic Americans, but the health care system's inability to provide effective care to diverse populations.¹⁸¹ If increased compliance and improved health status are the goals, then the health care system must be flexible enough to match a community's cultural, ethnic, lifestyle and socioeconomic needs.¹⁸²

The HSA does little to address the issue of assuring culturally competent care. For instance, despite the fact that ethnic Americans respond well to community-based health education programs, the Act fails to require health plans to provide such activities.¹⁸³ Furthermore, it fails to require removal of the barriers to the effective utilization of such services. Rather, the Act permits, but does not require, states to provide financial incentives to ensure that health plans provide for extra services such as interpreting services.¹⁸⁴ Finally, since the HSA never explicitly defines "disadvantaged groups,"

¹⁷⁸ Bonnyman, Jr. *supra* note 104, at 875-76.

¹⁷⁹ Barbara M. Aved et al., *Barriers to Prenatal Care for Low-Income Women*, 158 WEST. J. MED. 493, 497 (1993).

¹⁸⁰ *Id.*

¹⁸¹ Michelle A. Bardack & Susan H. Thompson, *Model Prenatal Program of Rush Medical College at St. Basils Free Peoples Clinic*, 108 PUB. HEALTH REP. 161, (1993) (inadequacy of medical care for the disadvantaged is due, at least in part, to the result of the lack of committed physicians capable of providing culturally relevant care).

¹⁸² Jaime A. Davidson, *Diabetes Care in Minority Groups: Overcoming Barrier to Meet These Patients' Special Needs*, 90 POSTGRADUATE MED. 153, 158 (1991).

¹⁸³ "A health plan may offer education and training classes at its discretion." HSA § 1127(b).

¹⁸⁴ *Id.* § 1203(e)(3).

the scope of the incentives is indeterminate.

Health care requires interaction between the patient seeking care and the provider. When individuals do not understand, speak or read English, they may avoid contact with the health care system. Although some Americans do not understand English well enough to be able to talk with their physicians, the Act does not require that health care plans address these language barriers.¹⁸⁵ Language barriers can defeat the provision of health care if essential information cannot be conveyed.¹⁸⁶ Consequently, although universal coverage makes it easier for many ethnic Americans to seek and obtain effective health services, language barriers will continue to inhibit their use of the health care system, unless the system is required to restructure itself to address those concerns.¹⁸⁷

B. Ineffective "Comprehensive" Coverage

The HSA's universal coverage does not cover many of the services needed by poor Americans.¹⁸⁸ For instance, it does

¹⁸⁵ Twenty-five percent of Hispanic Americans do not understand English well enough to be able to talk with their physicians. Davidson, *supra* note 182, at 162.

¹⁸⁶ Davidson, *supra* note 182, at 162. Language and communication barriers exist beyond the role language plays in shaping reality. An emphasis on written communication ignores that many individuals prefer to understand information through oral or visual communications. Simply providing information (written, oral or visual) does not ensure knowledge or understanding. Providing written information will not be an adequate means of communicating to persons from cultural backgrounds other than middle-class European American. Furthermore, expressed language, whether written or oral, is a major source of conflict and misunderstanding in intercultural situations. ROSS, *supra* note 173, at 4-5. For instance, an inability to understand the expressions of others or of others to understand the individual can be a major source of frustration for ethnic Americans. With sufficient frustration, non-English speaking clients may delay seeking care. Even for English speaking clients, illness, depression, frustration and embarrassment may cause persons proficient in English to revert to their native language. Culture also influences the forms of responses in conversation. ROSS, *supra* note 173, at 6-7. Similarly, a patient's emotional response to treatment will differ across cultures. ROSS, *supra* note 173, at 5-7; Laguerre, *supra* 174, at 191. Finally, culture influences which topics a person considers appropriate for conversation among strangers. ROSS, *supra* note 173, at 6-7.

¹⁸⁷ Ginzberg & Ostow, *supra* note 158, at 2559. Communication barriers exist because of how different linguistic groups see and conceive reality. They exist because of cultural differences in interpreting expressed language. Culturally different forms of response, affect, approach and the appropriateness of the topic for conversation, all maintain communication barriers. Universal coverage does not remove those barriers.

¹⁸⁸ The Act, however, does require the National Health Board to specify particu-

not cover eyeglasses¹⁸⁹ or hearing aids,¹⁹⁰ and provides that no person 18 years or older can receive prevention, diagnosis or treatment of dental disease before January 1, 2001.¹⁹¹ These items may be of marginal expense to middle-income persons, but to the poor they are not only expensive but they are also essential corrective treatment.

The Act also provides insufficient "comprehensive coverage" for mental health and substance abuse. Although the Act covers inpatient and residential mental illness and substance abuse treatment, intensive nonresidential mental illness and substance abuse treatment, and outpatient mental illness and substance abuse treatment,¹⁹² these services are available subject to significant limitations.¹⁹³ Given the serious significant mental health and substance abuse problems in ethnic American and poor communities, basic mental health services are inadequate.¹⁹⁴ In addition, the proposal to phase-in men-

lar clinical preventive items and services for high risk populations. HSA § 1153.

¹⁸⁹ Eyeglasses and contact lenses are covered only for individuals who are less than 18 years of age. HSA § 1141(b)(4).

¹⁹⁰ *Id.* § 1141(b)(3).

¹⁹¹ *Id.* § 1126(b)(1), (2).

¹⁹² *Id.* § 1115(a).

¹⁹³ Coverage for inpatient and residential mental illness and substance abuse treatment is limited by criteria determined by the plan. HSA § 1115(c)(2). Furthermore, prior to January 1, 2001, treatment for inpatient and residential mental illness is limited to 30 days. *Id.* § 1115(c)(2)(C). A maximum of 30 additional days of treatment may be covered if a health professional designated by the health plan in which the individual is enrolled determines in advance that (i) the individual poses a threat to his or her own life or the life of another individual; or (ii) the medical condition of the individual requires inpatient treatment in a hospital or a psychiatric hospital to initiate, change or adjust pharmacological or somatic therapy. *Id.* Coverage for intensive nonresidential mental illness and substance abuse treatment is at the discretion of the health plan. *Id.* § 1115(d)(2)(A). However, the plans may not exercise the discretion adequately in areas that have significant substance abuse problems.

Prior to January 1, 2001, the number of covered days of intensive nonresidential mental illness and substance abuse treatment is limited to 60 days. *Id.* § 1115(d)(2)(D). An additional 60 days may be approved at the discretion of the plan. Coverage for outpatient treatment is at the discretion of the health plan. *Id.* § 1115(d)(2)(A). Prior to January 1, 2001, the HSA limits psychotherapy and collateral services to 30 visits for each type of service per individual. *Id.* § 1115(e)(2)(C)(i). The Act limits coverage for substance abuse counseling and relapse prevention to 120 visits and group therapy substance abuse counseling and relapse prevention to 30 visits. *Id.* § 1115(e)(2)(C)(ii).

¹⁹⁴ The large homeless population, at least 33% of whom suffer from some form of mental illness, is one indication of the need for a more significant mental health approach.

tal health benefits over five years is particularly troubling since political changes may result in the non-delivery of benefits.

While the evidently cut-throat competition of a health care market will make ethnic American patients fair game, the HSA fails to assure that ethnic American communities have providers who can provide culturally competent care. Nor does the Act anticipate the need to direct the regional alliance and health plans to develop culturally competent policies for the treatment of ethnic Americans. While there is a generalized list of Uniform Conditions of Participation for health plans to be established by the National Health Board, these conditions are oriented to management, contract conflict resolution, financial and marketing.¹⁹⁵ They are not patient- or service-oriented. More specifically, they do not require plans to show that they have the infrastructure to assure services to all population groups. To assure that health plans do serve the needs of ethnic Americans and poor communities, an additional conditions of participation should be added: to require health care plans to decrease the health status deficits of ethnic and disadvantaged Americans; to provide culturally competent care; and to prohibit adherence to rules, regulations and laws that discriminate on the basis of race, class, ethnicity, language, gender or sexual preference.

While the Act certainly has a number of provisions that are beneficial to ethnic Americans, one wonders why the only sections which mention culturally appropriate care are those which provide for financial incentives,¹⁹⁶ training of providers,¹⁹⁷ and the funding of school-based health clinics.¹⁹⁸ Why

¹⁹⁵ The health plans must meet Uniform Conditions of Participation established by the National Health Board. These include requirements for enrollment and coverage, HSA § 1402; community rating, *id.* § 1403; truth-in-marketing, *id.* § 1404; grievance procedure, *id.* § 1405; Utilization Management, *id.* §§ 1406, 1412; financial solvency, *id.* § 1408; quality assurance *id.* § 1410; verifying credentials of practitioners and facilities, *id.* § 1411; confidentiality, *id.* § 1413; and data management and reporting. *Id.* § 1413.

¹⁹⁶ *Id.* § 1203(e)(3) (permitting states to use financial incentives for health plans to remove barriers to access based on cultural differences); *Id.* § 3424(d) (federal funding to qualified community health group to remove barriers to access to the including those based on cultural groupings); *Id.* § 3424(e) (federal funding to qualified community health group to provide services to individuals with limited English within the individuals' cultural context most appropriate to such individuals).

¹⁹⁷ *Id.* § 3031(a) (federal funding to train health professionals and administra-

doesn't the HSA require health care plans to provide culturally appropriate care? Its failure to do so assures that the private sector will not provide culturally appropriate care to ethnic Americans.

V. THE HEALTH SECURITY ACT RATIONS HEALTH CARE THROUGH A TIERED SYSTEM BASED ON PRIVATE INTERESTS

It is only recently that the need for reform was characterized as a need for universal access. Health care reform was motivated not by the desire or need to provide better access, but by a concern for cost containment. More specifically, they were motivated by problems associated with uncompensated care and the cost of health care to employers and the government. To control costs, individuals, providers or health insurance plans will need to ration care. The Act places the rationing function in the hands of managed care plans owned by private enterprise.¹⁹⁹ Private enterprise, however, will not be able to control cost if the majority of Americans do not elect managed care plans. Consequently, universal portable coverage has been offered as the *quid pro quo* for accepting managed care rationing. Snake oil salesmen are selling managed care with the following pitch:

Your doctor will still be responsible for making decisions about your health care. However, we all know that there is way too much waste in the health care system. This waste raises the cost of care for all of us. The managed care organization will merely look over your doctor's shoulders to assure that the waste stops. Look at what you are going to get in exchange for a little gatekeeping, a little utilization review—universal, portable coverage.

tors in the provision of culturally sensitive care).

¹⁹⁸ *Id.* § 3602(a)(6); *Id.* §§ 3631(b), 3631(b)(10), 3635(a)(4), 3671(c)(9) (requiring programs which receive funding for comprehensive school health services to assure that instructional materials and approaches are sensitive to cultural and ethnic issues). The Act requires state plans, applications from local educational agencies, and applications from educational grantees for school health implementation grants to discuss how such school health education programs will be tailored to the extent practicable to be culturally and linguistically sensitive and responsive to the various needs of the students served, including individuals with disabilities, and individuals from disadvantaged backgrounds (including racial and ethnic minorities). *Id.*

¹⁹⁹ Randall, *supra* note 99, at 38-40.

Sadly, the HSA envisions not across-the-board rationing, but the continuation of a tiered health care system with rationing only for some. The reformed health care system will continue to ration health care based on economics.²⁰⁰ It will continue to ration health care based on race.²⁰¹ It will continue to ration health care based on class.²⁰² Universal portable cov-

²⁰⁰ In a society such as ours, which bases the availability of services and goods on the ability to pay, a poor person will have limited access to even an essential service such as health care. Thus, despite having the world's most technologically advanced health care, the United States (like South Africa) does not assure its citizenry universal health care or universal health insurance coverage. See George Lundberg, *National Health Care Reform: An Aura of Inevitability is Upon Us*, 265 JAMA 2566 (1991). The inability to afford quality health care restricts access both directly—some people cannot afford the services—and indirectly—some people cannot afford the supplemental activities which facilitate accessing the services.

Without sufficient insurance or money for services, access is limited. The magnitude of the problem is shocking. For the ethnic American or poor person who has neither health insurance nor sufficient wages to purchase health insurance or afford adequate health care, economic barriers are significant. A person may not be able to afford even a "small" co-payment.

²⁰¹ Economic proposals for improving access are based on the premise that the primary barrier to health care is socioeconomic. These proposals discount race and racism as a barrier to health care. The focus on racial barriers is not intended to imply that all ethnic Americans are affected the same. Ethnic Americans are not a homogeneous group. See Jose E. Becerra et al., *Infant Mortality Among Hispanics: A Portrait of Heterogeneity*, 265 JAMA 217 (1991); B. Josea Kramer, *Health and Aging of Urban American Indians*, 157 WEST. J. MED. 281 (1992). Consequently, when considering racial barriers, along with class and economic barriers, it is important to remember that the barriers will affect individuals within racial groups differently. However, race is a separate and independent barrier that affects not only a person's socioeconomic status, but institutional behavior and provider behavior as well. Randall, *supra* note 79, at 144-46. The racial barriers to health care are exhibited in barriers to health care facilities, to health care providers and to discriminatory medical treatment. *Id.* at 146-60. When institutional policies and practices have a discriminatory effect on the access of ethnic Americans to health care and a discriminatory effect on the quality of medical treatment, then racism is the problem. *Id.* at 160-62. Any attempt to reform the health care system must provide mechanisms to remove racial barriers to health care. Proposals which focus on socioeconomic barriers will certainly improve access, but as universal coverage does does not remove racial barriers, it is inadequate by itself.

²⁰² See Lundberg, *supra* note 200, at 2566-67. We live in a class-based society. The structure, organization and kinds of health care services delivered traditionally have focused on the needs of the upper-middle class. Class barriers manifest themselves when the health care system organizes and conducts itself based on certain assumptions about the middle class. For instance, the system assumes that individuals can take off work to obtain care; individuals can obtain transportation necessary to seek care; individuals have access to a telephone to call for appointments for health care or for authorization to seek health care; individuals have

erage, by itself, is not "good" if, in fact, the care received is discriminatory, inadequate, incompetent and inappropriate. The Act contains a number of provisions for federal funding in an attempt to assure care to ethnic Americans, but financial incentives will be inadequate, and as a result, a multi-tier system will continue to exist.²⁰³

access to child care; individuals have "money" to eat "right," sleep eight hours, and clothe themselves adequately; individuals have knowledge about where to seek health care services. Furthermore, clinics that serve the poor tend to have long lines and waiting periods indicating that lower-class individuals' time is less valuable than that of middle-income individuals. Lower-class individuals are likely to find all those assumptions to be barriers to health care services.

In one study, 30% reported inadequate child care as a barrier, 25% reported the lack of a telephone as a barrier, and 31% reported not knowing where to go as a barrier. Aved et al., *supra* note 179, at 495. Transportation problems include the lack of a car, lack of transportation fare, and the long distance required to travel to obtain care. *Id.* Thus, the quality of health care depends on where the health care provider is located relative to the patient's residence. Ginzberg & Ostow, *supra* note 158, at 2559. When health care providers are not located in the community, patients normally do not use follow-up care. Davidson, *supra* note 182, at 154. As one author has noted:

Health care is only one of many concerns of [families and individuals] . . . Providing their families [and themselves] with food, shelter, transportation, day care, and other essential matters requires the investment of substantial financial resources and occupies a good deal of time. If inefficient and understaffed clinics require inordinate amounts of time to provide simple services, individuals understandably may choose to forego certain [health care] services . . . to meet other daily needs

Gary L. Freed et al., 71 *MILBANK Q.* 32, 79 (1993).

However, the single most significant class barrier to lower-class individuals in seeking care is locating a provider willing to serve them. Aved et al., *supra* note 179, at 497; Bardack & Thompson, *supra* note 181, at 161. In one study, 64% of all women seeking prenatal care reported this as a problem, and 96% of women who tried to obtain care but were unable to reported this as a problem. Aved et al., *supra* note 179, at 497-99. The reasons for refusing to accept patients included administrative difficulties in obtaining payment from Medicaid and low Medicaid reimbursement rates. Ginzberg & Ostow, *supra* note 158. It also included prevailing negative attitudes of medical providers toward serving lower class communities. Freed et al., *supra*, at 79.

These attitudes reflected feelings that lower-class patients are difficult to work with, that lower-class patients are unclean, and that lower-class individuals don't care about their health. *Id.* These attitudes were held by "respected physicians in some communities and are promulgated through medical societies and informal networks." Freed et al., *supra*, at 79. Furthermore, the attitude of physicians is contributed to by the failure of medical schools to train physicians to provide community-based ambulatory care and to educate physicians to the particular health needs of ethnic Americans. Bardack & Thompson, *supra* note 181. In particular, physicians are not taught to deal "sensitively and understandingly" with the special problems of ethnic Americans. *Id.* In the end, class barriers such as these will not be removed by providing universal coverage.

²⁰³ By relying on price competition among providers, the Act segments the mar-

A. Health Care Plan Tiering

In addition to the coverage difference between cost-sharing policies, the higher cost-sharing fee-for-service option and the combination option will charge higher premiums.²⁰⁴ It is assumed that cost-conscious consumers will respond to differences in premiums by not spending their own money to purchase relatively expensive fee-for-service or PPO plans. Many consumers, particularly middle-class consumers, however, will not be satisfied with minimal health benefits. Individuals with significant health problems are likely both to want comprehensive benefits and to stay with their current physicians. Furthermore, many consumers will not be responsive to the premium difference.²⁰⁵ But, those who are likely to be the most responsive to premiums are the ethnic Americans and the poor, resulting in a health care ghetto.

Will these plans use their higher premiums to provide different services to their clients? Supporters of the Act argue no. Proponents argue that because all plans are required to provide access to the same basic comprehensive services, these plans will provide more amenities, not more services, i.e., better carpet on the floor, quicker service.²⁰⁶ However, proponents fail to realize that these "amenities" can make a difference in quality of care. For instance, quicker service is vital. Quicker service can make a difference in health status, if quicker service means that a person can see the provider within a day or two and the alternative is a two-week wait for an ap-

ket into at least two tiers. One tier would be composed of lower-income individuals and families who, because of economics, must join the least costly plan. The other tier would include everyone else. Rice et al., *supra* note 61, at 1359.

²⁰⁴ Cf. HSA § 1423(d)(B) (The price of any cost-sharing policy shall take into account any expected increase in utilization resulting from the purchase of the policy by the individual).

²⁰⁵ Rice et al., *supra* note 61, at 1357. There is much uncertainty pertaining to the magnitude of the price elasticity of demand for health insurance, measured as the percentage of change in the amount of insurance purchased divided by the percentage of change in premiums. *Id.*; see, e.g., M.A. MORRISEY, PRICE SENSITIVITY IN HEALTH CARE: IMPLICATIONS FOR HEALTH CARE POLICY (1992) (Estimates price elasticity as high as -2.8.); M. Holmer, *Tax Policy and the Demand for Health Insurance*, 3 J. HEALTH ECON. 203 (1984) (estimates price elasticity of -0.16).

²⁰⁶ In a private discussion with Lawrence Gostin, he indicated that the economist on the health care taskforce held this view and that it was a view that appeared to be winning the day in the design of the health care system.

pointment. Quicker service can make a difference in health care seeking behavior if a person has to wait in a waiting room for 2-3 hours to obtain service rather than 15-20 minutes.

Moreover, higher cost-sharing plans and combination plans will provide more than amenities; they will provide more services. For example, the basic health care benefits allow for a pap smear once every three years. Presumably, individuals with the higher cost-sharing plan could obtain a yearly pap smear. If yearly pap smears diagnose cervical cancer earlier than the basic health care benefits, then women in the higher cost-sharing and combination plans (primarily upper middle-income and European American women) will have better health care than women in the lower cost-sharing plan (largely ethnic American and poor). Furthermore, lower cost-sharing plans will be managed care plans while the higher cost-sharing plans will be fee-for-service plans. Managed care plans ration health care by using physicians as gatekeepers and by using strict utilization criteria.²⁰⁷ Fee-for-service plans ration care based on ability to pay.²⁰⁸

Notwithstanding the explicit rationing that occurs based on the "medically necessary"²⁰⁹ concept, the plan also provides for implicit rationing based on economics. First, the plan has significant deductibles and co-payments.²¹⁰ While health

²⁰⁷ Randall, *supra* note 99, at 27-28.

²⁰⁸ *Id.*

²⁰⁹ Health insurance policies insure against the risks of loss occasioned by sickness or disease. A common provision limits the risk of loss to medical services, equipment or supplies which are "medically necessary." Annotation, *What Services, Equipment or Supplies are "Medically Necessary" For Purposes of Coverage under Medical Insurance*, 75 A.L.R.4th 763 (1990). If the language employed is unambiguous and clear about who will make that medically necessary decision, then there is no occasion for construction. *Sarchett v. Blue Shield of Cal.*, 729 P.2d 267, (Cal. 1987) (policy unambiguously provided for impartial review of disputes between insurer and physician as to medical necessity of hospitalization for which benefits were claimed, and thus insurer was not precluded from challenging medical necessity of hospitalization recommended by treating physician); *Strassberg v. Connecticut Gen. Life Ins. Co.*, 182 A.D.2d 1055, 1056, 583 N.Y.S.2d 48, 48 (3d Dep't 1992) (health insurer, whose policy provided for coverage of professional nursing services when "recommended by a Physician and are essential for the necessary care and treatment of * * * a Sickness," did not reserve to itself the right to make independent determination on questions of medical necessity). When the terms are ambiguous, however, then terms are "strictly construed against the insurer and in favor of the insured." Annotation, *supra*, at 770.

²¹⁰ See *supra* notes 24-32 and accompanying text.

coverage is guaranteed, everyone will pay some out-of-pocket money for co-payments even if they are unemployed, homeless, disabled or poverty stricken.²¹¹ And while the HSA provides that failure to pay premiums will not result in loss of coverage,²¹² co-payments take place at the point-of-service. It is unclear whether inability to pay will restrict access at point-of-service.²¹³ But even if it does not in theory, it may still serve as a barrier to service. Some individuals who are unable to pay will want to avoid being embarrassed at the point-of-service, while others may want to avoid the civil monetary penalties, which could amount to as much as \$5000 for repeated failure to pay.²¹⁴

Second, the Act requires each family to pay 80% of the premium.²¹⁵ One obvious problem is the potential growth of the insurance premiums. The HSA reduces the rate of growth to the overall level of inflation by capping the growth of the premiums.²¹⁶ A cap on expenditures will provide a disproportionate advantage to higher income families because a smaller percentage of their income will be directed toward health care. Furthermore, a premium cap will probably result in rationing by health care plans as a method of maintaining profits. Consequently, higher income individuals and families with more disposable income will be able to buy themselves out of the rationing bind.²¹⁷

²¹¹ While the plan requires reduction for cost sharing, such reductions are limited to families who are enrolled in Aid for Families with Dependent Children ("AFDC"), Supplemental Security Income ("SSI"), or have an adjusted income below 150 percent of the poverty level. HSA § 1371(a). However, no reduction in cost-sharing shall be available for families if there are sufficient low-cost or combination plans available. *Id.* Consequently, reduction of cost-sharing is limited to low-income individuals who are enrolled in higher cost plans because of the non-availability of low-cost or combination plans.

²¹² *Id.* § 1344 (in no case shall the failure to pay amounts owed result in an individual's or family's loss of coverage under the Act).

²¹³ The Act allows for any family collection shortfall to be included in the family's plan premium. *Id.* § 1342(a)(1)(A).

²¹⁴ *Id.* § 1345(d)(2).

²¹⁵ *Id.* § 6101(a).

²¹⁶ *Id.* § 6001 (outlines the factors to be considered limiting the growth of premiums for the comprehensive benefit package in regional alliance health plans).

²¹⁷ Rice et al., *supra* note 61, at 1359 (citing M. Kolodinsky & T. Arnold, DEVELOPING A SLIDING FEE SCALE FOR HEALTH CARE INSURANCE IN VERMONT: THE CALCULATION OF DISPOSABLE INCOME (1989) (families below 200% of the poverty line have little or no disposable income available for sliding-scale contributions to

Families enrolled in Regional Health Alliances are entitled to a premium discount if the family is an AFDC or SSI family, has an adjusted family income below 150 percent of the applicable poverty level, or incurs a family obligation amount exceeding 3.9% of the adjusted family income.²¹⁸ But what happens to a family whose income is 151% of poverty? Eligibility for subsidies is rigidly means-tested on an annual basis, and burdened with retroactive penalties and redetermination, including investigation of tax returns. Like Medicaid, the HSA excludes help for many who need a subsidy. Furthermore, federal subsidies are not available for families who choose to register in a corporate alliance. Corporate alliances are required to provide a premium discount to low-wage employees, defined as any full-time employee earning less than \$15,000 annually.²¹⁹ Consequently, a person earning less than \$18,000 but more than \$15,000 will be penalized for working; had they enrolled in a regional alliance they would have been eligible for premium discounts. The net result is that health care will be more illusory than real for many working poor.²²⁰

The HSA allows the higher cost-sharing (fee-for-service)

health insurance premiums)); Holmer, *supra* note 205 (low-income individuals' price elasticity estimates for health insurance were twice as high for families with incomes between \$15,000 and \$25,000 and six times higher (-0.39) than for those with incomes of more than \$40,000).

²¹⁸ HSA § 6104(a)(1), (c)(3). The amount of the premium discount will be equal to 20% of the weighted average premium for the health plans offered by the regional alliance for that family type, reduced (but not below zero) by the sum of the family obligation amount, and the amount of any non-required employer payment towards the family share of premiums. *Id.* § 6104(b). The discount will be increased if a family is unable to enroll in an at-or-below-average-cost plan, but only to such an amount that will allow the family to enroll in a regional alliance health plan without the need to pay a family share of premium in excess of an at-or-below-average-cost plan. *Id.*

As of 1994 this eligibility for discounts applies to dual parent families with incomes below \$22,200; single parent families with incomes below \$18,400; childless married couples with incomes below \$14,600; and single individuals with incomes below \$10,800. THE PRESIDENT'S REPORT, *supra* note 31, at 29.

²¹⁹ HSA § 6104(a)(2).

²²⁰ The illusion of services is significant: patient educational provisions are elective under the health plan and accompanied by significant co-payments; mental health services, long-term health care and hospice care are inadequate; home health care services are severely time-limited; prosthetic dental devices, adult dental services, eyeglasses and hearing aids are excluded. Furthermore, virtually all the services have significant cost-sharing provisions.

plans to perform utilization review,²²¹ to require prior approval for specified service,²²² and to exclude providers because of poor quality of care.²²³ While these provisions provide some aspects of managed care plans, the Act specifically provides that prior approval for specific services shall not be construed as permitting a plan to require prior approval for non-primary health care services through a gatekeeper or other process.²²⁴ Thus, the HSA allows a person to "buy" their way out of "gatekeeping" rationing. And so, when people pay higher premiums for a higher cost-sharing (fee-for-service) plan, they are actually saying: "Don't ration my care. Don't use any gatekeeping mechanism that can ration care to me. I want to be able to get whatever I can afford to buy."²²⁵ Consequently, even with utilization review, individuals in higher cost-sharing plans will have greater access. As one commentator has noted:

These plans would entice middle- and upper-income groups to pay more of their after-tax income for more choice of physicians, shorter waits for appointments with primary care physicians and specialists, more conveniently located physicians, hospitals, and pharmacies, and/or broader coverage. Market segmentation would adversely affect people who are unable to afford more than a basic plan. They would find that there are not enough plans with enough capacity willing to participate; they would find few providers willing to serve them; and they would have less access to specialty care and expensive medical technologies.²²⁶

Thus, many of the inequities in the current system will continue to exist: individuals will be tiered among health care plans;²²⁷ few plans will choose to market aggressively among

²²¹ HSA § 1322(b)(2)(B)(i).

²²² *Id.* § 1322(b)(2)(B)(ii).

²²³ *Id.* § 1322(b)(2)(B)(iii).

²²⁴ *Id.*

²²⁵ See Rice et al., *supra* note 61, at 1359 (suggesting that "persons with family incomes below 200% of the federal poverty level are unlikely to be able to afford premium surcharges" and that "80 million people—32% of the entire population—will be able to 'choose' only among basic plans").

²²⁶ Rice et al., *supra* note 61, at 1359-60. "Low-income persons are likely to have a difficult time finding plans in which they can enroll because few plans may choose to market themselves at the most affordable basic plan rates." *Id.* See M. MERLIS, *MEDICAID SOURCE BOOK*, Congressional Research Service (1993); M.D. Anderson & P.D. Fox, *Lessons Learned from Medicaid Managed Care Approaches*. 6 HEALTH AFF. 71-86 (1987).

²²⁷ See Rice et al., *supra* note 61, at 1359-60.

ethnic Americans and the poor;²²⁸ physicians will refuse to join plans that have "too many" ethnic Americans and poor individuals.²²⁹

B. Health Care Service Tiering

Even where physicians and plans accept ethnic American patients, they may discriminate in dispensing medical services. This problem exists in the current system and will be aggravated by the HSA, because the Act places premium limits on health care plans, but does not place limits on the types of managed care that plans can institute to make a profit and provide services.²³⁰ Consequently, plans, through utilization review, may find it easier to deny services to ethnic American patients rather than to middle-class European American male patients.²³¹ That is, even under the same health care plan, it will be easier to deny services to the less articulate, persons preceived as powerless, etc.²³² Consequently, health care

²²⁸ See *id.* (citing a survey where only 22% of HMOs were participating in the Medicaid program because of low premiums paid by Medicaid, discontinuous Medicaid eligibility of enrollees and marketing problems).

²²⁹ See Peggy McNamara, *Patchwork Access: Primary Care in Eds on the Rise*, 67 HOSP. 44 (1993) (explaining that Medicaid patients are often left with nowhere to seek medical care but the emergency room because of physicians' refusal to see them); Thomas S. Nesbitt, *Access to Obstetric Care in Rural Areas: Effect on Birth Outcomes*, 80 AM. J. PUB. HEALTH 814, 817 (1990); Rice et al., *supra* note 61, at 1360.

Under the Act physicians are not required to belong to any particular plan. Consequently, physicians can avoid poor and ethnic American patients by merely refusing to join plans which have a large percentage of those patients. Even where physicians belong to a plan they may still refuse to accept ethnic American and poor patients. Lundberg, *supra* note 200, at 2.

²³⁰ HSA § 6001. For example, the HSA outlines the computation of factors that limit the growth of premiums for the comprehensive benefit package in regional alliance health plans. *Id.*

²³¹

Plans would also vary in their access to specialty care and expensive technologies. This difference in access between basic-premium plans and those that impose a premium surcharge would perpetuate differences in access to health services based on socioeconomic status rather than on medical condition and appropriateness only, continuing fundamental inequities in access to care.

Rice et al., *supra* note 61, at 1360.

²³² As noted in one report:

at their worst some HMOs make the elderly fight for benefits, especially those for costly skilled nursing or home care that plans must provide as

plans may, in fact, provide different services based on race and class. This is particularly true since the adjustment of premiums based on regional trends compared to national trends does not specifically include adjustments based on race and ethnicity.²³³ Thus, ethnic Americans who are sicker than European Americans will seek more services. Yet, health care plans may not be compensated adequately for the difference because of the failure to adjust the premium. Granted, the HSA allows for adjustment based on demographic characteristics.²³⁴ For instance, it requires age, gender, socioeconomic status and health status to be considered.²³⁵ However, socioeconomic status and health status are only partial and inadequate substitutes for race and ethnicity.

Arguably, this problem exists in the current health care delivery system. But the problem with the Act is not just that it retains the problem, it institutionalizes and condones it. Every poor person, every unemployed person, every person who does not have the money to get into the higher cost-sharing or combination plan will be in some form of managed care plan, if not by explicit choice, at least by economic reality.²³⁶

Most middle-income Americans will obtain their health insurance through their employment. The Act is designed to economically tempt these individuals to choose a managed care or combination plan. Managed care plans will not only have a lower premium but also require a smaller out-of-pocket cost.²³⁷ Given the choice of going to the health care provider

part of the customary Medicare package of coverage. Some HMOs have dragged out the process so long that Medicare beneficiaries have died before ever receiving the nursing care they are legally entitled to.

Byrd & Clayton, *supra* note 69.

²³³ HSA § 6001(c)(1)(A).

²³⁴ *Id.*

²³⁵ *Id.*

²³⁶ In fact, the choice feature of the health care plan may be a sham for all but the wealthy. Over time, the reform would decimate all but the large corporate health care entities. Currently, ten insurers control 70% of the HMO market. Only the larger insurers will have the resources to develop nationwide networks necessary to serve national corporations. Such health care networks will force out all other competition. "When the Big Three ran the auto industry, they controlled prices effectively, and no one imagines that compact health care plans from Japan will ever penetrate (or even be allowed to enter) this market." HIMMELSTEIN & WOOLHANDLER, *supra* note 92, at 4.

²³⁷ *Id.*

of your choice while paying a \$3000 deductible and 20% of the cost afterwards (higher cost-sharing/combination plan), or paying no deductible and only \$10 per physician visit (managed care), many middle-income persons will have to choose managed care. Although every health care plan will theoretically offer the same comprehensive basic services, they will do so through different organizational structures with different gatekeeping mechanisms and different utilization review standards. Currently many employers offer a traditional fee-for-service plan and a managed care plan as an alternative. The same incentives exist in the HSA. However, the Act goes beyond the existing system. It legally delegates to private enterprise (insurance companies) the rationing of health care in America. Thus, health care plans will ration health care differently, since theoretically in the current system private physicians still make the ultimate decision on medically necessary care.

Insurance companies will ration health care to those services deemed "medically necessary," based on standards, guidelines or practice parameters.²³⁸ In fact, the Act specially provides that no benefits are available unless the benefit is "medically necessary or appropriate."²³⁹ While the HSA gives authority to the National Health Board to determine when a specific item or type of service is not medically necessary or appropriate,²⁴⁰ it apparently leaves to the health care plan the authority to determine medical necessity on an individual basis.²⁴¹

Several issues are presented by limiting health care based on "medical necessity". First, because medical necessity is based on utilization review decisions and financial risk-shifting at the insurance level, the patients are not likely to know that their treatment was reduced or a service was denied.²⁴² Sec-

²³⁸ See generally Mark A. Hall & Gerald F. Anderson, *Health Insurers' Assessment of Medical Necessity*, 140 U. PA. L. REV. 1637 (1992).

²³⁹ HSA § 1141(a).

²⁴⁰ *Id.* §§ 1141(a)(2), 1154 (allowing the National Health Board to develop regulations).

²⁴¹ *Id.* §§ 1141(a)(1), 5201(e)(3) (providing notice and disclosure requirements for health care plan that denies coverage based on a determination that the treatment is not medically necessary).

²⁴² Rosenblatt, *supra* note 4, at 6; see generally Randall, *supra* note 99, at 28-29.

ond, decisions which find that a service is not "medically necessary" at best will be based on a concept of utilization review, a "series of working hypotheses and partial solutions that are continually revised, discarded, and even reinvented as changes occur in medical technology, social values, economic conditions and other circumstances."²⁴³ Third, given that most health care research has been based largely on European American males and that providers are largely European American males, medical care decision-making is culturally biased.²⁴⁴ This is particularly troublesome since ethnic Americans suffer from more health problems than middle-class European Americans.²⁴⁵ Finally, the most significant problem is the lack of any authoritative guidelines as to what constitutes "medically necessary."²⁴⁶ Consequently, the decision is left to the whims of insurance companies. This arrangement invites discrimination.²⁴⁷

Requiring the plans to rely on qualified physicians does little to protect the individual from the culturally biased vagrancies of utilization review. Plan physicians are not likely to contradict their employer's decision to deny service,²⁴⁸ which means that we are institutionalizing a decision-making process that is largely determined by middle-class European American males.²⁴⁹

²⁴³ INSTITUTE OF MEDICINE, COMMITTEE ON UTILIZATION MANAGEMENT BY THIRD PARTIES, CONTROLLING COSTS AND CHANGING PATIENT CARE: THE ROLE OF UTILIZATION MANAGEMENT 1 (Bradford H. Gray & Marilyn J. Field eds., 1989) [hereinafter, IOM STUDY]; see also, Rosenblatt, *supra* note 4, at 7.

²⁴⁴ For example, it has only been in the last several years that the medical profession has begun to recognize the significance of testing drugs and treatment modalities on women and on people of different races. Therefore, we actually have very little data as it relates to treatment modalities and the impact of those treatment modalities on anyone other than white males.

²⁴⁵ See *supra* note 79 and accompanying text.

²⁴⁶ Rosenblatt, *supra* note 4, at 7.

²⁴⁷ HSA § 5201(b)(4)(C).

²⁴⁸ Randall, *supra* note 99, at 18; Rosenblatt, *supra* note 4, at 13 (citing Sally Hart and Alfred J. Chiplin, *Proposed Revisions to Health Care Reform Act* (submitted to Office of Health Legislation, HHS)); see also Bradford H. Gray, *THE PROFIT MOTIVE AND PATIENT CARE* 309 (1991) (reporting that when utilization review companies determine that further hospital care is not medically necessary, in almost all cases, the attending physician will discharge the patient).

²⁴⁹ In authorizing the development of practice parameters, the Act outlines certain requirements, none of which require that guidelines be culturally relevant or appropriate. HSA § 5006(a)(2).

In sum, cost sharing, co-payments, supplementary policies, reliance on volunteerism instead of mandates, temporary "special programs" and set-asides continue institutionalized elitist health care. Because of barriers and tiering, ethnic Americans and poor communities with the worst health status and most complex health care problems will be penalized as they are forced to pay premiums, co-payments and deductibles that they cannot afford. To be effective, market choice requires the financial means to choose and requires plans to be willing to serve ethnic Americans. Absent these factors, managed competition would limit the choice of low income and ethnic Americans.

C. *Health Care Physician Tiering*

Even among physicians there will be tiering. Plans must limit the number of physicians who operate in the plan to control costs.²⁵⁰ They may limit participation to "board certified" physicians. Plans with lower premiums will have more restrictive utilization review and gatekeeping mechanisms. Managed care plans must have physicians willing to abide by their utilization review standards and gatekeeping guidelines. As a result, younger, less experienced physicians will begin their careers in the managed care plans, while the older, more experienced physicians will practice in fee-for-service plans, with obvious implications for ethnic Americans and the poor.²⁵¹

If quality of care is related to the experience of the providers, then the more costly fee-for-service plans will offer higher quality service because they will be more attractive to the more experienced physicians. Furthermore, even though physicians may participate in more than one plan, physicians may limit the number of patients from the lower cost-sharing plans if those plans pay them less than the higher cost-sharing, fee-

²⁵⁰ Managed care plans skimp on doctors. For instance, they employ one physician for every 800 patients, even though currently, the United States has one physician for every 400 patients. As more Americans enroll in managed care plans, non-managed care physicians will find it impossible to maintain a practice. HIMMELSTEIN & WOOLHANDLER, *supra* note 92, at 4.

²⁵¹ Rice et al., *supra* note 61, at 1361 (suggesting that the lower cost plans would be more likely to contract with physicians who are less experienced and less skilled).

for-service plans. Since nothing in the HSA requires that a physician accept any patient from any plan to which the physician belongs, eventually individuals may find that significantly fewer physicians are available in lower cost-sharing plans.²⁵² The lack of adequate protections will inevitably result in limited access for ethnic Americans. As one author has noted, "It is difficult to imagine how managed competition will not result in a class-based access through a multi-tiered system of benefits and eligibility. Moreover, both insurers and health service groups will find it easiest to "compete" via favorable selection of healthier groups."²⁵³

In conclusion, although the lowest-cost plans will be the ones that are the least desirable, they are likely to be the only ones affordable to the poor. They may also be the only ones available to serve ethnic American communities. Although all plans would be required to provide a comprehensive benefit package, ethnic Americans enrolled in basic plans may find it difficult to obtain many of the services that are covered by the plan. Because low-cost plans would be unable to match the fees paid by higher-cost plans, many providers will not contract with them. Consequently, ethnic Americans and the poor enrolled in the basic plan will have "limited-access and sometimes lower-quality"²⁵⁴ health care.

²⁵² Assuming that physicians are rational economic actors, this is common sense. If a physician is a prominent heart surgeon and the higher cost-sharing plans pays more per patient for rendering the service than the lower cost-sharing plans, economically it would be irrational for a physician not to limit the number of patients from the basic plan.

²⁵³ *U.S. Health Reforms: Cliches, Cost and Mrs. C.*, 341 LANCET 791, 791 n.5 (1993).

²⁵⁴ Rice et al., *supra* note 61, at 1360. As one author has noted, "[Ethnic Americans and the poor] will have limited provider networks that may be geographically inconvenient, provide only the most basic services required, provide the least choice of physicians and hospitals, make it difficult to obtain specialist care and new technologies, and have the least thorough quality assurance programs. We thus anticipate segmentation of the market for health plans and health services, with more costly plans providing more accessible and often better-quality services for their enrollees—in short, a continuation of two-tier medicine" Rice et al., *supra* note 61, at 1361.

VI. THE HEALTH SECURITY ACT INADEQUATELY PROTECTS AGAINST HEALTH CARE DISCRIMINATION

It is clear that the potential for continuing discrimination is significant. Any effort to create a just health care system will depend on the ability of advocates to litigate and prevent discrimination. Advocates' effectiveness will depend on the anti-discrimination provisions of the HSA. The Act contains express anti-discrimination enforcement provisions, but they are insufficient.

A. *Potentially Counterproductive Provisions*

1. National Health Board

The Health Security Act is silent on the prohibition of discrimination by the National Health Board.

2. States

States are expressly prohibited from discriminating based on race, ethnicity, language, religion, national origin, socioeconomic status, disability or perceived health status, but only when setting Regional Health Alliance boundaries.²⁵⁵ Furthermore, if a state chooses to operate a statewide single-payer system, the state may not discriminate against health plans on the basis of race, sex, national origin, religion, mix of health professionals, location of the plan's headquarters, or organizational arrangement.²⁵⁶

As far as preventing discrimination by states, the Act has several flaws. First, it does not specifically forbid the states from discriminating in the design of the state system. The prohibition against discrimination focuses only on the drawing of boundaries of the regional alliance. No doubt many decisions will have the "effect" of discriminating, but will be difficult to

²⁵⁵ HSA § 1202(b)(4). This is broader coverage than Title VI of the Civil Rights Act of 1964 which only prohibits discrimination based on race, color or national origin, or Title VII of the Civil Rights Act of 1964 which only prohibits discrimination based on race, color or national origin. This act includes ethnicity, language, socioeconomic status, disability or perceived health status as well.

²⁵⁶ *Id.* §§ 1223(c)(4), 1328(a).

challenge on constitutional grounds.

Second, the HSA has insufficient protections against redlining²⁵⁷ in developing the regional alliances. There are no limits on the number of regional alliances a state may create.²⁵⁸ On the other hand, the alliance area must be large enough to provide an adequate market share and thereby ensure effective negotiations with health plans.²⁵⁹ However, since health plans are not required to negotiate with all alliances within a state, insurance companies are likely to lobby to develop small, homogeneous alliances, so that they can target particular populations.²⁶⁰ While the Act includes a specific prohibition against establishing boundaries that discriminate, it is unclear whether this provision will apply to "effect discrimination." That is, if a state does not draw lines with an evident intent to isolate ethnic American communities, will the fact that the boundaries have the effect of discriminating be sufficient for a cause of action?

Third, the prohibition against splitting Metropolitan Statistical Areas ("MSAs") may be insufficient to protect ethnic Americans.²⁶¹ It is uncertain what would happen if states created separate regional alliances for each MSA. Furthermore, The Act does not include Primary Metropolitan Statistical Areas ("PMSAs") which could be split. Splitting PMSAs would be devastating to many major cities that have significant ethnic American populations.²⁶²

Finally, states are not required to narrow health status disparities among different population groups. Without such requirements, states could implement systems which, while technically nondiscriminatory, in fact have an effect of not improving the health status of ethnic Americans. Such consequence would be as devastating as discrimination.

²⁵⁷ Redlining is the pattern of discrimination in which institutions refused to provide services to certain geographic areas. It most commonly occurs in connection with financial institutions. See BLACK'S LAW DICTIONARY 1150 (1979).

²⁵⁸ HSA § 1201(1).

²⁵⁹ *Id.* § 1202(b)(2)(A).

²⁶⁰ Wiley, *supra* note 80, at 10.

²⁶¹ HSA § 1202(b)(5).

²⁶² Wiley, *supra* note 80, at 13.

3. Regional Health Alliances

Regional health alliances are not permitted to discriminate against health plans on the basis of race, gender, ethnicity, religion, mix of health professionals, location of the plan's headquarters or organizational arrangement.²⁶³ They must assure that all eligible individuals in the alliance area enroll in a health plan.²⁶⁴ The HSA extends § 504 of the Rehabilitation Act of 1973,²⁶⁵ § 303 of the Age Discrimination Act of 1975,²⁶⁶ and § 601 of the Civil Rights Act of 1964²⁶⁷ to Regional Health Alliances.²⁶⁸ Unfortunately, the provisions regarding discrimination by the regional health alliances are similarly inadequate. Specifically, regional health alliances are not forbidden to engage in practices that have the effect of discriminating. Furthermore, the current interpretation of Title VI of the Civil Rights Act has proven inadequate in protecting ethnic Americans from cost-containment health care discrimination.²⁶⁹

4. Corporate Health Alliances

The HSA provides that the provisions applicable to regional alliances relating to redlining and metropolitan statistical areas apply to the establishment of premium areas by corporate alliances.²⁷⁰ However, the same problems exist with corporate alliances that exist with regional alliances. Moreover, the Act does not require corporate health alliances not to discriminate. This oversight is likely to have significant effect on health plans owned by ethnic Americans or plans that serve a

²⁶³ HSA § 1328(a).

²⁶⁴ *Id.* § 1323(a).

²⁶⁵ 29 U.S.C. § 794 (1988 & Supp. IV 1992).

²⁶⁶ 42 U.S.C. § 6102 (1988).

²⁶⁷ 42 U.S.C. § 2000d (1988).

²⁶⁸ HSA § 5239.

²⁶⁹ See generally Kenneth Wing, *Title VI and Health Facilities: Forms Without Substance*, 30 HASTINGS L.J. 137 (1978). "With respect to the modern American health facility. Title VI is an illusory promise and an unused tool of public policy. The signing of a Title VI assurance form by a hospital or a nursing home is little more than the execution of another boilerplate form, one of many incident to the receipt of federal funds." *Id.* at 190.

²⁷⁰ HSA § 1384(b)(2).

large portion of ethnic Americans. Since only employers who have 5000 or more employees can opt out of the regional alliance, the corporate alliances will be predominately middle-class European Americans.²⁷¹ In attempting to serve this distinct population, corporate alliances are likely to discriminate by not contracting with health plans owned by ethnic Americans or that otherwise serve a large portion of ethnic Americans.

5. Health Plans

There is no doubt that some health plans will try to avoid serving ethnic American and poor communities. These communities are often high-risk with a backlog of untreated or undertreated illness. There are a number of ways that a health plan can minimize or restrict, if not exclude, services to undesirable patients. Health plans could enroll individuals and then not provide meaningful access to covered services by either failing to provide supplemental support services needed to access services or by locating the services outside the immediate community. They could provide services in a culturally inadequate and inappropriate form. They could use utilization review and financial risk-shifting to deny or at least delay the receipt of specialist services. They could fill their rolls with European American middle-class enrollees and then claim a lack of capacity.

At first blush, provisions of the Act, as it relates to preventing these problems, appear comprehensive. For instance, the criteria for certifying plans includes evaluating each plan for its relationship with the community and its capacity to deliver the comprehensive benefits package, anti-discrimination protections, marketing, grievance procedures and quality assurance.²⁷² These provisions, however, only help the states assure that plans have the general ability to serve ethnic American communities; they do not assure that the plans will not avoid the communities altogether, and nothing in the plan

²⁷¹ There has been discussion regarding allowing employers with less than 500 employees to opt out of regional alliances. If these discussions prove to be true, regional health alliances will becoming nothing more than ghetto plans for the low income, poor and underserved.

²⁷² HSA § 1203.

requires health plans to serve all parts of the regional alliance.

However, while health plans are allowed to serve only part of an alliance,²⁷³ health plans may not engage in any activity that has the effect of discriminating against an individual on the basis of race, national origin, gender, income, health status or anticipated need for health services.²⁷⁴ Furthermore, plans are prohibited either directly or through contractual arrangements from discriminating in the selection of providers.²⁷⁵ This provision is significant since it provides some protection in the event that a health plan refuses to contract with ethnic American providers. However, to provide additional protection for ethnic American communities, the HSA needs to protect the provider against discrimination based on the race, national origin, language, ethnicity and gender of the provider's patient.

Notwithstanding this important anti-discrimination language, the HSA includes language that substantially undermines the anti-discrimination protection. Except in the case of intentional discrimination, the Act specifically excuses a person from an action otherwise prohibited if the action is required because of business necessity.²⁷⁶ Furthermore, it fails to define business necessity. This is a significant problem for a health care system based on managed care (utilization review or financial risk-shifting). In such a system, plans have an inherent need to institute activities to contain cost. For instance, a plan may desire to contract with the most cost-effective physicians. The cost of providing services to inner-city patients is often "higher" than that of the urban patient. Inner-city patients require more testing and more services. Thus, in comparing the inner-city physician, whose patients are comprised largely of ethnic Americans, to a physician with a largely European American patient population, a plan might decide not to contract with the physician serving the ethnic American population because the patients were not "cost-effective". If contracting based on "cost-effectiveness" is a business necessity, then the health care plan will be able to discriminate in a

²⁷³ *Cf. id.* §§ 1404(a)(2), 1406.

²⁷⁴ *Id.* § 1402(c)(1).

²⁷⁵ *Id.* § 1402(c)(2). The prohibition includes race, national origin, or gender of the provider, or income, health status or anticipated need for health services of a patient of the provider. *Id.*

²⁷⁶ *Id.* § 1402(c)(3).

way that essentially bars physicians who serve primarily ethnic American and poor patients.

Similarly, health care plans could decide to contract only with board-certified physicians as a means to screen physicians and as a marketing tool. However, board certification does not establish quality.²⁷⁷ Furthermore, a large number of ethnic American physicians are not board-certified.²⁷⁸ But, if the requirement is deemed a business necessity, then the health care plan will be able to discriminate in a way that in effect bars physicians who serve primarily ethnic American patients.

Likewise, health care plans use utilization review to determine whether a procedure or treatment is "medically necessary." Assume, for example, some type of cancer treatment (maybe a bone marrow transplant) is more often found not to be "medically necessary" for ethnic American males than for European American males. Assume further that the health plan can justify this discriminatory care on the basis of medical protocols. The use of the protocols, therefore, may be a business necessity, and the health care plan can discriminate in the authorization of this treatment decision. Consequently, such a business necessity requirement would have the effect of excluding minority physicians. While health plans will have a provider advisory board, unfortunately its members will be selected by the providers in the plan, and there are no provisions to assure representation of ethnic American providers and providers who serve the poor. Furthermore, these potential problems cannot be corrected with regulations since the Act specifically provides that no regulation can overcome a deter-

²⁷⁷ Consumers consider specialty board certification to be one of the fundamental criteria of medical competency. In theory, certification assures the public that a physician meets certain standards of knowledge, experience and skills set by other medical professionals to ensure high quality care in the specialty. In reality, certification is not a foolproof indicator of competence. While board certification may indicate that the doctor has advanced knowledge, experience and skills, a doctor does not have to be board-certified to be a good practitioner. Furthermore, board-certification does not guarantee that the doctor has advanced medical knowledge, experience and skills. See generally, *Special Certification: Meaningful or Meaningless?*, 8 PEOPLE'S MED. SOC'Y NEWSL. 1, 1-3 (1989).

²⁷⁸ Many minority providers have lacked the money and time to become board-certified, a requirement for working for many HMOs. Janice Sommerville, *Managed Care May Help, Hurt Inner-City Medicine*, 36 AMER. MED. NEWS 12 (Oct. 25, 1993).

mination (presumably a court's) of "business necessity."²⁷⁹ Thus, while the HSA has important language forbidding activity that has a discriminatory effect, it effectively nullifies the language by exempting activities that are done for a business necessity.

6. Enforcement

The key, of course, to the civil rights provision of the Health Security Act is the inclusion of substantial enforcement mechanisms. The Act has some significant provisions providing for a private cause of action for discrimination.²⁸⁰ Notwithstanding the significance of these provisions, substantial issues remain. For instance, merely incorporating by reference the standards for age and disability discrimination from the Age Discrimination Act and the Americans with Disabilities Act is

²⁷⁹ HSA § 1402(c)(3).

²⁸⁰ The HSA provides that an aggrieved person has a private right to enforce state responsibilities under § 1983 of the Civil Rights Act. Aggrieved persons will also have private enforcement rights if the federal government fails to carry out its responsibilities related to the operation of the Alliance or if health alliances fail to fulfill their responsibilities. *Id.* §§ 5236, 5236. Furthermore, "essential community providers" may bring civil suits against health plans which fail to enter participation or payment agreements with them. *Id.* § 5240.

As to discrimination claims, the Act provides that any person who is discriminated against may commence a civil action against the plan in either a state court or federal district court. *Id.* § 5239(a)(1). The HSA provides that the standards used to determine whether a violation has occurred in a complaint alleging age discrimination shall be the standards applied under the Age Discrimination Act of 1975, 42 U.S.C. § 6101, and that the standards used to determine whether a violation has occurred in a complaint alleging disability discrimination shall be the standards applied under the Americans with Disabilities Act of 1990, 42 U.S.C. § 12101. An aggrieved person may recover compensatory and punitive damages and any other appropriate relief. HSA § 5239(a)(3). The court may allow the prevailing party, other than the United States, to recover a reasonable attorney's fee (including expert fees) as part of the costs, and the United States shall be liable for costs the same as a private person. *Id.* § 5239(a)(4).

In addition to the private cause of action, the Act allows HHS to refer discrimination by a health plan to the Attorney General with a recommendation that an appropriate civil action be instituted or to terminate the participation of the health plan in an alliance. *Id.* § 5239(b). The Attorney General may bring a civil action in a federal district court for such relief as may be appropriate, including injunctive relief. *Id.* § 5239(c). The court may award equitable relief, compensatory and punitive damages, and may assess a civil money penalty against the health plan. *Id.* The civil money penalty may not exceeding \$50,000 for a first violation and may not exceed \$100,000 for any subsequent violation. *Id.* § 5239(c)(3).

not sufficient. Exactly what standards are being incorporated? Is the reasonable accommodation requirement of the Americans with Disabilities Act to be used with health plans? If so, why make reasonable accommodation a requirement of disability and not of other forms of discrimination?

Furthermore, the standards governing enforcement are incomplete. In particular, the Act does not address issues of burdens of proof or statutes of limitation. Given the importance of health care, the burden of proof should be shifted to the defendant to show that the practice is a business necessity. The level of proof should be heightened by requiring that the practice be "substantially related to an essential business goal consistent with business necessity." The plaintiff should be able to overcome a business necessity defense by demonstrating that other less discriminatory alternatives were available that would have substantially met the business goal or showing that the articulation of business necessity is merely a subterfuge. Furthermore, when the defendant's defense of business necessity is based on cost containment, cost control or financial issues, the defendant should retain the burden of proof to show that no less discriminatory alternatives were available. Additionally, any motivation for undertaking an unlawful health care practice should be made *per se* irrelevant.

Moreover, just as in the area of fraud and abuse, the HSA should enumerate specific forms of unlawful health care practices.²⁸¹ Such enumeration would assure that certain

²⁸¹ For example, the Act should prohibit the following: denying an individual any service, financial aid or other benefit; providing different service, financial aid or other benefit to an individual; providing a service in a different manner from that provided to others; segregating an individual or providing separate treatment in any matter related to the receipt of any service, financial aid or other benefit; restricting an individual's enjoyment of any advantage or privilege enjoyed by others receiving any service, financial aid or other benefit; treating an individual differently from others when determining whether she satisfies any admission, enrollment, quota, eligibility, membership or other requirement or condition which individuals must meet to be provided any service, financial aid or other benefit; denying an individual an opportunity to participate in a plan, program, activity or insurance through the provision of services or otherwise without affording him an opportunity which is different from that afforded to others (including the opportunity to participate in the plan, program, activity or insurance as an employee or contractor); denying an individual the opportunity to participate as a member of a planning or advisory body that is an integral part of the plan, program, activity or insurance. Furthermore, it should be a specific unlawful health care practice for a plan, program, activity or insurance to discriminate against a person based on

forms of health care discrimination are prevented. However, to prevent the court from limiting the definition of discrimination to the enumerated examples, the Act should specifically state that the enumeration of specific forms of discrimination does not limit the generality of the prohibition. At the same time, however, efforts to overcome the effects of discrimination, to reduce the disparity in health care, or to assure access to culturally competent care should not be labeled unlawful health care practices.

Finally, the HSA fails to define the identity of an aggrieved person. This lack of definition of an "aggrieved person" will result most certainly in a judicial interpretation which defines it as someone who has actually been the victim of discrimination. However, to discourage health care discrimination, an "aggrieved person" should include not only the individual who has been injured, but also one who believes that he or she will be injured, as well as individuals engaged as testers and organizations engaged in testing. This is important because much of health care discrimination goes unreported or undetected.

7. Data Collection

Effective enforcement of civil rights is dependent on the availability of reliable, relevant data. Currently, no such system of data collection exists.²⁸² The HSA requires that the National Health Board develop a health information system to collect and disseminate information.²⁸³ This system will collect data on enrollment, utilization, outcome, health care provider certification and consumer satisfaction.²⁸⁴ Unfortunately, the Act does not make it clear that data must be collected with respect to race, ethnicity, gender and disability. As for ethnic Americans the collection of information will be of little

language ability or linguistic characteristics.

²⁸² Title VI requires HHS to collect data and information from applicants and recipients of federal financial assistance. 28 C.F.R. §§ 42.406(a), 80.6 (1993). Unfortunately, the information about race is not collected uniformly. Jane Perkins, *Race Discrimination in America's Health Care System*, CLEARINGHOUSE REV. 371, 377 (Special Issue 1993).

²⁸³ HSA § 5101(a).

²⁸⁴ *Id.* § 5101(e).

benefit if information about the consumer's race, ethnicity, gender, disability and socioeconomic status is not routinely collected.

8. Summary

Ethnic Americans have always had to contend with discrimination in health care. That discrimination was based on the behavior of providers. Now individuals will have to contend with not only provider discrimination, but regional alliance and health plan discrimination. This is a significant change which has the potential of completely undermining access to care. As greater pressure is placed on physicians to curtail treatment services, physicians may not ration across the board. Rather, they may more strictly ration services to vulnerable populations (i.e., ethnic Americans). As health care plans find their premiums caps insufficient, not only will they place increasingly strict gatekeeping requirements on physicians, they may also significantly increase their utilization review denials and they may do so in a discriminatory manner. The Act will not prevent these practices.

B. *General Failures*

The HSA fails generally in several respects. First, it forbids only limited discrimination by states and alliances and contains no direct prohibition against discrimination by providers. Because of the historical problems with determining to whom a discrimination law is applicable, the prohibition should be applicable to both public and private organizations and for profit and not-for-profit organizations. It should also be applicable both to an individual person and to a broad range of organizational forms including private organizations, sole proprietorship, partnerships, associations and corporations. Furthermore, health care providers should be specifically responsible for their discrimination.

Second, the Act takes an inconsistent approach to banning discrimination. On the one hand, it significantly broadens equal access by prohibiting discrimination based not only on race, national origin, age and disability but also on language, socioeconomic status, health status, affiliation, mix of health

professionals or anticipated need for services. Unfortunately, the listing of protected groups is not consistent throughout the HSA. For instance, prohibiting activities by health plans has the effect of attracting or limiting enrollees on the basis of personal characteristics. Only the following characteristics are identified: health status, anticipated need for health care, age, occupation, or affiliation with any person or entity.²⁸⁵ In the same section, in prohibiting health care discrimination the characteristics identified are: race, national origin, sex, language, socioeconomic status, age, disability, health status, or anticipated need for health services. Furthermore, while alliances are required to ensure enrollment of all eligible individuals, the anti-discrimination provisions include only race, sex, national origin, religion, mix of health professionals, location of the plan's headquarters, or organizational arrangement, but not language, socioeconomic status, age, disability, health status, or anticipated need for health services. To ensure the civil rights of individuals under the complex reformed system, the listing of protected groups should be broad and uniform throughout the Act.

Third, the HSA only uses the "effects" test to measure discrimination by health plans. While it specifically addresses forms of discrimination to the activities of the states and Alliance, the Act does not explicitly apply the "effects test" to those activities. By including the "effects test" in the health plan's prohibition against discrimination, some may argue that only intentional discrimination is prohibited in all other areas of the Act.²⁸⁶ This is a substantial problem since, in all likelihood, the type of discrimination which will be most prevalent by the National Health Board, States, Alliances (Regional and Corporate) and providers is "effects" discrimination.

Finally, the HSA also fails to provide comprehensive protection based on language discrimination. For instance, neither

²⁸⁵ *Id.* § 1402(a) (prohibiting health plan underwriting).

²⁸⁶ *Cf. id.* § 1201(b)(4) (prohibiting discrimination by states in setting boundaries); § 1203(d) (prohibiting discrimination by states against health plans based on domicile of the entity); § 1223(d)(4) (prohibiting discrimination against health plans in a state's single-payer system); § 1328(a) (prohibiting discrimination by regional alliances against health care plans); § 1605 (prohibiting discrimination by employers based on the health status of employees); and § 1607(a)(3) (prohibiting discrimination by employers based on the plan selected by employees).

the National Health Board, alliances nor health plans are forbidden from discriminating based on language. This is important to a large number of ethnic Americans who are most likely to be incorrectly denied service as a direct result of the HSA's failure to cover undocumented aliens.

CONCLUSION

The current health care system is flawed in a number of ways. There are significant economic barriers, including no insurance, no money, co-payments and deductibles. People do not have universal portable health care coverage. Moreover, even the massive financing reforms of the Health Security Act that are aimed at increasing coverage do not automatically translate into broadened access and improved services. After some years, when government and private institutions encounter budgetary stringency, it is likely that they will economize by decertifying persons and placing limits on benefits.²⁸⁷

Furthermore, the reformed system lacks adequate infrastructure to provide culturally competent care. Instead, it perpetuates a middle-class European American focus for the delivery of health care. Where services do exist, there is significant fragmentation with ill-defined or inadequately defined community health or public health programs. Furthermore, the Act permits different population groups to receive different health care treatment. This is due in part to the institutional racism in the system but also to the insufficient or nonexistent health research data that is race or culture-specific (including quality assurance or utilization review data). Given the focus of cost containment on middle-class health care needs, there exists the potential for significant health care discrimination. The existing anti-discrimination laws will not effectively combat this discrimination. For these reasons, the Health Care Security Act is only a partial answer and, in many ways, an inadequate answer to the need for health care reform.

²⁸⁷ Ginzberg & Ostow, *supra* note 158, at 2561. For instance, during shortfalls of Medicaid, states arbitrarily limited the number of physician visits, days of hospitalization, and number of prescriptions for which they provided reimbursement." *Id.*

