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MAKING MANAGED COMPETITION A SOCIAL ARENA: STRATEGIES FOR ACTION

*Louise G. Trubek**

INTRODUCTION

Currently, the United States is debating new systems of health care financing and delivery. This process may result in an unexpected social policy success: universal coverage. But universal coverage may be paired with a strange new managed competition structure. This scenario prompts the question: will universal coverage come at too high a cost?

In the last decade, Wisconsin has previewed two managed competition programs. Advocates, government administrators and providers have adapted surprisingly well and have made managed competition an ongoing process that gives consumers a voice. More particularly, mechanisms have been invented and utilized to adjust and modify the new system to local conditions. Although the programs are new, and admittedly contain many flaws, the Wisconsin experience may be worth emulating.¹

This Article has a two-part theme. After briefly explaining managed competition, it describes the experience of Wisconsin advocates who strive to obtain quality health care for their

* Clinical Professor of Law, University of Wisconsin Law School. I would like to express my appreciation for the able research and editorial assistance of Elizabeth Hoffmann. I would like to thank Neva Kaye, Section Chief of the Managed Care Section, Ruth Belshaw, Unit Chief of the Managed Care Operations Unit, each at the Bureau of Health Care Financing, and Tom Korpady, Director of Health and Disability Benefits at the Department of Employee Trust Funds for their helpful comments on this Article. I also would like to thank Shirin Cabraal of Legal Action of Wisconsin, Nur Jawar and Lisa Monagale of HealthWatch, and Mark Bengry, Manager of Member Services at the Department of Employee Trust Funds for their cooperation in providing information. Errors and opinions expressed in this Article are my own.

¹ I have been a lawyer for disadvantaged consumers in the health care system for nearly twenty years. This Article reflects some of my own practice, writing and teaching.

clients within Wisconsin's new managed competition structure. The Article then discusses how national and state legislation and institutional development can encourage advocacy based on the lessons learned from that experience. Now is the time for us to reflect on how to train, compensate and coordinate advocates for quality health care and to consider new strategies and institutions which will protect consumers and allow for their participation.

I. MANAGED COMPETITION AND CONSUMER CONCERNS

Managed competition is "a purchasing strategy to obtain maximum value for money."² Its main goal is to divide providers into competing economic units so that market forces will encourage them to develop more efficient delivery systems. This strategy, as proposed by Professor Alain C. Enthoven, uses concepts of competition borrowed from theories of rational microeconomics. It "reward[s] with more subscribers and revenue those health plans that do the best job of improving quality, cutting cost, and satisfying patients," without segmenting the market, covering only low-risk patients, or circumventing the goals of managed competition in other ways.³

Like all forms of market competition for health care, the basic goal of organizational competition is to achieve maximum efficiency.⁴ "Efficiency" is generally defined in two ways: (1) efficiency in the use of health services, i.e., providing only services whose demonstrated health benefits exceed their costs; and (2) efficiency in the delivery of health services, i.e., providing even cost-efficient health services in the most efficient manner and setting.⁵

To increase efficiency in the use and delivery of health care, the organizational competition model relies on "alterna-

² Alain C. Enthoven, *The History and Principles of Managed Competition*, 12 HEALTH AFF. 24, 29 (Supp. 1993).

³ *Id.* The managed competition model proposed by the Clinton Administration, the Health Security Act, H.R. 3600, 103d Cong., 1st Sess. (1993), S. 1757, 103d Cong., 1st Sess. (1993), is an organizational competition approach similar to that proposed by Professor Enthoven and discussed by Rand Rosenblatt in his article *Health Care, Markets, and Democratic Values*, 34 VAND. L. REV. 1067 (1981).

⁴ Rosenblatt, *supra* note 3, at 1078.

⁵ Rosenblatt, *supra* note 3, at 1078.

tive delivery systems." These systems consist of prepaid plans that deliver relatively comprehensive health care to the enrolled populations. They provide sufficient economic incentive to other suppliers to keep costs down and presumably have "more capacity and willingness to do so through increased efficiency."⁶

Adopting this organizational competition model offers consumers a choice among competing health and insurance plans. To achieve what Enthoven labels "socially desirable competition," all health care plans have to meet government-established criteria.⁷ The criteria include community rating of premiums and open-enrollment, which are considered necessary to ensure access for "high-risk" patients, such as the elderly, the poor and the chronically ill.

Governmental monitoring of the open-enrollment practices is essential to guarantee that all health plans are competing to provide high-quality comprehensive health care at a reasonable cost, without profiting by practices such as preferred-risk selection, limiting enrollment to the healthy, or selling inadequate coverage.⁸ Clearly, in any market approach where there is a concentration of economic power, there is also a need for carefully designed mechanisms for consumer protection and social regulation.⁹

Even with such mechanisms, advocates and scholars have questioned whether a managed competition model will adequately serve consumers who may have difficulty asserting their claims. The anticipated difficulties include: underutilization of medical services due to the financial incentives of capitation payments, a limited number of providers in each managed care system, and the reliance on the "informed consumer" to make choices of plans.¹⁰

In addition to these reservations, the work of Rand Rosenblatt outlines his belief that market models are by na-

⁶ Rosenblatt, *supra* note 3, at 1086.

⁷ Rosenblatt, *supra* note 3, at 1077.

⁸ Rosenblatt, *supra* note 3, at 1077.

⁹ Rosenblatt, *supra* note 3, at 1088.

¹⁰ Alan L. Hillman et al., *Safeguarding Quality in Managed Competition*, 12 HEALTH AFF. 116 (Supp. 1993); Rand E. Rosenblatt, *Medicaid Primary Care Case Management, the Doctor-Patient Relationship, and the Politics of Privatization*, 36 CASE W. RES. L. REV. 915, 919 (1986).

ture necessarily individualistic and counter to group processes and values.¹¹ He states that "the market approach conceives health care choices to be a highly individual matter, which separates the already fragmented individual from the rest of society and makes conscious social choices even more difficult than they are presently."¹² Professor Rosenblatt suggests another perspective which recognizes the limits of the existing fee-for-service system and market models and attempts to build a democratic social process able to make decisions about health care delivery.¹³

Although Professor Rosenblatt's critique of the market model presents issues of genuine concern about consumer power under the Clinton bill, this Article uses the Wisconsin model to demonstrate how aspects of the market model can in fact produce the "democratic social process" that will lead to positive community-based and individual decisions about health care. Indeed, the experience in Wisconsin demonstrates the potential to overcome the problems raised by the critics.

II. THE WISCONSIN EXPERIENCE

Over the past decade, during which Wisconsin encouraged the formation of Health Maintenance Organizations ("HMOs") through a state policy initiative, managed care initiatives have caused difficulties. The financial incentives to maximize provider income at the expense of medically necessary services resulted in underserving some consumers. The availability of and payment for certain types of services, especially prenatal, obstetric and gynecological, as well as alcohol and drug abuse and mental health services, diminished. Consumers experienced difficulties in accessing and understanding the new managed care system. Comparative and usable information was scarce. Surprisingly, however, the government management and social participation suggested by Professor Rosenblatt did develop. Moreover, the HMOs themselves have realized that consumer participation and protection can assist them in creating a cost-effective and quality product.

¹¹ See Rosenblatt, *supra* note 3, at 1068.

¹² Rosenblatt, *supra* note 3, at 1068.

¹³ Rosenblatt, *supra* note 3, at 1069.

The process of modifying the managed competition model was significantly influenced by advocates and client groups. When they observed the negative effects of managed competition, the Wisconsin advocates realized the necessity for participation and protection, and began working with clients and client groups. From the observations and experiences gathered from these meetings, the advocates developed mechanisms for accountability and regulation that have responded to the market failures of the past decade. None of the mechanisms are completely successful; all are "works in progress."¹⁴ These particular techniques involve group processes that include advocates, clients and client groups, providers and government regulators. They have resulted in increased government oversight, participation by the community, advocates and clients, and modification of provider behavior. In a sense, the mechanisms are a hybrid of the "organization" model proposed by Professor Enthoven and the need for a democratic social process expressed by Professor Rosenblatt.

A. Background

In the early 1980s, Wisconsin commenced a strategy of cost containment through the encouragement of managed competition. The initiative originated in the legislature under the leadership of Senator Paul Offner¹⁵ and was implemented in three parts: the formation of a state employee plan; the regulation of private sector; and the reformation of the Medicaid program. The reform began when the Department of Employee Trust Funds, with the guidance of the Group Insurance Board, developed a managed care package entitled the "Dual-Choice Plan" for all state employees. This plan provided state employees with financial incentives to enroll in HMOs instead of fee-for-service systems.¹⁶ Next, the legislature promulgated

¹⁴ For discussion of the mechanisms—participating in the bid process, coordinating consumer complaints within the HMOs, producing information for consumer choice, and ensuring jobs and community development—see *infra* section II.B.

¹⁵ Senator Offner is now a top aide to Senator Daniel Moynihan and a key player in the national health care debate.

¹⁶ Stephen C. Hill & Barbara L. Wolfe, Testing the HMO Competitive Strategy: An Analysis of Its Success and Failure in Wisconsin 18 (Jan. 5, 1994) (on file with author).

changes in the insurance regulatory statutes to encourage the private sector to use pre-paid systems.¹⁷ Finally, in 1984, the State Medicaid Bureau requested and received a waiver from the federal government to experiment with a mandatory managed care program for Medicaid recipients. The program applies almost exclusively to AFDC recipients and is located primarily in Milwaukee, Wisconsin.¹⁸ The three-part initiative has enrolled successfully a high percentage of Wisconsin citizens in managed care systems. Figures for 1992 indicate that Wisconsin had 22.3% of the population enrolled in HMOs as compared with the National average of 16.1%. This places Wisconsin among the ten states with the highest HMO enrollments.¹⁹

The two parts of the Wisconsin initiative that resemble the current federal managed competition proposals are the State Employees' Dual-Choice Plan and the Medical Assistance Health Maintenance Organization ("MA/HMO") Program. These two programs vary in the type of choice they offer to consumers. The MA/HMO Program is mandatory for all AFDC recipients in Milwaukee. The recipients are given a choice, however, in selecting from managed care alternatives.²⁰ All of the HMOs that participate in the MA/HMO program have other enrollees through other payors. That is, none of the plans exclusively or primarily serve Medicaid recipients. In contrast to the AFDC recipients' mandatory participation, state employees are encouraged through financial incentives to enroll in managed care systems. Both parts allow recipients to choose among the managed care plans.²¹

¹⁷ 1983 Wis. Legis. Serv. 27 (West).

¹⁸ OFFICE OF POL'Y & BUDGET, WISCONSIN DEPT OF HEALTH AND SOC. SERV., AN EVALUATION OF THE MEDICAID HEALTH MAINTENANCE ORGANIZATION PROGRAM: 1989-91 (1992). In 1994, there will be a pilot managed care project for the disabled enrolled in Medical Assistance. In addition, a primary care gatekeeper project will be implemented for AFDC recipients in several counties outside of Milwaukee.

¹⁹ GROUP HEALTH ASSOCIATION OF AMERICA, 1993 NATIONAL DIRECTORY OF HMOs 14 (1993).

²⁰ Some categories of AFDC recipients in Milwaukee are exempted from the managed care requirement. For example, women in their third trimester of pregnancy can opt out of HMO enrollment, as can HIV-positive individuals who need anti-retroviral drug treatment. See 1994 DEPARTMENT OF HEALTH AND SOCIAL SERVICES, CONTRACT FOR SERVICES BETWEEN DEPT OF HEALTH & SOC. SERV. AND HMO 40 (1994) [hereinafter 1994 CONTRACT].

²¹ GROUP INSURANCE BOARD, GUIDELINES FOR COMPREHENSIVE MEDICAL PLANS

When the two programs were instigated there was considerable confusion and dissatisfaction. The programs began a quick, rapid transformation of the health care system. In Milwaukee, the Medicaid-managed care system, which eventually included nearly 125,000 people,²² had a tremendous effect on health care and the availability of providers in the central city. In Madison, where the State Employees' Dual-Choice Plan had the greatest impact, there was a major reorganization of the health care delivery system.²³ These transformations resulted in anticipated problems for consumers: limited access, difficulty in obtaining services, and confusion in understanding new procedures.

B. Mechanisms for Consumer Protection and Participation

In response to these rapid and major transformations, advocates for consumers and poor people experimented with various strategies to provide protection and participation for their clients. Over the past ten years, advocates have conceptualized and implemented four mechanisms for protection and participation to ameliorate the difficulties for enrollees in a managed care system. These adaptations emerged in both the MA/HMO and the State Employees' Dual-Choice Plan. The mechanisms provide for participation in the bid process, coordinating consumer complaints within the HMO, producing information for consumer choice, and ensuring jobs and community development. The mechanisms may be characterized as organized group actions. While often triggered by individual complaints about health care, they amplify consumer concerns into system-wide issues and help develop solutions. They can be distinguished from traditional individual claims handling sys-

SEEKING GROUP INSURANCE BOARD APPROVAL TO PARTICIPATE UNDER THE STATE OF WISCONSIN GROUP HEALTH BENEFIT PROGRAM (1993) [hereinafter GUIDELINES].

²² OFFICE OF THE COMM'R OF INS., CONSUMER'S GUIDE TO PREPAID HEALTH PLANS IN STATE OF WISCONSIN 16 (1992).

²³ Hill & Wolfe, *supra* note 16, at 18-19. The impact included: consolidation of health care providers in larger units, such as reducing the number of single physician offices; a merger between two hospitals, thereby reducing the number from four to three; one hospital turned into a non-profit hospital from a municipal one; and many small doctors offices merged with HMOs, resulting in an increase in multi-group and family practice doctors (from 17% in 1983 to 20% in 1990) and a decrease in single and specialty doctors.

tems, such as grievance procedures and law suits utilizing court processes.

1. Participating in the Bid Process

Prior to the initiation of the MA/HMO Program, most of the control over the Medicaid program was carried out through an administrative agency rule-making process. In Wisconsin, this process was subject to statutory provisions that included legislative review and mandatory input from the public.²⁴ When the HMO program was initiated, administrative control was exercised through a contract model. In the move from rule-making to contract, the methods for input by advocates for the Medicaid recipients shifted.

The crucial step for advocate input became the contract bidding process. All aspects of the program were addressed through the bidding process and subsequent individual contracts with HMOs. The request for bids consisted of federal and state requirements, as well as specifications concerning organizational, financial, access and quality issues. Because negotiations with the HMOs involved a purchasing contract, the public initially was thought to be excluded from participation. The bids, however, were public documents that had to comply with specifications from the Department of Health and Social Services ("the Department"), federal Medicaid rules, and the stipulations of the waiver that had been granted for the program.

Quality and access issues became recurring problems for health care advocates under the new system. These problems concerned mental health services, alcohol and drug abuse treatment, quality ob/gyn care, grievance procedures and usable consumer information. To correct quality and access issues, the activists presented well-documented reports to the Department about incidents and suggested changes in HMO procedures and practices.²⁵ In addition, the advocates formed

²⁴ See generally WIS. STAT. ANN. §§ 641.02-.25 (West 1980).

²⁵ Interview by Elizabeth Hoffmann with Shirin Cabraal, attorney, Legal Action (Nov. 17, 1993); interview by Elizabeth Hoffmann with Lisa Monagale, representative of HealthWatch (Nov. 17, 1993). One example is the provision of adequate mental health services. As a result of documented complaints about the availability of mental health services presented by the activists, the State conducted three

an ad hoc group which began to meet regularly with the HMOs and the Medicaid administrators. Eventually these groups evolved into several on-going organizations and arenas for discussion.²⁶

Health care activists realized that once the administrators were convinced that their concerns were legitimate, the administrators could implement the needed changes in the requirements contained in the Request for Bids ("RFB"). Thus, in order for the HMOs to qualify to bid for the contracts, they would have to address the advocates' concerns.²⁷ For example, the 1994 RFBs included the following requirements: 1) HMOs must be able to communicate with a caller in the caller's language or be liable for the cost of care; 2) HMOs must encourage and foster cultural competence among providers and permit enrollees to choose and change providers from among the HMO network based on cultural preference; 3) HMOs' oral complaint logs must be made available to the public; and 4) HMOs must involve and engage the enrollees in selecting a provider and treatment option for mental health and alcohol and drug abuse treatment.²⁸ These changes in the requests for bids were a direct result of the participation by various advocacy groups throughout the year prior to the dissemination of the bids.

Another significant change in the bid process occurred in 1991, when early discussion within the Department revealed that there was no legal requirement for public hearings or community participation in decisions regarding bid evaluations and awards. Although there still is no such requirement, the committee which evaluates the bids and selects the successful

audits of the Milwaukee Mental Health Complex and other mental health providers. Interview with Shirin Cabraal, *supra*.

²⁶ See *infra* section II.C. for discussion of the advocacy groups and arenas that were created. HealthWatch is an advocacy group composed of health activists. HMO Forum is an arena where the HMOs', government agencies', and community health groups' representatives meet to discuss issues.

²⁷ Letter from Shirin Cabraal, attorney, Legal Action, to Neva Kaye, Chief, HMO Section Bureau of Health Care Financing (May 20, 1993); letter from Kevin Piper, Director, Bureau of Health Care Financing, to Shirin Cabraal, attorney, Legal Action (June 3, 1993) (on file with the *Brooklyn Law Review*).

²⁸ Memorandum from Kevin B. Piper, Director, Bureau of Health Care Financing, to All Interested Parties (Oct. 1, 1993) [hereinafter Piper Memorandum] (on file with the *Brooklyn Law Review*).

bidders has included at least one advocate in each yearly review.²⁹

The bid process appears to be one of the most effective means to achieve needed changes in the HMO practices and procedures. Because the HMOs want to remain as providers to the Medicaid recipients, the Department is able to impose requirements to address the concerns raised by the advocacy groups. Interestingly, the Department has no information on the profitability of the individual HMO contracts. However, the number of HMOs that continue to participate in the program indicates that they are receiving sufficient reimbursement.

The State Employees' system has not developed a similar pattern of participation by outside groups of consumers and advocates in the bid process. Although the state system is quite similar to the Medicaid/HMO model in its bid process, in the state system a board with citizen and labor union representatives makes the decision on bids. In contrast, the Medicaid/HMO model program's administrators make the decisions without any outside review.

2. Coordinating Consumer Complaints within the HMO

Originally, consumers who were dissatisfied with HMO service had recourse both to grievance systems and to the court system. But these systems proved insufficient to consumers, providers and administrators, as such an individualized approach often is expensive and does not yield system-wide improvements. Therefore, both the Medicaid/HMO and the State Employee systems developed methods to group consumer complaints to provide both consumer redress and system-wide input.

The Medicaid/HMO system established an HMO Advocates Program. The HMO contract requires each HMO to provide an advocate position, funded by the HMO. The advocates' role is primarily one of outreach to and education of the enrollees. Thus far, they have targeted their efforts at disseminating information about transportation services covered by their HMO, teaching enrollees how to use the HMO, and encour-

²⁹ Interview with Neva Kaye, Department of Health and Human Services, in Madison, WI (Apr. 8, 1994).

aging the utilization of the prenatal, Healthy Start and HealthCheck programs.³⁰

One example of an HMO advocate response to enrollee dissatisfaction is a program called "Dental Days." This project cooperated with Head Start to deal with the underutilization of dental care by recipients. The program found that Head Start children were not able to get dental visits soon enough and, therefore, were delayed in Head Start enrollment. The HMOs and Head Start developed an improved dental appointment system which has been highly successful.³¹

To coordinate its consumer complaints, the Employe Trust Fund, in 1992, created the position of HMO ombudsman, officially entitled Manager of Member Services.³² The ombudsman advocates for plan members, and attempts to resolve their complaints and disputes with the health plans. In addition, using information gained from individual complaints, the ombudsman provides input on behalf of participants in contract design, policy developments and procedures. For example, the current ombudsman reported to the supervising board that the member fee-for-service complaints were higher than those from the HMO plans, on a percentage basis.³³

3. Producing Information for Consumer Choice

Both Wisconsin systems—MA/HMO and the State Employees' Dual-Choice Plan—rest their claims for combining cost containment and quality care on consumers' ability to change plans if they are dissatisfied. If consumers are to make these choices, they must have good information on quality, access and cost.

The State Employees' Dual-Choice Plan has effectively used cost incentives to encourage employees to switch to cost-

³⁰ Minutes from HMO Community Advocates Meeting, Milwaukee, Wisconsin 1-2 (Feb. 25, 1994) (on file with the *Brooklyn Law Review*).

³¹ *Id.* at 2.

³² STATE OF WISCONSIN DEPARTMENT OF EMPLOYE TRUST FUNDS, POSITION SUMMARY: MANAGER OF MEMBER SERVICES (June 1, 1992) (on file with the *Brooklyn Law Review*).

³³ Memorandum from Mark Bengry, Manager of Member Services, State of Wisconsin Department of Employee Trust Funds, to the Group Insurance Board 3 (Jan. 13, 1994) (on file with the *Brooklyn Law Review*).

effective plans. Because the standard plan—a fee-for-service system—is considerably more expensive, substantial numbers of consumers have moved into the HMOs with significant cost savings to the state. As of 1992, 90% of active state employees were enrolled in an HMO, while 10% remained in the standard plan.³⁴ But cost is only one factor of importance to a consumer.

Scant consumer information on quality or satisfaction has been available to state employees making their annual choices. In 1992, the Group Insurance Board, which oversees the plan, contracted with the University of Wisconsin Survey Research Laboratory to conduct a consumer satisfaction survey, the results of which later were presented to the Board. The survey included questions on convenience of facilities, staff helpfulness, length of time to get appointments, and ability to get a referral. There also were questions about satisfaction with grievance procedures and usefulness of information. The survey made no attempt to discuss other quality indicators.³⁵ The Administrator of the Board has stated that he had no resources to obtain data on care quality. He also indicated a skepticism about the reliability of data systems available for quality determinations. In more recent conversations, he did concede that the newest systems might be more reliable and that he is considering implementing such systems.³⁶ However, there is still no consumer group or other agency providing comparative information directly to the enrollees.

The MA/HMO Program, however, is currently collecting quality and access information. The contracts that the HMOs enter require the provision of quarterly utilization reports. These reports are crucial because there is no cost incentive for a consumer to choose a particular HMO. In 1993, the Department gathered extensive data on comparative indicators on the use of preventive care, such as mammograms and many surgical procedures. This data collection, due in part to the activity of the advocacy groups, enabled quality and accessibility comparisons between HMOs.³⁷

³⁴ Hill & Wolfe, *supra* note 16, at Table I.

³⁵ Interview with Tom Korpady, Administrator, State of Wisconsin Department of Employee Trust Funds, in Madison, WI (Nov. 18, 1993).

³⁶ *Id.*

³⁷ MANAGED CARE SECTION, BUREAU OF HEALTH CARE FINANCING, REPORTS

The Medicaid Bureau has shared the information with each HMO. The data is also shared with advocates and state legislators. This method of distributing the quality-analysis data has been effective and the administrator foresees the data discussions leading to substantial quality improvements.³⁸ In addition, advocates may use the data to assist clients to make more informed decisions when choosing among HMOs.³⁹ Groups also could use the data to set goals for an HMO to improve its quality of care during bid negotiations.

4. Ensuring Jobs and Community Development

The HMO initiatives have substantial effects not only on the delivery of services to consumers but on the viability of communities where a disproportionate number of enrollees live. Both Wisconsin programs have instituted methods to ensure that the economic well-being of these communities is not negatively impacted by the large scale utilization of managed care systems.

Rural communities and rural legislators expressed concerns about the possible loss of accessible health care and local jobs in health care because of the institution of the managed competition plan. In response, the Group Insurance Board used its participation requirements in the bid process to encourage the maintenance of rural providers. The administrator of the Dual-Choice Plan believes that these requirements for participation were crucial in maintaining rural service which otherwise might have been substantially reduced. The bid requirements contain an addendum entitled "Providers Under Contract Physically Located in Each Major City/County/Zip Code."⁴⁰ This addendum specifies rates of primary physicians to subscribers, requires that there be at least one general hospital per county or major city, assures access to pharmacies and dentists, and provides that after being offered for a year, the plan must achieve a minimum enrollment amount in the service area.

(1993).

³⁸ Interview with Neva Kaye, *supra* note 29.

³⁹ Interview with Shirin Cabraal, *supra* note 25.

⁴⁰ GUIDELINES, *supra* note 21, at 43.

The administrator believes that these requirements contribute to a pattern of cooperating agreements or actual integration of the rural providers into managed care networks. Without these requirements, he believes that the larger city-based hospitals and clinics would have required rural clients to use the city-based facilities for primary care, and as a result the health-care services and jobs would have left the rural communities. The administrator considers the bid requirements to be crucial for the development of the strong presence of competing rural clinics for rural communities that now exists.⁴¹

Ironically, while the rural health care system was adapting to the HMO initiative, health care providers were leaving central city locations. The Milwaukee central city business development was greatly impacted by the MA/HMO initiative. The distribution of primary care and other providers in the metropolitan area was substantially reduced by the MA/HMO Program. At one time, as many as forty black physicians and health practitioners worked in the central city. By 1993, only seven or eight remained. In addition, few hospitals remain in the central city areas. While it was difficult to maintain an independent practice prior to the Medicaid initiative, most observers believe the managed care system exacerbated this situation.⁴² As a result, community groups have been outspoken about the lack of cultural sensitivity and accessible providers available in the central city.

Several new approaches have been implemented to promote the health business development of the central city. The Milwaukee Economic Development Commission began to encourage minority health practitioners to stay in the central city through a combination of private philanthropic money and bank loans.⁴³ The Medicaid program has made several additions to its bid requirements aimed at aiding the location and maintenance of such providers. In its response to the RFB,

⁴¹ Interview with Tom Korpady, *supra* note 35.

⁴² See, e.g., Marilyn Marchione, *Physicians Get a Healthy Boost With Economic Development Loans*, MILWAUKEE J., Oct. 19, 1993, at B1; Paul W. Nannis, *Maternal and Child Health in the Cities: A Local Perspective 3* (Sept. 15, 1992) (Address at CityMatCH in Washington, D.C.) (transcript on file with the *Brooklyn Law Review*).

⁴³ Marchione, *supra* note 42, at B1.

each bid must identify all minority business enterprises that it proposes to utilize in the performance of the contract activities. Those bidders who are unsuccessful in securing a subcontracting agreement with a minority business enterprise must provide in their response a description of the nature and scope of the efforts expended to do so.⁴⁴

Another section of the RFB specifically relates to mental health and alcohol and drug abuse treatment providers for minority communities. Attached to the RFB is a listing, by zip code, of the minority providers. The RFB states: "The Department strongly encourages all contracting HMOs to contract with community providers that are culturally relevant, sensitive and in close geographic proximity to the recipient community."⁴⁵

Both the State Employees' Dual-Choice Plan and MA/HMO contracts contain affirmative action requirements, including the maintenance of plans to be made available to regulators.⁴⁶ Although advocacy groups have paid little attention to these plans, these documents could be sources of valuable information for groups wishing to encourage job development in low-income communities.

C. *Analysis of the Wisconsin Advocacy*

The description of the mechanisms that developed in Wisconsin provides a basis for examining possible methods of advocacy for the beneficiaries. There are three entities that provide some insight into how and why the voices of consumers are heard: client groups, advocates and arenas. The interrelationship between these three entities is responsible for the development of protection and participation mechanisms.

1. The Client Groups

The two principal groups in need of advocates to speak on their behalf—the AFDC population, which was the target for

⁴⁴ Piper Memorandum, *supra* note 28, at 31.

⁴⁵ Piper Memorandum, *supra* note 28, at 14.

⁴⁶ 1994 CONTRACT, *supra* note 20, at 16; *see also* GUIDELINES, *supra* note 21, at 43.

the HMO initiative, and the state employees—are distinctly different from one another. Medicaid recipients in Milwaukee have poor health statistics.⁴⁷ They also reside in central city neighborhoods within the City of Milwaukee. AFDC recipients are primarily young women with children, clients of the welfare system who live in contiguous communities. Medicaid recipients as a group traditionally have been considered to require protection because of their dependency on government programs.

In contrast, state employees are based primarily in small cities and rural counties. The beneficiaries are heterogeneous in age and gender. Although many are represented by labor unions, the employees who are not members of unions resemble unorganized consumers who require protection because of their large numbers and inability to organize into groups.⁴⁸

All consumers require usable information, monitoring of quality and protection against inefficient cost-containment. Both the Medicaid beneficiaries and the state employees require assistance handling the managed care and managed competition approaches. Moreover, without protection of and participation by these consumers, the health-care system will not function efficiently and equitably. Client group involvement must exist in both governmental oversight and within the provider plans.

2. The Advocates

The advocates who have been active in Milwaukee in the MA/HMO program include groups that were active prior to the initiation of the program, as well as newly organized agencies that formed in response to the program. Legal Action of Wisconsin, funded by the Legal Services Corporation, had an existing health unit which was able to respond when the initiative was announced. The Center for Public Representation ("CPR"), a public interest law firm based in Madison, also had a long-standing interest in health issues and was actively involved in

⁴⁷ DEPARTMENT OF HEALTH AND HUMAN SERV., HEALTHIER PEOPLE IN WISCONSIN: A PUBLIC HEALTH AGENDA FOR THE YEAR 2000 (Oct. 26, 1993).

⁴⁸ See generally Burton A. Weisbrod, *Introduction to PUBLIC INTEREST LAW: AN ECONOMIC AND INSTITUTIONAL ANALYSIS* 1-3 (Burton A. Weisbrod et al., eds., 1978) [hereinafter PUBLIC INTEREST LAW].

all aspects of the state legislative move toward encouraging managed care. In the early years of the initiative, each group provided one attorney and several law students to advocate on HMO issues.

HealthWatch, a coalition of community groups, health professionals and advocacy groups,⁴⁹ arose directly from community concerns about the effects on the Milwaukee community from the implementation of the HMO system. Its declared mission is "to advocate for Milwaukee County Medicaid recipients as it relates to access and quality of health care services [To] facilitate communication among groups affected by the Medicaid HMO program, identify areas of concern regarding access to health care services, participate in problem solving activities to identified issues, and offer policy changes to the Department of Health and Human Services."⁵⁰

Another active player in the HMO interactions is the Black Health Coalition, "a group of local organizations and individuals whose collaborative goal is to address the health problems of African Americans."⁵¹ The Black Health Coalition started as a small group with scant funding in response to general concern about the situation of blacks in the Milwaukee community. Its mission is to "improve the health status of African Americans in the State of Wisconsin and to insure equitable and comprehensive health for all people."⁵² Indeed, through its visibility, it has greatly assisted with job and business development issues, both widespread concerns in the black community. Additionally, the Coalition has worked extensively with the minority health care providers and has successfully emphasized the relationship between effective health care and the presence of minority providers.

In addition to these groups, the Commissioner of Health for Milwaukee, Paul Nannis, views himself as an advocate for health in the community and has played that role with great dedication. His support on the issues of diversity in the staffing of the health care system assisted in establishing the link

⁴⁹ HEALTHWATCH, 1994 MISSION, GOALS, OBJECTIVES: MISSION STATEMENT (1994) (on file with the *Brooklyn Law Review*).

⁵⁰ *Id.*

⁵¹ THE BLACK HEALTH COALITION OF WISCONSIN, FOCUSING ON THE HIGHEST QUALITY OF LIFE FOR AFRICAN AMERICANS (on file with the *Brooklyn Law Review*).

⁵² *Id.*

between the community providers and quality health care. He also used his position to persuade the business and banking communities to provide financial support for alternative providers.⁵³

As to the State Employees' Dual-Choice Plan, initially the CPR advocated for adequate grievance procedures and usable consumer information when the program was first implemented. The CPR supported managed care as a cost-effective and quality alternative if, and only if, adequate consumer protection and participation were integrated into the program. Due to funding limitations, however, the CPR's level of activity diminished. Subsequently, no group has taken on a consumer voice in that system. Thus, only two voices remain to advocate for the state employees' health care concerns and to effect health policies in the state employee sector: unions and the members of the Group Insurance Board.

3. The Arenas

The literature on representation of unorganized groups contains an extensive discussion of the most effective arenas, or locations where advocates may pursue their activities. The choice of location often revolves around legislative versus administrative agencies, or state level versus national level.⁵⁴ The Wisconsin experience provides some guidance for selecting the best forum. At the time of the plan's implementation the Legislature seemed overwhelmed by the complexity and unimpressed by the importance of the constituency. Moreover, the U.S. Department of Health and Human Services continued to give waivers for the MA/HMO initiative, despite early complaints, and was committed to managed care primarily as a cost-savings approach. An effective arena for the MA/HMO beneficiaries was the state administrative agency that administered the program. Without the responsiveness of those administrative personnel, the effectiveness of the advocates would have been limited. The HMOs would have ignored the complaints about mental health treatment, emergency care and inadequate information.

⁵³ Marchione, *supra* note 42, at B1.

⁵⁴ See generally PUBLIC INTEREST LAW, *supra* note 48, at 151-470.

In addition to the responsive agency, new "community arenas" developed in Milwaukee. The HMO Forum, a group of providers, regulators and community group representatives, meets on a regular basis. At the meetings, a membership of close to forty people raise and discuss various issues concerning HMOs.⁵⁵ For example, the comparative data on the quality indicators produced by the Department of Health and Social Services was discussed at the Forum. Also, HealthWatch regularly invites representatives from a particular HMO to their meetings to discuss problems that they perceive in that HMO. The creation of these community arenas, where providers and regulators meet frequently with advocates, combines community organizing and quasi-public participation.⁵⁶ Although the community arena is "in the shadow" of the regulatory structure, it may prove an influential private/public arena.

The primary arena for the State Employees' Dual-Choice Plan is the Group Insurance Board. The Board is a governing body whose members are appointed by the Governor, with interest group representation as one criterion.⁵⁷ Because the Board oversees other insurance benefit plans as well, its mandate is extremely broad. The state employees' unions are well-organized and participate in the Board's activities. Thus, this constituency may be able to communicate effectively their complaints directly to the Board, unions and the legislature. In addition, the administrator of the Health Insurance Program of the Board has indicated that, because state employees number in the thousands, their concerns are expressed and no additional advocacy is needed.⁵⁸ The recent institution of an ombudsman position at the Department, however, may indicate that the Board realizes that additional input from consumers is required.⁵⁹ This position handles complaints and provides input to the Board and also has assisted in the increased production of data about consumer satisfaction. Recent discussions of expanding the enrollees to the private sector may produce some reassessment of the Board's effectiveness in providing

⁵⁵ MILWAUKEE HMO FORUM, HMO FORUM MAILING LIST: SUMMARY MEETING NOTES (May 12, 1992) (on file with the *Brooklyn Law Review*).

⁵⁶ Interview with Lisa Monagale, *supra* note 25.

⁵⁷ WISCONSIN BLUE BOOK (1993-94).

⁵⁸ Interview with Tom Korpady, *supra* note 35.

⁵⁹ See *supra* note 32 and accompanying text.

sufficient protection and participation for consumers.

III. ENABLING PROTECTION AND PARTICIPATION

Major national legislation on health care, with the accompanying state legislation and market reorganization, will begin a period of ferment. During this period, opportunities exist to assist in creating group action on behalf of the poor and other disadvantaged groups within the managed competition approach.⁶⁰ The Wisconsin experience may serve to guide others in constructing a package to assist consumers to participate effectively in health care decisions.

Public actions can substantially influence and assist the effective expression of social concerns. For example, in the 1960s and 1970s, consumer movements and public interest groups developed theories and programs for consumer protection and participation.⁶¹ This literature demonstrated that federal and state legislation, funding from private foundations and the government, educational innovations, and strategic planning can be crucial in creating the conditions for social processes. A range of strategies for accomplishing social actions can be constructed by looking to the Wisconsin experience, as well as scholarship and models from an earlier epoch. This package requires developing new institutions, encouraging representation of disadvantaged groups, writing statutory language and training advocates.

A. *Developing New Institutions*

Three institutions that developed in Wisconsin are worth a close look during the developmental stage of a model health care plan: the community forum, the link between health care and community development and the consumer report card. The community forum, where providers, advocates and regula-

⁶⁰ A project to develop criterion to evaluate national health proposals on the basis of their potential to assist social action on behalf disadvantaged groups was proposed by Professor Rand E. Rosenblatt in 1993. Rand E. Rosenblatt, *The Courts, Health Care Reform, and the Reconstruction of American Social Legislation*, 18 J. HEALTH POL. POL'Y & L. 439, 471 (1993).

⁶¹ See generally Arthur Snow & Burton A. Weisbrod, *Consumerism, Consumers and Public Interest Law*, in PUBLIC INTEREST LAW, *supra* note 48, at 395-445.

tors meet together to discuss consumer complaints, provider difficulties, and regulatory issues, are institutions that should be encouraged. They offer an informal place for communication and strategizing. Financial support for community forums can come from providers, charitable foundations and government agencies. Coalitions formed by businesses, providers, and government, important elements in the managed competition model, must also include the consumer voice. Legislation and financial incentives may be needed to ensure that these "community arenas" flourish and include all voices.

The link between the financing and delivery of health care and community development is another key finding. The reorganization of the market that results from managed competition reveals the connection between the provision of service, the economic units and the financial well-being of the community.⁶² The health care sector is a potential source of jobs and income to a community, and managed competition will substantially change that configuration. Community economic development agencies and regulatory bodies should be aware of this connection and should seek to use the changes to strengthen economically depressed or underserved neighborhoods and regions.

A critical problem is the inadequate production of usable consumer information. Medicaid recipients need simple, easy-to-use information as well as comparative information. In Wisconsin, state employees were provided with understandable information, but were not provided with comparative information. The current system, even with traditional advocates in place, will require new methods of producing and distributing consumer information. The current actors in the market will not provide this information unless given additional incentives. The administrators are too timid and the advocates are not sufficiently organized to produce and distribute this type of information.

The provision of usable comparative consumer information has been barely initiated in Wisconsin. Although both the Medicaid and state employees' programs have started to gather data, they are just beginning to distribute the information. Recently, both programs began to consider how to gather and

⁶² Hill & Wolfe, *supra* note 16, at 3.

distribute the information more effectively. The success of the Medicaid experience using data to improve quality may indicate that significant attention should be given to funding and developing quality data information programs.⁶³

Information provided to consumers has been identified as a traditional weakness in the market system.⁶⁴ New institutions will have to be developed to obtain and supply this information. For example, the federal government might give grants to assist in starting up state-based consumer information publishers. Also, there has been talk of "consumer report cards" which would assist consumers in selecting their providers. The institutions that produce these "report cards" could be linked to advocates or could be placed in universities or non-profit community groups.

B. *Representing Disadvantaged Groups*

Wisconsin utilizes two of the many models for incorporating group representation of the poor and disadvantaged consumers:⁶⁵ representation of consumers on the decisionmaking board and grass roots activism.⁶⁶

The Group Insurance Board includes both union representatives and recipients. The Board originally took a narrow view

⁶³ A two day conference representing consumers, local purchasers, state health data and quality assurance communities was held in Washington, D.C. The conference focused its attention on how information is "collected, analyzed, and used to advance the health reform goals of informed consumer choice, value purchasing, performance measurement and quality improvements." Building Blocks of Health Reform: Health Information and Quality Assessment 1 (May 12-13, 1994) (on file with author). In recent months, the activity of business, provider and consumer groups in encouraging more consumer information is visible.

⁶⁴ Shoshanna Sofaer, *Informing and Protecting Consumers under Managed Competition*, 12 HEALTH AFF. 76 (1993); see also Snow & Weisbrod, *supra* note 63, at 401-06. Consumer Reports is the only successful example of an attempt to provide this information. Such magazines cannot function for local-level services since the financing of the Report depends on a sufficiently large market so that it can support itself through subscriptions.

⁶⁵ See generally Snow & Weisbrod, *supra* note 61; see also David M. Trubek, *Public Advocacy, Administrative Government and the Representation of Diffuse Interests*, in 3 ACCESS TO JUSTICE: EMERGING ISSUES AND PERSPECTIVES 445 (Mauro Capelletti & Bryant Garth eds., 1979).

⁶⁶ Louise G. Trubek et al., *The Executive Order on Consumer Affairs Programs: New Voice for "Consumers" in Federal Agencies?* 6 (July 2, 1980) (unpublished manuscript on file with the *Brooklyn Law Review*).

of its role and employed little innovation. Two recent events, however, may demonstrate a renewed interest by the Board in improving and expanding the State Employees' Dual-Choice Plan. The consumer satisfaction survey discussed earlier may indicate that the Board realizes that it must actively monitor the health plan as part of its oversight and regulatory function.⁶⁷ Also, the recent legislative proposals to expand the state employee system to allow private employees to enroll is a promising development.⁶⁸ In effect, the State Employees' Dual-Choice Plan could become the health alliance for the state. If the health plan expands, the Board would be required to rethink how to include other interests in its deliberations.

The Medicaid experience is an example of how grass-roots activism can drastically impact a bureaucratic system. Initially, no program existed to include recipients in the new managed care system. But a dynamic and innovative group of advocates discovered ways to become part of the process. They accomplished this without financial assistance from the health care system or any officially recognized position.

Even with these improvements, however, neither Wisconsin program adequately represents the consumer voice. The Board model relies too heavily on individual political appointees and the Medicaid model depends too much on the energy of advocates. Thus, other options or methods must be found. In the 1970s and 1980s, there were two different approaches to consumer participation in public policy decisionmaking, both of which deserve serious consideration. One approach, proposed by Ralph Nader, is the creation of a formal government agency with the mission of representation.⁶⁹ The ombudsman concept, proposed in the Health Security Act, is a version of this gov-

⁶⁷ Employee Trust Funds, *State Employees' Health Care Plan Survey Report #1: The Survey Sample* (1992); Employee Trust Funds, *State Employees' Health Care Plan Survey Report #2: Analysis of Frequency of Use of Medical Services* (1992); Employee Trust Funds, *State Employees' Health Care Plan Survey Report #3: Health Care Providers* (1993).

⁶⁸ Wisconsin State Assembly Bill #AB1160, 1992-93 Legislative Session. This plan failed at the end of the 1993 legislative session, but may be revived as the national plan evolves or when the State legislature returns for the 1994 legislative session.

⁶⁹ Walter A. Zelman, *Who Should Govern the Purchasing Cooperatives?*, 12 HEALTH AFF. 49 (1993). See also Snow & Weisbrod, *supra* note 61, at 395, 406.

ernment advocate model.⁷⁰ A group of law professors, who testified before Congress on the Clinton Plan, have proposed expanding the ombudsman role. This expansion would include using consumer complaints to identify systemic problems and assisting community groups in participating in the health care system.⁷¹

The second proposal requires outside advocate representation on governing bodies funded by the state.⁷² The governing bodies, whether alliances or state agencies, must include formally appointed representatives of the poor and other disadvantaged groups. In addition, this approach must emphasize that there be a companion program to support, encourage and fund groups to participate in the decisionmaking process. Legal service offices, minority groups, consumer activists and small business groups should be able to apply for these ongoing funds. In Wisconsin and Michigan, utility advocacy programs have versions of "citizen intervention programs" which have experimented successfully with this model.⁷³

C. *Writing Statutory Language*

In Wisconsin, the ability of the Medicaid activists to participate in the actions of the HMOs was related directly to their access to the bid process at the state agency level. Current Medicaid statutes contain little to ensure that such a process will continue in the managed competition model. This process is particularly crucial because it is anticipated that the Medicaid program will be folded into new managed competition pools.

The enabling statutes at both the state and federal level

⁷⁰ See HSA §§ 1300-1397.

⁷¹ Rand E. Rosenblatt, On Access to Justice, Discrimination, and Health Care Reform 14 (Jan. 31, 1994) (testimony before the Subcomm. on Health and Env't of the Comm. on Energy and Commerce) (rev'd text for the record, Feb. 14, 1994) (on file with the *Brooklyn Law Review*).

⁷² See generally Louise G. Trubek & David M. Trubek, *Civic Justice Through Civil Justice: A New Approach to Public Interest Advocacy in the United States*, in MAURO CAPPELLETTI, ACCESS TO JUSTICE AND THE WELFARE STATE 119 (1981); see also Jack H. Nagel, *Combining Deliberation and Fair Representation in Community Health Decisions*, 140 U. PA. L. REV. 1965 (1992).

⁷³ WILLIAM T. GORMLEY, JR., THE POLITICS OF PUBLIC UTILITY REGULATIONS (1993).

should include specific language to allow public inspection of the documents in the bid process, including requests for bids and final negotiated contracts.⁷⁴ Moreover, specific language to encourage input from outside groups representing the beneficiaries would be helpful. The legislation also should include incentives for the managed care systems to meet with such groups. For example, these incentives could provide for membership on the HMOs' boards of directors or advisory committees.

Perhaps an even more radical proposal would be to emulate the recent Wisconsin developments that allow consumer advocates into the bid evaluation process. Despite the fact that there is no requirement of public participation in the Wisconsin statute, the government agency has added a consumer representative to lend legitimacy to the process.

D. *Training the Advocates*

The advocacy work described in this Article is not based on the norm for most legal service, public interest and clinical lawyering—the litigation-individual case model. Rather, the advocacy encompasses counseling organizations, educating clients, and lobbying legislative and administrative bodies. This work includes data gathering and writing investigative reports.

To provide this expanded health advocacy, law school education should be modified and lay advocates encouraged and trained. There are surprisingly few clinical programs or legal service and public interest groups that work on health issues. Perhaps with the national and state attention focused on these issues, this is a time to encourage more activity. Law schools are excellent areas for recruitment since health law is an active area for law school teaching and many law schools have developed a specialty in health law. Moreover, the approach suggested here, with the tie to jobs and community development, may encourage more interest in consumer-based health law careers.⁷⁵

⁷⁴ A similar proposal was urged by Professor Rosenblatt in his testimony before the Health and Environment Subcommittee. See *supra* note 71, at 45-47.

⁷⁵ An alternative point of view in integrating health law theory and practice is

The challenge is to convince advocates that counseling, legislative and administrative lobbying, and educating are appropriate and professional methods of health care advocacy. While this type of work is the mainstay of corporate lawyers, the public interest and student communities continue to prefer individual client skills and are reluctant to assume the counselor and lobbyist roles.⁷⁶ In the legal service world under the conservative Reagan and Bush administrations, this work was often prohibited. Thus, attention must be paid to eliminating restrictions and encouraging these activities.

There remains the challenge of training community and health care activists to serve as lay advocates.⁷⁷ Only a small number of the activists involved in the Milwaukee HMO actions were attorneys. The others were health care providers and community activists. The coalition of these groups and individuals accounted for a great amount of energy. No proposed program should exclude or discourage the activity of, or job development for, lay people. In fact, every plan should make a conscious effort to develop community organizations for advocacy, job development and consumer information.

CONCLUSION

As we look ahead towards a redesigned health care financing and organizational system, we might also look back to the writings and experiments of the 1960s and 1970s. The public interest law and consumer movements reflected on how the voices of disadvantaged groups could be heard in government and market processes. Pioneers, like Ed Sparer, envisioned government-funded legal services using court processes to obtain state entitlements. In addition, these pioneers spoke out for the planning and lobbyist roles of advocates. Scholars of the

expressed in an article by Professor David F. Chavkin. He suggests that law students are best taught about health-law practice in a litigation-based clinic. David F. Chavkin, *Training the Ed Sparers of Tomorrow: Integrating Health Law Theory and Practice*, 60 BROOK. L. REV. 303 (1994).

⁷⁶ Jeffrey S. Lehman & Rochelle E. Lento, *Law School Support for Community-Based Economic Development in Low-Income Urban Neighborhoods*, 42 J. URB. & CONTEMP. L. 65 (1992); Edward V. Sparer, *The Poor Man's Lawyer and Governmental Agencies*, in LAW AND POVERTY (1965).

⁷⁷ Edward V. Sparer et al., *The Lay Advocate*, 43 U. DET. L. REV. 493 (1966).

consumer movement pondered alternative systems that would enable consumer groups to effectively present their interests to government regulators and market providers. They discussed the market failure resulting from the absence of these concerns in the political and economic sectors. They proposed a series of institutional changes to facilitate the ability of these groups to speak out. While the role of lawyers was crucial, citizen organizations and consumer participation were also emphasized.⁷⁸

The conservatism of the 1980s effectively silenced many of the utopian and visionary writing and experimentation on group action and organization for disadvantaged groups. The maintenance of the institutions and groups that had developed in the 1960s and 1970s preoccupied progressive scholars and activists.

In health care, escalating costs in the 1980s resulted in a modification of the system for health care delivery and financing. This system shifted to a new organizational structure that reshaped the role of the state and market. The new system will give consumer advocates an unexpected opportunity to rethink the lawyer, client and institutional arrangements for the participation of disadvantaged groups in the health care system.

Recent testimony on health care reform presented before Congress⁷⁹ proposes a comprehensive system of rights and remedies to achieve a pro-consumer system. The testimony explains that "a great many important issues may not be raised, or may not receive adequate attention, in a process based solely on the initiative of individual patients."⁸⁰ The testimony proposed organized consumer advocacy as an essential component of a workable health care system.⁸¹

The Wisconsin experience demonstrates the possibilities for consumer protection and participation in managed competition. The earlier literature and experiments can provide in-

⁷⁸ See PUBLIC INTEREST LAW, *supra* note 48; Trubek & Trubek, *supra* note 72.

⁷⁹ Rosenblatt, *supra* note 71, at 43-47.

⁸⁰ Rosenblatt, *supra* note 71, at 44.

⁸¹ Rosenblatt, *supra* note 71, at 43-47. "As currently written, the Health Security Act does not acknowledge the role of organized consumer advocacy or explicitly support its functioning." *Id.* at 45. Professor Rosenblatt proposed three kinds of support for such advocacy: availability of information, access to decisionmaking processes and funding for consumer groups. *Id.* at 45-46.

sights into today's health care challenges. Looking back may provide shards of experience that could be incorporated into programs for the future.