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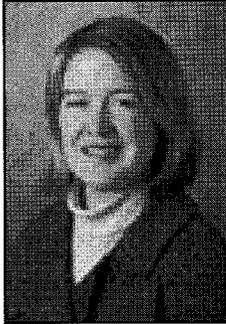
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What I Talk About When I Talk About Health Law*

*Elizabeth Weeks Leonard***



I am honored to write for this twenty-fifth Anniversary Edition of the Annals of Health Law and congratulate the Beazley Institute for Health Law and Policy for its formative role in shaping the field of health law. As I write Congress stands poised to enact what could be the most dramatic set of changes to the health care system since I entered the field, not quite a decade ago, after two years in practice and seven years in the academy. I take this opportunity to explain what compelled me to become a health lawyer and why this is such an extraordinarily exciting time to be a health law scholar and teacher.

My first encounters with “health law,” although I did not think to call it that, began before law school, in Chicago, in 1993. I had graduated from Columbia University with a degree in Latin American Studies and a keen interest in public health. I had interned at non-governmental organizations in New York and the Carter Center in Atlanta. Unsure of my plans and unemployed, I moved to the more affordable second city of Chicago. I was looking for any human services or social work opportunity that an unlicensed, bachelor’s level college graduate could find. After four years of high-level theory and abstract discussions of underdevelopment, cultural exploitation, and revolution, I was hungry for direct service work. I wanted to *see* that I was actually helping a person. I wanted to *know* that I had made a difference.

I accepted an entry-level clinical social worker position with an agency serving severe and chronically mentally ill adults in Rogers Park. The position was well outside of my comfort zone as I had no mental health training, only an introductory course in psychology, and little awareness of

* *Allusion to HARUKI MURAKAMI, WHAT I TALK ABOUT WHEN I TALK ABOUT RUNNING* (2008) (a fiction writer’s memoir on being a runner. He begins: “Though I wouldn’t call any of this a *philosophy* per se, this book does contain a certain amount of what might be dubbed life lessons. . . . They may not be lessons you can generalize, but that’s because what’s presented here is *me*, the kind of person I am,” at vii – viii).

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neighborhoods north of Lincoln Park. The agency was a community-based service provider that grew out of the era of psychiatric deinstitutionalization facilitated largely by development of the new class of atypical antipsychotic drugs. To assist patients' transition into the community, my agency provided case management, and supported residential and vocational rehabilitation services. As an intake worker and community liaison to the state-operated hospital, my job was to build relationships with patients in the inpatient wards and help them move into the community by assessing their needs and linking them to resources.

In that role, I was immersed in intricacies of the health care and welfare systems. When I took the job, the Clinton health plan was being hotly debated. But I was only vaguely aware of the contours of the proposal and had little perspective on its significance. But I had hands-on, up-to-the-elbows experience with many aspects of the system, including inpatient and outpatient care, public and private hospitals and clinics, and the full gamut of public benefits programs. I learned the nuances of civil commitment procedures and *Tarasoff* duties. I observed patient-provider interactions in emergency rooms, inpatient units, and community clinics. I got a crash course in abnormal psychology, attending clinical rounds and discharge planning meetings regarding my clients. I became aware of the strict coverage limits of private health insurance on length of stay, individual therapy, partial hospitalization programs, and drug formularies. I interacted with the criminal justice system, facing the impossible task of finding community services for arsonists, petty thieves, and other forensic patients institutionalized at the Elgin Mental Health Center.

An essential case management task was to help patients apply for and begin receiving public benefits. Thus, I gained working knowledge of Supplemental Security Income and Medicare eligibility requirements, including the Social Security Act's restrictive definition of "disability" and arcane method of crediting prior employment. Health care "rationing" was glaringly revealed in Illinois Medicaid coverage limits, which, at the time, would pay for my client's full set of dentures if she would agree to have all of her teeth pulled, but not her root canal. I realized that the Section 8 waiting list was nothing more than a pipe-dream of actually receiving housing assistance. I helped clients budget their food stamp allotments to buy canned fruit cocktail and frozen beef patties at the Aldi discount grocery store.

Most importantly, for purposes of my future career, I learned the limits of direct service work's ability to fix the broken system. My job was to help clients navigate the morass, but I could do little to change it. After three years of feeling that frustration and impotence, I decided to attend law school—and, incidentally, almost enrolled in Loyola Chicago's J.D./M.S.W. dual-degree program. Some of my most esteemed mentors

received social work degrees from Loyola, and I believed that legal training would greatly enhance my effectiveness as an advocate for change. But I opted instead for my home-state law school and in-state tuition at the University of Georgia. I was surprised to find the study of law, particularly Administrative Law and Health Law courses, incredibly stimulating. Through a number of twists and turns, I eventually joined the Health Industry section of a multinational firm in Houston, Texas, representing hospital corporations and large, institutional health care providers.

I once again found myself navigating the intricacies of Medicare, Medicaid, private health insurance, and a broad spectrum of inpatient, outpatient, and ancillary healthcare services. But I had “switched teams.” I now represented providers, rather than beneficiaries. Instead of challenging beneficiary eligibility determinations, I challenged provider reimbursement formulas, fraud investigations, staff privileging decisions, and patient-dumping accusations. Although feeling guilty for having departed from my public interest origins, I loved the work. I loved the scavenger hunts in regulatory provisions, Federal Register preambles, Centers for Medicare and Medicaid Services program manuals, and Office of Inspector General advisory opinions for the particular phrase or provision that advanced my client’s argument. I loved crafting client memoranda and response letters to government agencies, laying out our reasoning, as a step-by-step, undeniable, logical proof. With each assignment, I became more curious about the particular area of the law that I was researching. But almost as soon as I become conversant on one issue, another client and a new assignment would require me to shift gears, leaving those intriguing questions behind. I was always hungry and never quite satisfied. Any “study” of health law was necessarily directed by clients’ needs.

When the opportunity to enter academia came, I seized it. I traded the amenities of private practice for the great luxury of intellectual autonomy. As a health law professor, I am allowed and *encouraged* to pursue my curiosities as far as time, interest, and resources allow. Health law offers an endless font of questions, issues, and research questions. The topics that most pique my interest are those with real, current health policy implications. Consistent with my original mission for pursuing a law degree, I strive to produce scholarship that not only contributes to academic discourse but also provides guidance for improving the health care system and health status of the population. Thus, my scholarship reveals a certain wanderlust. I have written on the intricacies of Medicare reimbursement, public health emergencies, federal-state relations in health care, and healthcare reform. My social work background has found an outlet in medical-legal partnership projects, serving the needs of medically and legally underserved individuals. Each new reform proposal, each regulatory change, each health headline presents a new set of questions and

a new possible research agenda. Like a kid in a candy store, sometimes my eyes are bigger than my stomach.

The current health reform package is similarly multidimensional and ambitious in scope, perhaps biting off more than it can chew. By contrast, the Massachusetts health reform plan, on which the federal reforms are largely based, was selective and targeted.¹ Massachusetts lawmakers selectively addressed one issue: coverage. The goal was to achieve near universal health insurance coverage for individuals through a combination of individual and employer mandates, expansion of government health care programs, health insurance exchanges, and state subsidies. But the Massachusetts plan did not seek to guarantee that the newly insured individuals had access to healthcare providers. The plan did nothing to rein in healthcare costs or improve healthcare quality. The reforms did not significantly alter the business of health insurers, healthcare providers, pharmaceutical companies, and other politically powerful constituents. The plan had buy-in from both left-leaning health care rights proponents and right-leaning adherents of the view that health care is an individual responsibility, thus facilitating passage of the historic legislation.

The current federal legislation, by contrast, aims ambitiously across the board at coverage, access, cost, and quality. The comprehensiveness of the package has generated strong emotions and heated objections from various stakeholders. The plan's breadth may ultimately be its downfall. Even if no legislation passes, the current round of reforms should be deemed a tremendous success in terms of educating lawmakers and the American public on the unavoidable complexity of our health care system. For the first time in my experience, Congress, my students, my colleagues and friends, the media are realistically and squarely acknowledging the unavoidable interconnectedness of the complex, United States health care system. The robust, at times, painful, public debate has produced a more educated, insightful electorate. As a health law professor, it is heartening to hear a national conversation well versed in the arcane vocabulary and complex issues that I try to impart to my students each semester. As a health law scholar, it is affirming to see my seemingly disjointed research interests coalesce in various public policy proposals. This is a tremendously exciting time to be a health law professor. I can hardly wait to begin the new semester and my next research project.

1. For a comprehensive collection of articles on the Massachusetts Health Reform Plan, see Symposium, *The Massachusetts Plan and the Future of Universal Coverage*, 55 KAN. L. REV., 5 (2007).