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Growing the Toolbox

Diverse Strategies for Public Interest Lawyers in Campaigns to Expand Access to Health Care for Low-Income People

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The nation is focused on achieving access to affordable comprehensive health care choices for everyone. It is an immensely popular policy issue for voters, and most of the 2008 presidential candidates laid out plans to make it happen. For many years, the federal government and a variety of states have been making incremental progress toward this goal, fueled in part by relatively flexible federal matching funds under Medicaid and the State Children's Health Insurance Program (Schip). Massachusetts has enacted a plan for covering everyone. Several states, led by Illinois, have enacted coverage for all children, and a growing number of other states are planning to cover all their children.

In many states, especially the most successful ones, the expansion of access to care has consisted of repeated rounds of incremental change. The campaigns and circumstances that produced each of these expansions were varied and highly contextual to each state and each expansion, and it appears likely that the process will continue to be state-specific and incremental. Even if the new president has a comprehensive plan, it will take time to negotiate and then pass it, and after it passes the process will still have many state-specific choices and implementation issues. For years to come, there will be a role for lawyers in efforts large and small to expand access to care. Further, during periods of economic stress or political reaction, there will be a role for lawyers in protecting the expansions from attempts to dilute the coverage, increase the consumer's share of the cost, roll back eligibility, or otherwise limit access.

What can a public interest lawyer bring to campaigns to expand or protect access to care for low-income people? Traditional lawyer skills include technical expertise in the governing legal framework, drafting statutes and rules, and litigation. These are

welcome and extremely valuable skills, especially since in most state-level campaigns, the public interest lawyer is the only lawyer in the core coalition group. Here I focus on three specific campaigns in which I was personally involved and discuss various additional skills or strategies that public interest lawyers should consider. The examples have a central theme: In campaigns to expand or protect access to care, public interest lawyers who intend to be involved in the leadership of the campaigns must think about multiple and multiforum strategies, and a variety of skills and capacities.

A campaign public interest lawyer's burden of persuasion calls for more than the standard legal toolbox. It takes strategies with multiple components, a variety of players, and a wide range of skills. Public interest lawyers who want to be leaders in campaigns to expand or protect health care access should have an awareness of the various needs of a campaign and the diverse skills and capacities necessary to succeed. Further, lawyers should be aware of what they can provide themselves and what resources the campaign needs to secure from another source. These other skills and capacities include, for example, relationships with important policymakers, lobbying capacity, media relations, message development, grassroots contacts and organizing, academic research, access to religious leaders and groups, relationships with health care provider organizations, and contacts in the business community. Bringing all of these factors together into an effective strategy is the challenge for a successful campaign.

I. Traditional Lawyering Skills and Capacities Open a Leadership Role

It is important for public interest lawyers to develop and maintain classic lawyering skills and capacities. These skills are a rare commodity in public interest coalitions and can position a lawyer in a leadership role within a coalition. In broad terms, there are three areas of these traditional skills and capacities:

- Lawyers can develop unique subject-matter expertise on the applicable laws, regulations, subregulatory materials, budget allocations, intergovernmental relationships, and contractual arrangements. Access to health care is an immense and complex subject matter. Technical expertise across the range of issues is rare and by itself makes the public interest attorney who possesses the expertise highly valuable and a welcome addition to decision-making processes and core planning groups among the advocates. Technical expertise is always an important component of a campaign, but it rarely provides the most important political argument in favor of an expansion; nor does it offer persuasive public rhetoric. Thus by itself it rarely can win the day.
- Lawyers can develop unique drafting skills. This skill is also a valuable addition to any public interest campaign. Campaigns to expand health care access frequently have to do without this legal skill and sometimes fail to realize how important it is. This puts them at the mercy of legislative or agency staff attorneys for the drafting of the statutory language, and those experts may not share the same intent or understanding. Being able to write a tight bill or regulation accomplishes the intended goal, avoids traps or loopholes, and effectively lays groundwork for regulations, potential litigation or follow-up legislation. It is also important to use good political judgment about whether certain language is unnecessarily provocative, whether to be prescriptive or to leave more to agency rule-making, and other similar considerations. Still, these crucial skills are not what wins a campaign. Few voters and surprisingly few legislators read the actual language of a bill.
- Lawyers can engage in litigation. When litigation is appropriate, and when the stars line up properly, the ability to litigate successfully gives a lawyer the power to force officials to do things they have not been talked into doing and that they in fact do not want to do. The ability to litigate, or to threaten credibly to litigate, is exclusive to

lawyers and is usually enough to give lawyers access to decision-making processes and core planning groups in health care access campaigns when litigation is one possible option. But by itself the ability to litigate usually only provides power to stop something (like an eligibility cutback or a denial of access), not create something (such as an expansion of coverage or access).

While it is possible to win important victories by relying entirely on these traditional lawyer skills, important incremental advances in health care access almost always require more. These advances require big-picture public policy decisions and budgetary allocations that come only from the political branches of government—the executive and the legislative. Policymakers must be persuaded to make the expansion, to design it the most effective way, and to pay for it. People whose livelihoods depend on elections—and the people who work for them on their staffs and in the bureaucracy, must be convinced through any means available that the expansion of health care access is politically advantageous and that opposing it is politically dangerous. Similarly, when a cutback in access is under consideration, the policymakers must be convinced that carrying it out is more dangerous politically than adopting it, even to balance a budget.

II. Three Examples Using the Larger Toolbox

The three health care access campaigns described below contextualize the point that diverse strategies, skills, and capacities are important. The FamilyCare campaign in Illinois was a successful health coverage expansion over a period of years that resulted in coverage being expanded to as many as 400,000 working parents. The *Memisovski v. Maram* litigation dealt with a crisis in access to care for children covered by Medicaid that not only was successful but also morphed into a major "medical home" initiative and, along with the residual impact of the FamilyCare campaign, helped bring about an expansion of coverage for all children in Illinois. Finally, the *Bell v. Leavitt* litigation, while unsuccessful in court, was an important part of a larger strategy to limit the loss of access to health care that would be caused by the citizenship documentation requirement for Medicaid contained in the Deficit Reduction Act of 2005.

A. The FamilyCare Campaign: Working with Community Groups

In 2002, with the state in the clutches of a historically deep fiscal crisis, Illinois launched FamilyCare, a brand-new health coverage program aimed at the parents of children covered by Medicaid or Schip.[1] The governor was a moderate Republican, the state Senate was controlled by conservative Republicans, and the state House of Representatives was Democratic. Over the next three years, as the fiscal crisis continued and the political lines were redrawn, the program steadily was expanded until its eligibility threshold came to rest at 185 percent of the federal poverty level, offering coverage to approximately 400,000 working parents.

With respect to the expanded toolbox for health care access campaigns, perhaps the most important of several lessons of the FamilyCare campaign for public interest lawyers is the power that can be generated through collaboration between the lawyers and grassroots community organizations and organizers. This is generally not a body of information or skill set taught in law school. In fact, legal training is much more likely to get in the way of effective collaboration with community groups than it is to foster it.

Lawyers are trained to be linear thinkers and result-oriented, bringing legal expertise and adversarial skills to bear to solve the problems of clients. The prime interest to be served is that of the client, so that the goal of any particular representation is to achieve maximum results for the client. For a public interest lawyer engaged in policy or systemic work, the "client" is the low-income community

[1]See John Bouman, *The Power of Working with Community Organizations: The Illinois FamilyCare Campaign—Effective Results Through Collaboration*, 38 Clearinghouse Review 583 (Jan.–Feb. 2005), http://www.povertylaw.org//advocacy/health/working-with-community-orgs.pdf.

or the issue-specific interest group for whom the lawyer works. The prime goal of a health care access campaign is thus to win increased health care access to the fullest extent possible. This is of course laudable and correct, but working effectively with community organizers and groups requires understanding of a different way of thinking.

There are a number of community organizing doctrines and there are important differences among them, but as a general matter the goals of a community organizer are to build the power of the organization and to identify and build leaders—defined as people who are not professional advocates who decide to become involved in public life on issues that matter to them and their neighbors. The issues on which these organizations work must be identified through the organization's own processes that discern what is important to the members. Winning the issues is important, but secondary. The primary goal, toward which working on issues is only a means, is to build the organization's power and to grow the organization's leaders.

Thus, while there is significant potential for common health care access goals between public interest lawyers and community organizers, their primary goals are not the same. If the primary goals of each are not known and understood by the other, then misunderstandings are likely to arise, and a productive relationship can be difficult. The lawyer may shop an issue to a community organization that the lawyer thinks the organization obviously should support, given the demographics and apparent self-interests of the residents of the community the organization serves. But if the issue is not one that has gained legitimacy through the organization's own discernment process, the lawyer may not get the participation of the organization, and in fact the lawyer may be perceived as a carpetbagging person who might undermine the building of indigenous leaders. Similarly, while the lawyer is used to being the spokesperson on issues due to superior knowledge and public speaking skills, the community group will always want its own leaders out in front, especially in interactions with powerful officials (meetings with legislators, testimony, media appearances, etc.). This apparent reduction in the technical quality of a presentation can seem deliberately nonstrategic and be extremely frustrating for the lawyer if the lawyer does not understand how important it is to the organization, and vice versa. Moreover, the organizer's deep concern with building organizational power means that there is usually an intense interest in the organization gaining exclusive public credit and visibility. To a public interest lawyer who does not understand this, it might look like the organizer is simply egotistical and a publicity hound, unreasonably denying the public interest organization a needed opportunity to gain publicity, and vice versa.

If the lawyer and the organizer identify and talk through these issues, accommodations can be reached. When there is successful communication and collaboration is established, the results can be very powerful, precisely because the skills and capacities of the two participants are complementary. While there can also be substantial overlap, the lawyer and organizer each bring to the table assets that the other does not, so that the overall effort the two can put forth is much more nearly complete, strategic, and hard-hitting.

The community organizer and organization, for example, bring these assets:

- Access to powerful human stories that illustrate the health care access issues. These stories are extremely important in advocacy campaigns for media, testimony, and public storytelling, but they are chronically—famously—elusive and difficult for lawyers and other advocates to obtain.
- Ground-level perspective. This is especially important for lawyers or policy organizations that are not grounded in communities through their own direct service capacity. It is crucial to a pragmatic identification of issues and potential solutions: What will really work to solve the problem? The answer is not always revealed by academic research or political ideology. Perspective based on ground-level reality improves the

development of issues and policy solutions.

- The ability to "fill a room" or populate a public rally, and carry out district-level visits with politicians consisting of actual voting constituents and local leaders (such as clergy). This projection of apparent voter power is usually the number-one capacity that lawyers lack, yet it is crucial to the fundamentally political task of persuading politicians to expand health care access.
- Wide-ranging existing relationships. This is what organizers do: develop relationships, not only with residents of their communities but also with politicians, businesses, media members, and other sources of power and information. When an alliance is established, the lawyer can tap into these relationships.
- The ability and willingness to be confrontational and develop tension with political leaders. Because the organization consists of or has the appearance of representing voting constituents, it can and will use hardball tactics in the arena of political persuasion. The organization is concerned with its long-term relationship with the politician—it wants the politician to respect its power, so it will often seek and invite tension with the politician. Among other things, this can lead to a coordinated "good cop-bad cop" strategy, with the lawyer positioned as the friendly policy expert.

The traditional legal skills that a public interest lawyer possesses, and the lawyer's own relationships and credibility, are in turn complementary and valuable to the community organization. The lawyer and the organization have to communicate how the lawyer's assets can be framed as an enhancement of the organization's power.

The FamilyCare campaign is a strong example. FamilyCare began when the public interest lawyers at the Sargent Shriver National Center on Poverty Law identified an important public policy problem that grew out of the welfare reform process in the late 1990s. Low-income working people who did what was expected of them and left the welfare program through employment were getting punished by losing their health coverage. Medicaid would stop when welfare stopped. This population of working parents became the focus of the need for a health coverage expansion. The Shriver Center began to work on the problem by identifying program models and funding streams, initiating advocacy among legislative leaders, and beginning to build a coalition mostly consisting of allied advocacy organizations.

Meanwhile, on a separate track completely, a newly formed metropolitanwide community organization in the Chicago area, United Power for Action and Justice, was undertaking its initial issue-identification process through a lengthy on-the-ground series of meetings. Based mostly in over 300 religious congregations, local community groups, and unions, United Power was a unique collection of disparate economic, ethnic, racial, religious, and geographic forces united by shared values and a desire to find common ground, build power, and take action. One of the issues identified in the United Power discernment process was "access to health care for the uninsured." United Power developed a three-part strategy to address this issue: expanded coverage, more vigorous enrollment in existing coverage, and expanded capacity to provide care to the uninsured through community-based clinics.

To accomplish the expanded coverage feature of this strategy, United Power was shopping for a policy option. The organizers heard about the Shriver Center's existing campaign to expand coverage to low-income working parents and approached the Shriver Center about a possible collaboration. The Shriver Center had a worked-up and costed-out policy model, a strong head start in legislative advocacy, and a growing coalition behind it. United Power had grassroots capacity and a wide array of important relationships (including business interests) that the Shriver Center's campaign lacked.

While the collaboration may seem obviously advantageous to both sides, it was

not undertaken lightly and was by no means a foregone conclusion. By sharing leadership of an issue identified in its own processes, United Power risked losing public identification with the issue, with the attendant risk of diluting its organizational power and the growth of its citizen leaders. It also risked losing its freedom of movement to confront and create tension with political leaders in order to build respectful and balanced long-term relationships with those politicians if the Shriver Center tried to veto those tactics, seeing them as unproductive in accomplishing the expansion of health coverage, its prime goal. For its part, the Shriver Center risked losing its own well-earned identification with the issue, as United Power would demand major public leadership and recognition. The Shriver Center also risked losing control of the advocacy since it had to concede real power in the strategic and tactical decisions made about the campaign. It risked damage to its own relationships with politicians if displeasure with United Power's tactics were attributed to the Shriver Center. And, by sharing leadership and conceding much of the public identification with the issue to United Power, the Shriver Center risked some of its essential capital with donors and foundations, the lifeblood of the Shriver Center's budget.

With strong initial meetings and continuous communications, these issues were resolved. There was plenty of tension, but workable compromises emerged once each side understood the other's needs and the reasons for its positions. As trust and familiarity grew, a powerful combination emerged. In a burst of organizing energy, United Power directly provided or substantially assisted in

- the public relations acumen to suggest the name FamilyCare for the expansion (the lawyers had not named the program and had been clumsily calling it "KidCare for Adults");
- a postcard drive that produced and sent to the governor and speaker of the House 70,000 postcards demanding passage of FamilyCare (United Power also had an extremely effective media event with small children, delivering the postcards in wagons);
- large and very public actions with as many as 1,000 people in attendance;
- unlikely alliances with Blue Cross Blue Shield and large hospital systems;
- leadership in organizing an open letter signed by over 150 religious leaders;
- substantial contributions to favorable op-eds and editorials;
- strong turnout for lobby days;
- consistent production of powerful personal stories; and
- powerful district-level advocacy, including meetings with legislators, walking precincts and conversations with likely voters, and work with small local media).

The combination of these activities with the Shriver Center's own efforts and those of the wider coalition not only accomplished the establishment and year-by-year expansion of FamilyCare but also created a strong political and policy atmosphere in Illinois favorable to additional health care access expansions, which also stood as an effective block against health care cuts that may otherwise have surfaced in a fiscal crisis. This collaboration illustrates the value of adding to the toolbox of the public interest lawyer interested in a leadership role in health care access campaigns the knowledge and skills necessary to interact productively with community organizers and their organizations.

B. *Memisovski v. Maram*: Litigation in the Political Context

Litigation is a standard part of the lawyer's traditional toolbox, and it is one capacity that only lawyers have. A public interest lawyer, acting alone or with colleagues, can accomplish important health care access policy goals with a successful suit for declaratory and injunctive relief. There are many examples of good outcomes on health care access obtained through litigation by lawyers essentially working alone.

Yet there are limitations to what can be done through litigation. It is impossible to achieve anything on health care access solely through litigation if it is not already provided for in law. Thus it might be possible to achieve improved health care access in litigation through better enrollment efforts or a better program design to produce required levels of care, but it is not possible to expand coverage or improve the level of mandated enrollment or care. Litigation is also subject to the possibility of a bad outcome. There is always a chance of sinking years and great amounts of scarce resources into an effort that ends in a loss or a reversal on appeal, with the further risk that such a loss could also do lasting damage to the law itself through an unfavorable interpretation that limits the scope of the law or prevents its enforceability. Even with a victory, the favorable outcome is no good unless it is implemented productively and it is enforced. A court victory after years of litigation is often just the beginning of another years-long battle to win effective enforcement.

The toolbox of the litigator should therefore include the capacity to think beyond the four corners of the case. It should include the ability to recognize the need for an assessment of the larger political context, to make or acquire that assessment, and to develop and carry out—or have allies carry out—a political strategy that is a companion to the litigation. A litigator acting alone can force things. But in the larger picture, it is almost always more productive for the interests of the plaintiffs when the defendant officials willingly undertake the needed reforms, own and are proud of them, and have a stake in their success. It is close to impossible to achieve this solely through litigation, which invariably prompts resentment in a politician regardless of the merit of the plaintiffs' cause or the politicians' record with respect to that cause. Politicians reflexively fight litigation. Moreover, they turn it over to their counsel and try to forget about it or, worse, take retributive action. The politicians' counsel are not interested in policy concerns but in the adversarial contest. To turn that kind of situation around and get it on a track for productive resolution, the politician has to be convinced of the advantages of making the reforms—the political arguments more than the policy ones.

Since the litigator is bound by rules of ethics not to discuss the case with defendants outside of the presence of counsel, a political strategy requires allies and surrogates to carry the messages. If it is strategically warranted, the litigator can make the case to opposing counsel or to the defendant officials in the presence of counsel. But the litigator's toolbox should include not only an awareness of the larger political landscape but also access to allies who can develop and carry out a strategy to communicate directly to the officials. Media strategies can also be useful to reinforce the political framing.

The case of *Memisovski v. Maram* is an example of the benefits of this expanded toolbox for public interest health care access litigators.[2] The case was a class action involving the claims Cook County, Illinois, children covered by Medicaid (at least 600,000 at any given time) that they were not receiving the access to doctors and the levels of care mandated by several sections of the Medicaid Act. The case was filed in 1992 in response to crisis-level complaints from frustrated families to Legal Aid and other agencies in the communities. The litigation was immediately acrimonious, and the public officials turned it entirely over to their attorneys. There were repeated efforts to dismiss the case with claims that the Medicaid Act is not enforceable in court—claims that could always haunt the case on appeal even as the plaintiffs won them in the trial court. There was a long stay of proceedings and then an extremely intense discovery process leading to an eleven-day bench trial in May 2004.

[2] *Memisovski v. Maram*, 2004 WL 18783312 (N.D. Ill. 2004) (Clearinghouse No. 53,827). *See* John Bouman, Frederick H. Cohen, David J. Chizewer, Stephanie Altman & Thomas Yates, *Litigation to Improve Access to Health Care for Children: Lessons from* Memisovski v. Maram, 41 Clearinghouse Review 15 (May–June 2007), www.povertylaw.org//advocacy/publications/bouman-memisovski.pdf; see also John Bouman, *The Path to Universal Health Coverage for Children in Illinois*, 39 Clearinghouse Review 676 (March–April 2006), www.povertylaw.org//advocacy/publications/bouman-universal-health.pdf.

In August 2004 the judge issued, in favor of the plaintiffs, a comprehensive ruling declaring the whole Medicaid system for children out of compliance with the Medicaid Act and indicating a willingness to order sweeping reforms that implied substantial new expenditures for the state. The judge ordered the parties to attempt to negotiate a judgment order that would include the necessary injunctive relief. In the normal course of litigation, this resounding victory for the plaintiffs after a twelve-year litigation process would have been followed by negotiations over the remedial order, litigation of the inevitable disagreements, litigation of the issue of a stay pending appeal, and then appeal proceedings probably all the way to attempted review by the Supreme Court by the loser in the court of appeals with attendant stay pending appeal proceedings there. In addition, assuming implementation was ordered, there would be ongoing litigation over implementation issues caused by recalcitrant officials attempting to limit the sweep of the court's mandate and to manage compliance with inadequate funds voted by a legislature resenting federal court interference during a fiscal crisis. One foreseeable reaction from this kind of adversarial atmosphere could be a rollback of eligibility for coverage blamed on the expense of compliance with the court-mandated levels of care for those with insurance.

The attorneys on the *Memisovski* team recognized that these were the downside risks of proceeding solely within the litigation to consolidate their victory. They also knew from experience that reforms implemented by willing officials staking their reputations and careers on such reforms are more advantageous to their clients than efforts by unwilling officials under court constraints, even if on paper the court-mandated reform is stronger. This suggested the advisability of exploring settlement even after the victory.

Moreover, the attorneys recognized the need and had the capacity to make an assessment of the larger political environment and to consult allies to fill out and confirm their judgments. The goal was to frame the potential settlement politically and take it away from the lawyers' purely legal calculations (which indicated for the defendants that their chances on appeal might be good, given the judicial trend against enforceability of Medicaid rights in court). The relatively new governor was the first Democrat in that office in twenty-five years and had made health coverage, especially for children, a priority. He wanted to be a leader on that issue, and he would not want to be embarrassed by a court ruling holding his administration responsible for a terrible performance on children's access to care, especially smart and inexpensive preventive and primary care. There was also a steep fiscal crisis requiring the governor to do many austere things in the budget and have a positive accomplishment to balance his public image. In addition, Illinois was riding a years-long trend of health coverage expansions, including the FamilyCare campaign described above, and politicians, especially the governor, were beginning to identify the political advantages of being a leader on ambitious health care reforms.

The litigation team expanded its toolbox in several ways to take advantage of this political assessment. It developed a media strategy to keep the court victory relatively quiet and to place blame on prior administrations for a situation "inherited" by the incumbent one. This preserved the ability to make it a part of the settlement offer for plaintiffs to coordinate publicity and allow the administration to frame its own credit for the reforms without reference to the case or contradiction from the plaintiffs' attorneys. It was made clear to the defendants that the reason for this approach was to preserve the governor's opportunity to be the hero of children's health care by "fixing" the problem he inherited. This could not be said directly to the governor, so the lawyers informed a variety of surrogates in the legislature and the advocacy community, and they carried the message and suggested this framing. All of these same messengers also stressed the substantive points, based on research, that preventive and primary care for children is indeed sound policy, fiscally sensible over time, and long overdue.

The negotiations were not easy and took months. During that process, the political arguments began to gain traction. In the process of thinking through the settlement, the administration began to understand the relatively reasonable price of preventive care for children and indeed for everyone, and particularly the advantages of measures designed to acquire "medical homes" for everyone. Coordination of care can save money, in fact relatively quickly, in the cases of chronically ill people. The administration also began to appreciate the political advantages of leadership on bold health care reform initiatives. In the court case, a settlement reached in June 2005 was very strong on the mandates and the data reporting but was phased and reasonable on the measures requiring public expenditures. Before the settlement became final in November 2005, the administration announced in September 2005 that it would expand coverage to all children in the state, and that it would pay for that expansion over time with savings from a companion initiative to put the entire Medicaid, FamilyCare and children's health insurance system into a "medical home" initiative, in which every insured person would select or be assigned to a primary care doctor who would coordinate care.[3]

It is no doubt rare for litigation and political factors to line up as they did in the *Memisovski* context. Nevertheless, it is clear that litigators should have an expanded toolbox that allows them to be aware of and to associate with players in the wider political context.

C. *Bell v. Leavitt*: Litigation as Part of a Larger Defensive Strategy

A standard part of the public interest lawyer's toolbox is to be careful about litigation. Litigation requires significant resources of time and money, so public interest law organizations generally are very careful to undertake only cases that have a strong possibility of success. This is also important to the credibility of the organizations because their track record in litigation is what vindicates their views on what the law requires and what makes people pay attention to their implied or stated threats to sue. If they get a reputation for being unable to win in court, or for filing frivolous claims, their essential capital as law-oriented organizations—their power—is diminished. They will also have spent scarce resources on unsuccessful pursuits, and this can be of concern to supporters and boards.

An expanded toolbox can provide an understanding of how even difficult litigation with a low probability of success can be a productive strategy. As in *Memisovski*, the expanded toolbox involves understanding the larger political context and coordinating roles with allied advocates to achieve public policy goals. It brings to bear media, lobbying, grassroots, and research capacities in a coordinated way.

Litigation is an aggressive confrontational tactic. It is therefore often newsworthy, especially when there are political angles or powerful human interest stories associated with it. The news coverage and framing of the issues can be politically important, more so than the actual impact of the litigation in strictly legal terms. In that context, the litigation can serve as the news hook to publicize the issue and create political tension and pressure. Combined with grassroots pressure and lobbying resources, the total strategy can bear fruit, no matter how the litigation is resolved.

The litigation still has to be credible and nonfrivolous because the attorneys handling the case have ethical obligations as well as all of the normal considerations mentioned above. Indeed, regardless of the power of the claims, even or perhaps especially where the claims are solid, and the case would be filed anyway (such as *Memisovski*), the larger political context and the potential productivity of combined strategies should be considered. The point here, though, is that in some circumstances public interest lawyers who have an expanded toolbox of skills and allies might bring a meritorious but long-shot case as part of a larger strategy when they might not otherwise bring the case at all.

[3]See Bouman, *The Path to Universal Health Coverage for Children in Illinois*, *supra* note 2.

An example of the uses of this expanded toolbox is *Bell v. Leavitt*.[4] Early in 2006, Congress passed and the president signed the Deficit Reduction Act of 2005. Among its provisions was a requirement that, effective July 1, 2006, to be eligible for Medicaid, applicants and current recipients claiming to be U.S. citizens must provide documentary proof of their citizenship. Enacted as a tactic in the ongoing political conversation in the country around immigration issues, this provision would endanger the health coverage of millions of American citizens who were unable to procure the required documentation. The most endangered people were the most vulnerable ones: the infirm elderly, the disabled, people with mental illness, the homeless, victims of disasters whose records had vanished, children separated from their birth homes, and people born in places other than hospitals (often because of racially discriminatory policies and practices) who never had official birth records. It was not clear that the proponents had considered the potential impact. They clearly had not assessed the downside political risks and banked instead on what they perceived as a national antiimmigrant sentiment.

The Shriver Center began to assess legal claims for potential litigation and put together a litigation team. Meanwhile, however, the Shriver Center also realized the need for a political strategy to influence the rule making under the new law and potential congressional fixes in the event that litigation did not succeed. While this assessment and organizing was being done, the Shriver Center, hoping to influence the rule making, sent a threat-to-sue letter to the responsible federal authorities in April 2006. The Shriver Center agreed with its allies to be the only signatory on this letter in order to preserve the freedom of movement of allies who still wanted to engage in direct conversations with the federal officials (they would otherwise have to have had counsel present if they had threatened to sue).

The organizations which would be active in Washington, D.C., decided not to participate in the litigation in order to preserve their ability to work Congress and the bureaucracy. The organizations in the litigation included the Shriver Center, Health and Disability Advocates (a Chicago firm with substantial legal expertise on health issues), the National Health Law Project, the National Senior Citizens Law Center, and the Chicago litigation firm of Goldberg, Kohn, acting pro bono. The legal claims were under the U.S. Constitution and were legitimate claims, but it is not clear that any of the organizations would have undertaken them outside of the larger strategy. It was agreed early on to coordinate the media that would flow from the lawsuit with the legislative and administrative advocacy and grassroots pressure. It was agreed to file the case in Chicago to separate it from the Beltway pressures, foster the reality that what was at stake was more than squabbling over immigration policy and partisan point scoring, and insulate the Washington advocates somewhat from congressional pressure to back off the suit.

Less than three weeks before the law was to take effect on July 1, the administration released to state Medicaid directors a letter spelling out perhaps the worst possible implementation scheme in terms of damage to U.S. citizens who were in need of health care and who would be deprived of it in spite of being eligible for it (other than the technical documentation currently being required). On June 28 the plaintiffs filed a nationwide class action. The named plaintiffs were from across the nation and presented extremely powerful stories of need and impending doom if the law were carried out as specified in the letter. The lead plaintiff, Ruby Bell, for example, was born in Little Rock, Arkansas, in the early twentieth century, years before the county began collecting birth records and during the era when African Americans were often not welcome in hospitals and were born at home. She had never left the Mississippi River valley in her life and was in a nursing home in Rockford, Illinois,

[4] *Bell v. Leavitt*, 2007 WL 551553 (N.D. Ill 2007) (Clearinghouse No. 56,034).

without an original birth certificate, any living relatives to vouch for her, or any way to prove a citizenship that nevertheless was obvious. Loss of Medicaid would have probably led to her death.

Families USA, an ally not on the pleadings, coordinated a well-attended national telephone press conference. The case and the powerful stories of the plaintiffs received broad coverage. Grassroots pressure was brought to bear on key legislators and the administration. In the court case, a hearing on the motion for a temporary restraining order was set for June 13. Late on June 12, the administration published proposed and emergency regulations substantially softening the documentation requirements and procedures. Most important, the rules as a practical matter exempted all of the elderly and disabled Medicaid recipients and applicants from the new documentation rules (they were still subject to much more reasonable documentation rules that had previously been in effect). This relieved approximately eight million of the most vulnerable people—a substantial victory before the court ever made a ruling.

Plaintiffs reformulated their pleadings and added new plaintiffs, most of the original ones having been mooted by the new rules. The case became much more difficult because the new rules gave flexibility to states that made it hard to litigate nationally. The cleanest claim was on behalf of a subclass consisting of about a half million foster children. The media and legislative advocacy and grassroots pressure continued even as the case ran into procedural difficulties. In December 2006 Congress itself passed a "clarification" stating that it did not intend the documentation rule to apply to foster children. With that victory in hand, the plaintiffs voluntarily dismissed the case in early 2007, with no adverse rulings on the merits, preserving the issues for possible future state-by-state litigation if necessary.

The *Bell* story illustrates the value of public interest lawyers having an expanded health care access toolbox. Litigation, the consummate lawyer's skill and capacity, is just one of many tactics that can be melded into a larger strategy. In that context it can be highly useful to accomplish the goals of a larger strategy even if the litigation itself is not successful.

■ ■ ■

It is important to expand the toolbox for public interest attorneys engaged in leadership of health care access campaigns. It would be useful for law schools to consider a curriculum teaching additional skills, such as working with community organizations, lobbying, political assessments, media and messaging, and case studies of a variety of successful multidimensional advocacy campaigns involving attorneys. In any event, practitioners should think beyond the traditional legal skills and develop these added tools.

COMMENTS?

We invite you to fill out the comment form at http://tinyurl.com/JulyAugustSurvey. Thank you.

—The Editors

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