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**A Vision of an Emerging Right to Health Care in the U.S.:
Expanding Health Care Equity through Legislative Reform**

(forthcoming in *THE RIGHT TO HEALTH AT THE PUBLIC/PRIVATE DIVIDE: A GLOBAL COMPARATIVE STUDY*, Aeyal Gross & Colleen Flood, eds., Cambridge University Press)

Allison K. Hoffman¹

INTRODUCTION

When asked to write a chapter on how litigation has advanced a right to health in the U.S., I responded skeptically, both because evidence of the existence of any such right is weak and the role of litigation in promoting its development is small at best. A snapshot of the U.S. health care system evinces the absence of even a more narrow right to health *care* – a guarantee of equitable access to basic medical care.² Instead, it reveals a fragmented picture of public and private financing that leaves many people lacking meaningful access to care.³ More so, the places where hints of a right to health care appear in the U.S. are largely not the result of litigation, but rather a product of incremental legislative efforts to advance health care access, suggesting the more compelling picture might be one of legislation.

Litigation to advance a right to health care has faced paralyzing constraints. Unlike in many other countries, where litigation increasingly plays a central role,⁴ there is no overarching constitutional or statutory right to health in the U.S., to serve as a foundation for legal challenges. As further impediment, the Supreme Court has limited access to the courts and remedies for individual claims arising from statute or contract. Such structural barriers – legal, procedural, and political – have constrained the use of litigation to define or defend an American right to health care.

In light of these roadblocks, I consider whether legislative change may offer a better (albeit also problematic) pathway to expanding health care equity in the U.S. Over the past 50 years, incremental, majoritarian (sometimes barely) legislative efforts have created what can be described as pockets of a right to health care for some populations, such as the elderly or “deserving poor.” Now, I suggest, the 2010 health reform law, the Patient Protection and Affordable Care Act (PPACA), offers a vision for an emerging, broader American right to health

¹ *Assistant Professor of Law*, UCLA School of Law. My gratitude to Devon Carbado, Scott Cummings, Daniel Dumont, Russell Korobkin, Sam Krasnow, Amy Monahan, Abigail Moncrieff, Steve Munzer, and Kathy Stone for comments on various drafts of this chapter and to Billy Herbert for excellent research assistance.

² The more expansive notion of a right to health implies state obligations to promote population health, through protections and entitlements, by addressing “preconditions” of health outcomes, such access to food, clean water, and sanitation, as well as medical care. Siri Gloppen & Mindy Jane Roseman, *Introduction: Can Litigation Bring Justice to Health* in *LITIGATING HEALTH RIGHTS: CAN COURTS BRING MORE JUSTICE TO HEALTH* 1, 3-4 (Alycia Ely Yamin & Siri Gloppen, eds., 2011). Some suggest an even more expansive notion that requires attention also to social determinants of health, including education and housing. For research on these “social determinants,” see, e.g., RICHARD WILKINSON & KATE PICKETT, *THE SPIRIT LEVEL* (2009) (examining the effect of income inequality on health); Michael G. Marmot, *Social Differentials in Health Within and Between Populations*, *DAEDALUS*, Fall 1994, at 197; Geoffrey Rose, *Sick Individuals and Sick Populations*, 14 *INT’L J. EPIDEMIOLOGY* 32, 38 (1985); Peter Townsend & Nick Davidson, *Introduction to INEQUALITIES IN HEALTH: THE BLACK REPORT* 13, 20-23 (Douglas Black et al. eds., 1982).

³ For a description of fragmentation and its consequences, see Allison K. Hoffman, *Oil and Water: Mixing Individual Mandates, Fragmented Markets, and Health Reform*, 36 *AM. J. L. & MED.* 7 (2010).

⁴ Gloppen & Roseman, *supra* note 2, at 1-2 (describing the recent rise in health rights litigation globally).

care, realized by blending the role of public insurance and private insurance and relying on both to achieve more universal, affordable access to health care. The Supreme Court, while previously not influential in advancing an American right to health care, has now played a central role, by affirming PPACA's legal validity.⁵

Reflecting on the historical development of the U.S. health care financing system, the limited success of health care rights litigation, and the success of past legislative efforts, this chapter reveals two primary insights. First, it illustrates how and why the U.S. lies in vivid contrast to many other countries in this volume, where battles over health rights – defined narrowly or broadly – occur largely in the courts. Americans have been and will likely continue to be relatively more reliant on statutory advancement of health care rights. Second, it argues that, going forward, PPACA offers transformative potential for an American right to health care, by gradually redefining who does (and perhaps by implication should) have access to health care, regardless of ability to pay. Whether this formal legal change will shape social consciousness is still unclear.⁶ Early backlash to both the law and the Supreme Court decision raises doubts. Yet, past experience with incremental health reform in the U.S. offers some evidence that PPACA could provide the vision and foundation for an evolving American conception of a right to health care. If PPACA offers the best pathway to social change, supporters of a right to health care should be particularly invested in its success, even if they see its vision as flawed or incomplete.

As a preliminary matter, in this chapter, I focus on a right to health *care*. More precisely even, I examine a right to health insurance, which usually – but not always – enables access to medical care.⁷ This focus is admittedly and intentionally narrow. While there is rich debate among scholars⁸ and international human rights bodies⁹ on the advisability and meaning of a right to health, I do not intend to join this broader debate. Rather, I examine equitable access to health *care*, which most agree is a critical component of a right to health¹⁰ and which lies at the heart of current controversies in law, policy, and politics in the U.S. This right to health care demands equality of opportunity to access medical care but not necessarily equality of health

⁵ Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

⁶ Legislation alters health care financing in ways consistent with a right to health care, by increasing affordable access to meaningful health care. Whether social consciousness will follow is more complex and controversial. I suggest several reasons why legislative change *might* offer the potential to shape social consciousness of a right to health care, without asserting that it *will*, a question beyond the scope of this chapter. Catherine Albiston describes the academic debate on how law shapes social consciousness in INSTITUTIONAL INEQUALITY AND THE MOBILIZATION OF THE FAMILY AND MEDICAL LEAVE ACT 11-17 (2010).

⁷ *But see* David Orentlicher, *Right to Healthcare in the United States: Inherently Unstable*, 38 AM. J. L. & MED. 326, 336-37 (2012).

⁸ *See, e.g.*, PUBLIC HEALTH, ETHICS AND EQUITY (SUDHIR ANAND, ET AL. EDs., 2004); NORMAN DANIELS, JUST HEALTH: MEETING HEALTH NEEDS FAIRLY (2008); ALLEN E. BUCHANAN, JUSTICE AND HEALTH CARE (2009); Tom L. Beauchamp & Ruth R. Faden, *The Right to Health and the Right to Health Care*, 4 J. MED. & PHIL. 118 (1979) William W. Fisher & Talha Syed, *Global Justice in Healthcare: Developing Drugs for the Developing World*, 40 U.C. DAVIS L. REV. 581, 602-47 (2007); Martha C. Nussbaum, *Capabilities as Fundamental Entitlements: Sen and Social Justice*, FEMINIST ECON., nos. 2-3, 2003, at 33, 41.

⁹ Article 12, the place where a right to health is anchored in international law recognizes the right “to the enjoyment of the highest attainable standard of physical and mental health.” *International Covenant on Economic, Social and Cultural Rights art. 12*, G.A. Res. 2200 (XXI), 21 U.N. GAOR Supp. (No. 16), U.N. Doc. A/6316 (1966). For discussion of article 12, see U.N. Econ. & Soc. Council, Comm. on Econ. Soc. and Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health, PP 38-42, U.N. Doc. E/C.12/2000/4 (2000).

¹⁰ DANIELS, *supra* note 8 at 29-30.

outcomes, which requires well more than access to medical care.¹¹ I also do not intend to define what particular medical care is core to a right to health care, but I do illuminate how the design and regulation of health insurance implicitly asserts such definition.¹²

While circumspect about the future of PPACA and its ability to provoke broader social mobilization, my goal in this chapter is to show how it offers a transformative vision, and perhaps the most promising pathway in light of impediments to litigation, for an emerging right to health care in the U.S.

PART 1: BEFORE PPACA: INSURANCE FRAGMENTATION AND INEQUITABLE ACCESS TO HEALTH CARE

To understand attempts to improve health care equity in the U.S., it is necessary to examine the roots of inequity in the current system, which has become fragmented into many, incommensurate sources of financing. This fragmentation occurred in two ways. First, market and historical processes together created proliferation of sources and types of insurance, which I call “structural fragmentation.” Second, the legal standards among these types have diverged over time, which I call “regulatory fragmentation.”¹³ The result is that some types of insurance are superior to others. Because not everyone can access all – or any – of these types, fragmentation has resulted in inequitable access to medical care among Americans, depending on how – or whether – an individual is insured.

A. Structural Fragmentation

The U.S. health care financing system is a maze of public and private insurance programs, each covering different services and items for different populations. The primary fissure is between public and private insurance. The major public health insurance programs, Medicare and Medicaid, were created in 1965, intending to cover only a limited subset of Americans. Subsequently, private insurance developed to fill in the picture and, in so doing, diffused political pressure to expand public insurance, while still not meeting the needs of many not eligible for public insurance.

Public insurance programs create what could be considered a weak statutory right to health care for about 90 million Americans, mostly in medically vulnerable populations,¹⁴ by defining entitlements to membership in programs for financing medical care. These rights are weak, however, for several reasons. First, because they are statutory, these programs can be terminated or altered at any time by legislators and regulators. With regard to Medicaid, in particular, the Department of Health and Human Services can waive program requirements for state demonstration projects.¹⁵ Second, while these programs guarantee qualifying individuals *financing* for certain health care services, they do not necessarily guarantee *access* to covered

¹¹ See Jennifer Prah Ruger, *Ethics of the Social Determinants of Health*, 364 LANCET 1092, 1092-96 (2004) at 1092-94 (contrasting an equality-of-opportunity approach, as advocated by John Rawls and Norm Daniels, and an equality-of-results approach, closer to Amartya Sen’s vision).

¹² I have elsewhere discussed three competing models for allocative decisions. Allison K. Hoffman, *Three Models of Health Insurance: The Conceptual Pluralism of the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1873 (2011).

¹³ For in-depth examination of fragmentation, see Hoffman, *supra* note 3.

¹⁴ CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, CURRENT POPULATION REPORTS, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, at 71 tbl.C-1 (2010).

¹⁵ 42 U.S.C. § 1315 (2012).

services if providers are not available and willing to participate in the programs.¹⁶ Third, the public programs have limited enforcement mechanisms, making some statutory rights not individually enforceable, as discussed below.

Several public insurance programs, together, constitute this week right to health care for some Americans. Most significantly, in 1965 the U.S. Congress passed legislation to establish Medicare,¹⁷ a federal program to finance care for the elderly (generally those over 65 years old) and Medicaid,¹⁸ a joint federal and state health care program for the poor and disabled. Other public programs include the State Children's Health Insurance Program (CHIP) for near-poor children, Indian Health Services (IHS) for American Indians and Alaskan Natives, and TRICARE and the Veteran Administration's (VA) program for active duty military personnel, veterans, and their families. These programs share characteristics found in social insurance programs in other countries, such as tax-based financing, broad risk spreading, and access to a range of benefits with limited cost sharing.¹⁹ They are all publicly financed and pay for privately-delivered health care, except for the VA and IHS, where the delivery system is public as well. We could think of these programs as delineating who – including, for example, the elderly and deserving poor – deserve guarantees to medical care, even if unable to pay for it on their own.

In contrast, the U.S. private health insurance market, the source of coverage for 195 million Americans,²⁰ is not available to all, and lower income or less healthy individuals are less likely to have access to private insurance.²¹ The private market is itself split into three markets based on employee group size – referred to as “large group,” “small group,” and “individual” markets. The quality of coverage generally decreases and cost increases in this same order.

Most privately-insured Americans obtain large or small group employer coverage, where the employer has discretion over the design of this coverage.²² This system of “employer-sponsored insurance” (ESI) became common in the mid-20th Century as a work-related benefit and has become deeply entrenched since. While employers are not required to offer employees health insurance, many do because expenditures on health benefits are excludable from taxes for both the employer and employee. The beneficial tax treatment means that health benefits have become a less expensive way to compensate employees; health insurance costs employers approximately \$.65 per dollar of benefits.²³ In addition, some employees, especially if salaried and higher-income, expect health benefits.²⁴

Not all private insurance is obtained through employers. Some workers lack access to ESI, either because they work for an employer who does not offer it – more frequently the case with smaller employers – or because they do not qualify for employee benefits due to contingent

¹⁶ See *infra* notes 133-135 and text.

¹⁷ Social Security Amendments of 1965, Public Law 89-97, Title XVIII, 42 U.S.C. § 1395 (1965).

¹⁸ Social Security Amendments of 1965, Public Law 89-97, Title XIX, 42 U.S.C. § 1396 (1965).

¹⁹ See Richard B. Saltman, *Social Health Insurance in Perspective: The Challenge of Sustaining Stability*, in SOCIAL HEALTH INSURANCE SYSTEMS IN WESTERN EUROPE 3 (Richard B. Saltman et al. eds., 2004) (characterizing social insurance in Western Europe).

²⁰ DENAVAS-WALT ET AL., *supra* note 14, at 71. Over 250 million Americans are insured, some with both private and public coverage.

²¹ KAISER FAMILY FOUND. & HEALTH RESEARCH & EDUC. TRUST, EMPLOYER HEALTH BENEFITS 2011 ANNUAL SURVEY 48-50 (2011) [hereinafter KFF EMPLOYER HEALTH BENEFITS: 2011].

²² *Id.* at 36. Katherine Swartz, *Justifying Government as the Backstop in Health Insurance Markets*, 2 YALE J. HEALTH POL'Y L. & ETHICS 89, 94 (2001).

²³ Jonathan Gruber, *Covering the Uninsured in the United States*, 46 J. ECON. LITERATURE 571, 574 (2008).

²⁴ KFF EMPLOYER HEALTH BENEFITS: 2011, *supra* note 21, at 34.

work status, including part-time and seasonal employment. Without access to ESI, individuals seek out coverage on the “individual market,” purchasing a policy directly from a private insurer. Six to seven percent of the non-elderly (about 15 million individuals) have individual market coverage.²⁵ This market is more unstable and expensive, dollar-per-dollar, than group coverage, as explained below.

The remaining 16-17% of the total non-elderly population (about 50 million individuals) is uninsured and has limited access to medical care;²⁶ unless they can pay for it directly, they may only receive care in limited locations and circumstances, and, at times, at exorbitant costs. For example, the Emergency Medical Treatment & Active Labor Act (EMTALA) guarantees access to emergency services regardless of ability to pay.²⁷ However, if an uninsured person receives care in an emergency room and does not pay for it, the care is considered “uncompensated” at the point of service,²⁸ and the hospital may try to collect payment directly from the patient, resulting in bankruptcies for uninsured and underinsured Americans.²⁹ EMTALA could be understood as creating a limited right for all to access some care but with potentially very high costs.

In sum, U.S. health care financing has evolved into a system with many parts. In the public system, the least well off – the elderly and poor – benefit from a circumscribed statutorily-created right to care. In the private system, those with ESI, who tend to be higher-income earners, have more comprehensive insurance coverage, but that coverage exists at the employer’s whim. Many fall through the cracks between these two systems, left to rely on safety nets, such as EMTALA for limited access to care.

B. Regulatory Fragmentation

Structural fragmentation set the foundation for regulatory fragmentation – namely, regulatory inconsistency among the different insurance markets that exacerbated inequities in access to care, depending on the type of insurance coverage an individual has.

1. Regulation of Public Benefits and Eligibility

Public insurance covers a set of basic benefits for eligible populations that gives meaning to the entitlements created in these programs. For the two largest public insurance programs, Medicare and Medicaid, the federal government defines a floor of coverage. Above these baselines, benefits can vary based on what plan a beneficiary chooses or, for Medicaid, in which state she lives.

Medicare covers basic medical services for most Americans over age 65, including inpatient care, outpatient care, and, as of 2006, prescription drugs,³⁰ but generally does not cover routine dental or vision care or custodial long-term care. Most Medicare beneficiaries, unless low income, face moderate out-of-pocket expenses for premiums, deductibles, coinsurance for hospital services, and copayments for outpatient services and prescription

²⁵ KAISER FAMILY FOUND., HEALTH INSURANCE COVERAGE IN AMERICA: 2007 1 (2007).

²⁶ DENAVAS-WALT ET AL., *supra* note 14, at 22.

²⁷ 42 U.S.C. § 1395dd (2006).

²⁸ Hadley et al., *Covering the Uninsured in 2008: Current Costs, Sources of Payment, and Incremental Costs*, 27 HEALTH AFF. (WEB EXCLUSIVE) 399, 402 (Aug. 25 2008).

²⁹ David U. Himmelstein et al., *Marketwatch: Illness and Injury as Contributors to Bankruptcy*, HEALTH AFF. (WEB EXCLUSIVE) w5-63 (2005).

³⁰ KAISER FAMILY FOUND., KAISER COMMISSION ON MEDICAID AND THE UNINSURED, MEDICAID: A PRIMER 5 (2010) [hereinafter KFF MEDICAID PRIMER].

drugs. As a share of income, the median Medicare beneficiary's out-of-pocket spending increased from 12% in 1997 to over 16% in 2006, even though 90% also hold private supplemental coverage to fill in gaps.³¹

Medicaid programs likewise build on a required core of mandatory eligibility categories and benefits, albeit a thin core. Medicaid is funded by both by the federal (i.e., national) and state governments. The federal government dictates which beneficiaries and benefits states must cover to receive federal matching dollars, beyond which the states have discretion. Prior to PPACA, Medicaid eligibility has been "categorical," meaning that federal rules require coverage of certain populations, including children under age six and pregnant women in households with incomes below 133% of the Federal Poverty Line (FPL), children age six to eighteen in households with income below 100% of the FPL, and certain categories of people with disabilities.³² For reference, the 2011 FPL was USD \$22,350 for a family of four and USD \$10,890 for an individual.³³ Beyond these categories, states have had discretion to define eligibility, typically doing so sparingly. For example, in 2009, the eligibility threshold for the non-mandatory category of "working parents" ranged from below 17% of the FPL in Arkansas to below 215% of the FPL in Minnesota.³⁴ Many states do not cover childless adults at all.³⁵

For most beneficiaries, states must cover certain mandatory services, such as hospital and outpatient services, laboratory and x-ray services, family planning services, and comprehensive diagnostic and treatment services for children.³⁶ In addition, state Medicaid programs may and typically do offer "optional" services, including prescription drugs (which all states offer), dental services, and hospice services.³⁷ Eligibility thresholds and benefits thus define the reach and substance of the Medicaid entitlement, but it varies considerably among states. In other words, the meaning of the right to health care guaranteed by Medicaid is not static among enrollees.

2. Regulation of Private Benefits and Eligibility

Private insurance benefits and cost-sharing requirements have been less tightly prescribed, suggesting a less clear and consistent normative vision for private insurance. Regulation of private insurance is reserved to the states unless the federal Congress acts and expressly preempts state regulation, which it has done several times to meaningful effect.³⁸ For example, many employer plans are not subject to state regulation, because of the preemption language in the Employee Retirement Income Security Act of 1974 (ERISA),³⁹ a federal law enacted to enable large, multi-state companies to administer employee benefits (mostly pensions) seamlessly across states. As interpreted by the courts, ERISA preempts most state regulation of employer plans, including all state regulation of "self-insured" employee benefit

³¹ KAISER FAMILY FOUND., MEDICARE CHARTBOOK FOURTH EDITION 60 (2010).

³² KAISER COMM'N ON MEDICAID & THE UNINSURED, MEDICAID: AN OVERVIEW OF SPENDING ON "MANDATORY" VS. "OPTIONAL" POPULATIONS AND SERVICES (2005).

³³ HHS Poverty Guidelines, 76 Fed. Reg. 3637-3638 (January 20, 2011).

³⁴ KFF MEDICAID PRIMER, *supra* note 30, at 12.

³⁵ *Id.*

³⁶ *Id.* at 14. Some states offer an alternative "benchmark" plan for certain high-need beneficiaries. *Id.* at 17.

³⁷ *Id.* at 15.

³⁸ 15 U.S.C. § 1011 (2006).

³⁹ 29 U.S.C. § 1144 (2006).

health plans,⁴⁰ where an employer retains risk of high expenditures, rather than buying a group insurance product from an insurer to transfer the risk of unexpected high expenditures to that insurer.⁴¹ According to a recent estimate, 60% of all workers and 96% of workers in large companies are beneficiaries of self-insured plans and thus exempt from state insurance regulation.⁴²

Employer plans, however, must comply with ERISA and other federal laws that aim to reduce discrimination and spread risk more evenly among employees, who together form the group risk pool. For example, the Health Insurance Portability and Accountability Act (HIPAA), a 1996 statute that amends ERISA, prohibits discrimination against individual members of a group based on an individual's health status or history.⁴³ Furthermore, federal tax law also prohibits employers from discriminating in favor of more highly compensated employees⁴⁴ and other federal laws prohibit employers from discriminating against employees due to genetic information⁴⁵ or disabilities.⁴⁶ These laws effectively assert that access to health care should not differ on the basis of these characteristics, even in private markets. The prohibitions on discrimination, however, have limits in application because, apart from a few categories of mandatory benefits, employers can exclude whole categories of care if exclusions are based on actuarial principles and are not a "subterfuge for discrimination."⁴⁷

The limited, mandatory benefits for employer plans include a minimum hospital stay after childbirth⁴⁸ and parity between mental health and substance use disorder benefits, on the one hand, and medical benefits, on the other, to the extent a health plan covers both.⁴⁹ Although many employers do choose to offer relatively comprehensive health benefits, doing so is discretionary. Thus, apart from these few mandated benefits, employers give meaning to the employer health plan, but once defined, equal protection principles attach.

HIPAA also requires insurers to issue coverage to any group who applies ("guaranteed issue")⁵⁰ and renew coverage in subsequent years ("guaranteed renewal"), ensuring all groups can get coverage, even if at high prices.⁵¹ This means that all employers can obtain group plans and all members of an employer group can participate on relatively similar terms in any plan their employer chooses to offer.

Those seeking coverage on their own in the individual market have had fewer guarantees and less access to healthy risk pools, prior to PPACA. States regulate, to varying degrees, the

⁴⁰ 29 U.S.C. § 1144 (2006). For review and critique of ERISA preemption, see Russell Korobkin, *The Failed Jurisprudence of Managed Care, and How to Fix It: Reinterpreting ERISA Preemption*, 51 UCLA L. REV. 457 (2003).

⁴¹ Most buy stop-loss coverage, transferring risk to a stop-loss insurer; yet, the law maintains the distinction, even if myth.

⁴² KFF EMPLOYER HEALTH BENEFITS: 2011, *supra* note 22, at 151, ex. 10.1.

⁴³ Patient Protection and Affordable Care Act, Pub. L. No. 104-91, 110 Stat. 1936 (1996) [hereinafter PPACA].

⁴⁴ 26 U.S.C. § 105(h) (2010).

⁴⁵ See Genetic Information Nondiscrimination Act of 2008, Pub. L. No. 110-233, § 101, 122 Stat 881, 883-88 (2008).

⁴⁶ 42 U.S.C. § 12112 (2012), 29 C.F.R. § 1630.4 (2010).

⁴⁷ EQUAL EMPLOYMENT OPPORTUNITY COMMISSION, INTERIM ENFORCEMENT GUIDANCE ON THE APPLICATION OF THE AMERICANS WITH DISABILITIES ACT OF 1990 TO DISABILITY-BASED DISTINCTIONS IN EMPLOYER PROVIDED HEALTH INSURANCE, No. N-915.002 (June 8, 1993).

⁴⁸ 42 U.S.C. §300gg-25 (2012).

⁴⁹ 42 U.S.C. §300gg-26 (2012). Certain plans that cover under 50 employees or experience an increase in claims costs of over one percent as a result of compliance may be exempt.

⁵⁰ 42 U.S.C. §300gg-1 (2012) (guaranteed availability in the group market).

⁵¹ 42 U.S.C. §300gg-2 (2012) (guaranteed renewability in the group market).

design and content of insurance policies, including, for example, mandating coverage of certain benefits.⁵² While most states' laws include some substantive regulations of benefits, few regulate the pricing and issuance of coverage in the individual market. Only a small minority of states have extended HIPAA-like rules to the state individual market; six states require guaranteed issue and one-third of states limit the variability in premium prices allowed among insured.⁵³ The result is that individual market insurers in most states can issue, decline, or differentially price insurance based on an individual's health (or perceived health) – a practice known as underwriting or “risk rating.”⁵⁴ To the degree an insurer judges an individual as high-risk, it has historically been allowed to subject her to high premiums or coverage exclusions (e.g., carve outs of pre-existing conditions or low benefit limits), or deny her coverage, to the extent allowed by a state's laws.⁵⁵ Americans disagree on the desirability of risk rating, based on differing conceptions of which types of risks should be shared and which should be borne individually through higher premiums or coverage exclusions.

Underwriting is time consuming and expensive, resulting in high overhead costs that make the individual-market policies relatively more expensive than group-market policies.⁵⁶ In turn, many people cannot afford coverage or pay more than they would in group markets for the same level of coverage. One study reported that in 2005 nearly three in five adults who applied for coverage in the individual market didn't buy it because they were denied coverage, quoted unaffordable prices, or had a health problem excluded from coverage.⁵⁷ In states with relatively unregulated individual markets, insurers reject as many as 30-40% of applicants.⁵⁸ Some who do obtain coverage in the individual and small group markets are considered “underinsured.”⁵⁹ Only one-third of those with individual market coverage rate their coverage as “excellent” or “good.”⁶⁰

The combination of structural and regulatory fragmentation has thus led to highly variable insurance coverage among Americans and no coherent vision of what an American right to health care might entail. In particular, those who must resort to the individual market, especially if perceived as high-risk applicants, are more likely to have poor or no coverage. U.S. law and regulation has thus created a fragmented system with no common baseline in which people in need of health care often fall through the cracks.

⁵²See generally Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361, 1365 (2007).

⁵³ KAISER FAMILY FOUND, 50 STATE COMPARISONS: HEALTH INSURANCE & MANAGED CARE STATEHEALTHFACTS.ORG, <http://www.statehealthfacts.org/comparecat.jsp?cat=7&rgn=6&rgn=1> (last visited Jul 23, 2012).

⁵⁴ See Donald W. Light, *The Practice and Ethics of Risk-Rated Health Insurance*, 267 JAMA 2503 (1992).

⁵⁵ See, e.g., Melinda Beeuwkes Buntin et al., *The Role of the Individual Health Insurance Market and Prospects for Change*, 23 HEALTH AFF. Nov.-Dec. 79, 81 (2004); SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, SQUEEZED: WHY RISING EXPOSURE TO HEALTH CARE COSTS THREATENS THE HEALTH AND FINANCIAL WELL-BEING OF AMERICAN FAMILIES 3-4 (2006); Michelle M. Doty et al., *Failure to Protect: Why the Individual Insurance Market Is Not a Viable Option for Most U.S. Families*, COMMONWEALTH FUND PUB. 1300, Feb. 2009, at 1-3.

⁵⁶ See Gruber, *supra* note 23, at 574-75.

⁵⁷ COLLINS ET AL., *supra* note 55, at 4.

⁵⁸ *Id.* at 21.

⁵⁹ Cathy Schoen et al., *How Many are Underinsured? Trends Among U.S. Adults, 2003 and 2007*, HEALTH AFF. (WEB EXCLUSIVE) w298-309 (2008).

⁶⁰ *Id.* at 4.

PART 2: THE LIMITED ROLE OF THE JUDICIARY IN DEFINING A RIGHT TO HEALTH CARE

Attempts to address these inequities through litigation have faltered in the face of structural barriers – substantive, procedural and political. Because of these barriers, litigation has not played the role in defining or expanding health equity in the U.S. that it has in other countries. In fact, U.S. courts have largely rejected rights-based claims to health care.⁶¹ Litigants have, however, had some, limited success with contractual claims to remedy wrongful denial of covered benefits for eligible enrollees. These lawsuits serve to preserve the contractual status quo but do not markedly stretch the bounds of access to health care.

A. No Constitutional Right to Health

The American legal structure is one that in general favors negative rights – or liberties – and disfavors positive rights. A primary reason why litigation has not played a major role in defining or guaranteeing a right to health care is because the U.S. Constitution has no explicit right to health, nor have the courts read an implicit one. The Supreme Court, as part of its resistance to an expansion of welfare rights more generally, has declined to read a right to health into the substantive due process provision of the Fourteenth Amendment to the Constitution, a provision protecting against deprivations of life, liberty, or property.⁶² In the 1960s to 1970s, many scholars and activists thought the court would interpret the Fourteenth Amendment to guarantee welfare as a fundamental right, which would have implied a guarantee of health care, at least for the poor, but such predictions never came to fruition.⁶³

Quite the opposite has occurred. Over the past few decades, Supreme Court decisions have explicitly dismissed a state obligation to pay for or guarantee health care, even to indigent populations.⁶⁴ Even benefits under public insurance programs, Medicare and Medicaid, are not considered property for constitutional purposes and thus can be revoked.⁶⁵ Further, in some recent cases, the courts quashed claims of a right to access a particular medical service or item, regardless of the source of payment for care.⁶⁶

The Supreme Court has, however, delineated a very limited guarantee to medical care for those in state custodial control, under the Eighth Amendment to the Constitution's prohibition of cruel and unusual punishment.⁶⁷ This right was recently reaffirmed in *Brown v. Plata*, where the

⁶¹ Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413 (2008); TIMOTHY STOLTZFUS JOST, *DISENTITLEMENT?* 24-30 (2003). *But see* Abigail Moncrieff, *The Freedom of Health* 159 U. PA. L. REV. 2209 (2011) [hereinafter, Moncrieff, *Freedom*]; Jessie Hill, *The Constitutional Right to Make Medical Treatment Decisions: A Tale of Two Doctrines*, 86 TEX. L. REV. 277 (2007) [hereinafter Hill, *Constitutional Right*]; Jessie Hill, *Reproductive Rights as Health Care Rights*, 18 COLUM. J. GENDER & L. 501 (2009) [hereinafter Hill, *Reproductive Rights*].

⁶² PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *SECURING ACCESS TO HEALTH CARE: VOLUME ONE* 33 (1983); Puneet K. Sandhu, *A Legal Right to Health Care: What Can the United States Learn from Foreign Models of Health Rights Jurisprudence?*, 95 CAL. L. REV. 1151, 1162-1165 (2007).

⁶³ JOST, *supra* note 61, at 26.

⁶⁴ *See Harris v. McRae*, 448 U.S. 297, 311 (1980); *Maher v. Roe*, 432 U.S. 464, 469 (1977).

⁶⁵ JOST, *supra* note 61, at 28.

⁶⁶ *Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695 (D.C. Cir. 2007) (declining a right to experimental drugs, even for the terminally ill); *U.S. v. Oakland Cannabis Buyers' Coop.*, 532 U.S. 483 (2001) (declining a right to medical marijuana).

⁶⁷ *Estelle v. Gamble*, 429 U.S. 97, 104 (1977) (“deliberate indifference” to medical needs of prisoners violates the 8th Amendment); *see also Youngberg v. Romeo*, 457 U.S. 307, 315 (1982) (affirming extension of rights to involuntarily committed persons).

court ordered California to reduce its prison population by nearly 25% because prison overcrowding prevented provision of necessary medical care and mental health care to inmates.⁶⁸ This narrowly-defined right only attaches in circumstances when the state has first restrained the individual's liberty through incarceration or other means.⁶⁹

In addition, the Supreme Court has recognized health-related liberties, such as the right to refuse treatment,⁷⁰ obtain contraception,⁷¹ or have an abortion.⁷² Several scholars argue these liberties, together, could be read to carve out a “negative” right to health that protects individuals from excessive government interference with health decisions,⁷³ but the court has never explicitly acknowledged such a right. Even if read in such a light, these negative rights do not create any governmental obligation to guarantee health care; quite the opposite, they guarantee freedom from government interference.

State constitutions, while gesturing at health care rights textually, similarly do not tend to create any broadly enforceable right to health care in application.⁷⁴ According to research by Professor Elizabeth Weeks Leonard, about one-quarter of state constitutions mention the importance of public health and welfare or the responsibility of the state to care for the indigent, insane, or incarcerated, but court interpretation of these provisions has not construed them to confer a right to health care.⁷⁵ With no acknowledged positive constitutional right to health (or health care) at the federal or state level, litigants lack an overarching hook for legal claims to a right to health care.

B. Limitations on Private Rights of Action

The Supreme Court's cabining of private rights of action to enforce even contractual or statutory rights to medical care has further minimized the role of the courts.⁷⁶ This erosion of individual access to the courts, which has occurred beyond the sphere of health care,⁷⁷ has significantly limited health care litigation.⁷⁸

For example, courts have limited Medicaid beneficiaries' standing to sue state agencies or officials for violations of the federal conditions of the Medicaid program.⁷⁹ Medicaid does not have a private statutory enforcement mechanism of its own.⁸⁰ Beneficiaries have relied primarily

⁶⁸ *Brown v. Plata*, 131 S. Ct. 1910, 1928 (2011).

⁶⁹ *DeShaney v. Winnebago County*, 489 U.S. 189, 200 (1989) (declining to extend the right to child under state social services review, who was living with and abused by his father); *Wideman v. Shallowford Community Hospital*, 826 F.2d 1030 (11th Cir. 1987) (declining to extend the right to woman in a public ambulance who subjected herself to custody).

⁷⁰ *Washington v. Harper*, 494 U.S. 210 (1990); *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990) (assuming, not affirming, the right to refuse treatment).

⁷¹ *Carey v. Population Servs. Int'l*, 431 U.S. 678, 687-89 (1977).

⁷² *Gonzales v. Carhart*, 550 U.S. 124, 156-58 (2007); *Roe v. Wade*, 410 U.S. 113 (1973).

⁷³ See generally, e.g., Hill, *Reproductive Rights*, *supra* note 61; Hill, *Constitutional Rights*, *supra* note 61; Moncrieff, *Freedom*, *supra* note 61.

⁷⁴ Elizabeth Weeks Leonard, *State Constitutionalism and the Right to Health Care*, 12 U. PA. J. CONST. L. 1325 (2010).

⁷⁵ *Id.* at 1392-93.

⁷⁶ See generally Huberfeld, *supra* note 61; Moncrieff, *The Supreme Court's Assault on Litigation Why (and How) it Could be Good for Health Law*, 90 B.U. L. REV. 2323 (2011). [hereinafter, Moncrieff, *Assault on Litigation*]

⁷⁷ *Id.* See also Erwin Chemerinsky, *Closing the Courthouse Doors to Civil Rights Litigants*, 5 U. PA. J. CONST. L. 537, 537-39 (2003) (describing ways the Rehnquist Court limited private rights of action).

⁷⁸ Huberfeld, *supra* note 61, at 447-48; Moncrieff, *Assault on Litigation*, *supra* note 76.

⁷⁹ Huberfeld, *supra* note 61, at 443-50.

⁸⁰ *Id.* at 417.

on 42 U.S.C. § 1983, a Civil Rights Act provision that accords a private right of action against government actors for “deprivation of any rights, privileges, or immunities secured by the Constitution and laws.”⁸¹

Scaling back this practice, a 2002 Supreme Court decision, *Gonzaga University v. Doe*, narrowed the use of § 1983 to seek remedy for individual harms.⁸² In *Gonzaga*, the Court barred individual § 1983 challenges for the violation of conditions of federal spending programs, under the theory that such conditions – set by the federal government for participating states to follow – do not create *individually-enforceable* rights.⁸³ Applying *Gonzaga*, most federal courts of appeal have rejected the use of § 1983 suits by Medicaid beneficiaries for enforcement of certain Medicaid provisions,⁸⁴ including the so-called “Equal Access Provision.”⁸⁵ This provision requires states to pay providers reimbursement rates sufficient to enlist adequate provider participation in Medicaid with the stated goal of guaranteeing that Medicaid patients have the same access to medical care as their privately-insured neighbors.⁸⁶ The appellate courts have reasoned that the Equal Access Provision establishes a contract between the federal government and participating states and does not create any individually-enforceable rights, as in *Gonzaga*.⁸⁷

With § 1983 causes of action unavailable to challenge state Medicaid reimbursement policies, beneficiaries and providers have attempted novel approaches to expand health care rights via litigation.⁸⁸ After the state of California cut Medicaid provider reimbursement rates by 10% in 2008 to address budgetary crisis, litigants claimed state reimbursement policies were inconsistent with Medicaid’s Equal Access Provision, a federal law, and thus void under the U.S. Constitution’s Supremacy Clause, which invalidates state laws in conflict with federal laws.⁸⁹ The Supreme Court recently remanded this case on other grounds, not reaching a decision on the standing issue but suggesting hostility to the Supremacy Clause standing arguments.⁹⁰

As with public insurance, the Supreme Court has foreclosed many individual rights of action to remedy harms arising from private insurance practices. A 2004 Supreme Court decision, *Aetna Health v. Davila*, prevented enrollees in employer plans from suing insurers in state court for harms resulting from denials of coverage, by interpreting ERISA’s provision on remedies (§ 502)⁹¹ to preempt these state causes of action.⁹² Those injured by utilization review activities, insurance company review of requests for medical treatment under a policy, can still seek remedy in federal court under § 502, but remedies under § 502 do not include compensatory damages for harms or punitive damages, as available under state law.⁹³ This means that if an insurer denies a benefit under an employer plan as not “medically necessary,” and the insured, as

⁸¹ 42 U.S.C. § 1983 (2012); *Maine v. Thiboutot*, 448 U.S. 1 (1980) (articulating the use of § 1983 to challenge statutory violations).

⁸² 526 U.S. 273 (2002) (finding no individual cause of action to challenge the Family Educational Rights and Privacy Act, which protects the privacy of student education records).

⁸³ Huberfeld, *supra* note 61, at 434.

⁸⁴ See Moncrieff, *Assault on Litigation*, *supra* note 76 at 2333.

⁸⁵ 42 U.S.C. § 1396a(a)(30) (2012).

⁸⁶ *Id.*

⁸⁷ Huberfeld, *supra* note 61, at 447-48; Moncrieff, *Assault on Litigation*, *supra* note 76, at 2332-33.

⁸⁸ *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1207 (2012).

⁸⁹ *Id.* See also Sara Rosenbaum, *Equal Access for Medicaid Beneficiaries – the Supreme Court and the Douglas Cases*, 365 NEW ENG. J. MED. 2245 (2011).

⁹⁰ *Douglas*, 132 S. Ct. 1204.

⁹¹ 29 U.S.C. § 1132(a) (2012).

⁹² 542 U.S. 200, 209 (2004).

⁹³ 29 U.S.C. § 1132(a)(1)(B)(2012).

a result, suffers serious injury or death, the only remedy is the cost of the denied medical care. This interpretation provides little counterweight to managed care companies' incentives to limit care to save money, if the worst that can happen in the subset of denials actually challenged court is that they are later obligated to pay for denied benefits.

The one case in which both publicly and privately insured have recourse through litigation is to vindicate contractual claims if wrongly denied eligibility or medical items or services that are arguably within the scope of enumerated benefits. For example, beneficiaries can still bring § 1983 challenges for violations of Medicaid's "Reasonable Promptness Provision," limiting wait times to access covered services, and the "Minimum Services Provision," requiring states to provide beneficiaries services for which they are eligible, because both provisions have been interpreted as creating individually-enforceable rights.⁹⁴ Medicare beneficiaries have access to administrative appeals and, if they exhaust the administrative process and the amount in controversy is over USD \$1000, may challenge benefits or eligibility denials in federal court.⁹⁵ Such challenges, often seeking coverage of new technologies, drugs, and devices as "medically necessary," can unlock access to these items or services but more often than not fail, as courts usually defer to Medicare administrators' determinations.⁹⁶ Finally, for services that are not already covered, an individual may seek a "national coverage determination," a decision by the secretary of Health and Human Services to add coverage of a new item or service to Medicare benefits.⁹⁷

For private plans, even though a member of an employer plan cannot sue her insurer to remedy harms from utilization review, she can still challenge a benefits denial and, if successful, gain access to wrongfully denied benefits. First, she can bring a suit under § 502, as discussed above; however, courts are highly deferential to plan administrators, as they are to Medicare administrators.⁹⁸ Second, most states also have state external review statutes that require an independent review of plan utilization review decisions.⁹⁹ The Supreme Court determined these statutes survive ERISA preemption,¹⁰⁰ on the logic that reviews do not replace § 502 as the sole remedial provision; the court reasoned that decisions of external reviewers are only enforceable through a § 502 claim in federal court, in which the independent review serves as evidence.¹⁰¹ PPACA, however, attempts to reinvigorate and expand the reach of independent external reviews, by requiring that all health plan decisions be subject to a *binding* independent external review.¹⁰² Nonetheless, even if universal and binding, these external reviews provide, at best, access to benefits arguably covered within the terms of plan benefits.

In sum, the Supreme Court has limited private rights of action and remedies so that litigation is available only to vindicate contractual rights to covered medical care. Courts rarely expand access to health care beyond the explicit terms of coverage and generally do not hear cases attempting to challenge systemic barriers to care, such as low reimbursement rates. Thus, litigation can affirm the status quo and perhaps stretch it a bit, under broad interpretations of medical necessity, but it rarely pushes the bounds of access to health care beyond contractual

⁹⁴ Huberfeld, *supra* note 61, at 445-47.

⁹⁵ 42 U.S.C. § 1395ff (b) (2012).

⁹⁶ JOST, *supra* note 61, at 36, 40-41.

⁹⁷ *Id.* at 40.

⁹⁸ *Id.* at 42.

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¹⁰⁰ Rush Prudential HMO v. Moran, 536 U.S. 355 (2002).

¹⁰¹ *Id.* at 384. See also, Korobkin, *supra* note 40, at 528.

¹⁰² PPACA § 1001, 42 U.S.C. § 300gg-19 (2012).

terms.

PART 3: A RENEWED OPPORTUNITY FOR A RIGHT TO HEALTH CARE THROUGH HEALTH REFORM

In light of the constraints on litigation, legislation is proving a more successful pathway for an evolving right to health care in the U.S. Starting with the creation of Medicare and Medicaid, continuing with the federal and state regulations that increase risk pooling and thus promote more equitable access to care among members of a group health plan, discussed above, and most recently with PPACA, legislation has offered incremental steps toward a more robust notion of a right to health care. Each statute defines a new baseline for guarantees to medical care. With the initial statutory suggestion of a more ambitious baseline, some portion of the public often recoils but then, over time, largely adjusts to the new conception. For example, while Medicare was only slightly more favored than not at its passage, it is now one of the most popular U.S. social welfare programs with 90% approval ratings.¹⁰³ At a time when Americans agree on little, most support Medicare and the notion that the elderly *should* have affordable access to good health care.¹⁰⁴

PPACA offers an opportunity to advance a more expansive baseline conception of a right to health care for the non-elderly in two main ways. First, PPACA attempts to increase access to insurance by regulating private insurance markets to serve social ends and by expanding public coverage. Second, once coverage is more universal, it aims to make it meaningful, by more tightly regulating the content of all health insurance – public and private. Embodied in this expansion of coverage and benefits is an implicit conception of what risks should be shared more collectively. In other words, PPACA redefines who should have a right to care and the core of what this right must contain.

A. Expanding Access

PPACA's central goal is to make insurance available and affordable for many of the 50 million uninsured Americans, which can be seen as supporting a right to access health care through insurance for most Americans.¹⁰⁵ One key way PPACA actualizes this goal is by regulating private insurance, in particular the individual market. PPACA's regulation of the individual market for health insurance eliminates many of the mechanisms insurers previously relied upon to select healthier applicants and limit risk pooling. For example, PPACA requires that insurers must issue coverage to all applicants ("guaranteed issue")¹⁰⁶ and prohibits them from excluding coverage of preexisting conditions.¹⁰⁷ Further, it prohibits most discrimination in pricing based on health status, by limiting the factors on which premiums for a policy may vary to only four: age (allowing variation up to a ratio of 3:1); geography; family size; and tobacco use status (allowing variation up to a ratio of 1.5:1).¹⁰⁸ Permitting continued rating on these

¹⁰³90% of Americans support Medicare and nearly 90% support Social Security. Taylor Humphrey, *The Harris Poll: Medicare, Crime-fighting, Social Security, Defense – the Most Popular Federal Government Services*, HARRIS INTERACTIVE (2010).

¹⁰⁴ Support may not ensure survival, as evinced by Vice-Presidential candidate Paul Ryan's proposal to dismantle the Medicare program.

¹⁰⁵ It also addresses health care delivery and public health infrastructure. See Howard K. Koh & Kathleen G. Sebelius, *Promoting Prevention Through the Affordable Care Act*, 363 NEW ENG. J. MED. 1296, 1296-97 (2010).

¹⁰⁶ PPACA § 1201, 42 U.S.C. § 300gg (2012).

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

factors suggests a right to health care is not absolute and that smoking or living in an area with expensive care, for example, could qualify this right. These rules, however, make individual market policies more universally accessible and affordable, by requiring more even distribution of health risks among all individually insured, as has been the case previously for members in a group plan. PPACA also attempts to make it easier for people to find and purchase these newly-regulated private policies, by directing establishment of a state-based system of “exchanges” for individuals and small groups.¹⁰⁹

In conjunction with easing access, the law requires that most Americans carry health insurance, through a provision that has become known (and loved or hated) as the “individual mandate.”¹¹⁰ The individual mandate requires all Americans carry “minimum essential coverage,” defined as the level of coverage provided by most employer and exchange plans, or else pay a “shared responsibility payment” – a tax penalty, the amount of which is determined based on income but cannot exceed the average price of a bare-bones insurance policy on the exchange.¹¹¹ Some are exempted from the mandate and penalty for reasons including religious objection or affordability, defined as when premiums cost over eight percent of household income.¹¹² Nonetheless, the mandate will prevent adverse selection, or the tendency of healthier people to opt out of buying coverage, especially because new guaranteed issue and community rating requirements enable them to buy in later with impunity if their health worsens. The mandate nudges both healthy and sick to buy coverage, thus diversifying risk pools and moderating premiums. The mandate can be thought of as requiring all Americans take part in this evolving system, some by financing care for those in their risk pools for others who are less lucky or healthy.

Furthermore, to make coverage affordable for lower-income individuals, PPACA offers two solutions. First, it creates federal premium subsidies on a sliding scale for private insurance purchase by those who earn up to 400% of the FPL and do not have access to either Medicaid or an “adequate” and “affordable” employer plan.¹¹³ Second, in order to cover the lowest-income Americans, PPACA expands eligibility for Medicaid to individuals earning up to 133% of the FPL, regardless of their age, health status, or family status, beginning in 2014,¹¹⁴ growing this existing pocket of a right to health care for the poor to more people. The Congressional Budget Office initially predicted this Medicaid expansion would include about 17 million additional enrollees by 2021,¹¹⁵ but subsequently lowered its estimates by about 6 million because of the Supreme Court decision on the Medicaid expansion, discussed below.¹¹⁶

B. New Mandated Benefits and Cost-Sharing Limits

In addition to making insurance more accessible and affordable, PPACA creates new

¹⁰⁹ *Id.* § 1311(b), 42 U.S.C. § 18031(b) (2012).

¹¹⁰ *Id.* § 1501, 26 U.S.C. § 5000A (2012).

¹¹¹ *Id.*

¹¹² *Id.*

¹¹³ Adequate is defined as actuarial value of at least 60% and affordable is when the employee’s share of premium cost is under 9.5% of income. PPACA § 1401, 26 U.S.C. § 36B (2012) (providing for “premium tax credits”); *id.* § 1402, 42 U.S.C. § 18071 (2012) (providing for “cost-sharing reductions”).

¹¹⁴ *Id.* § 2001, 42 U.S.C. § 1396a(k) (2012).

¹¹⁵ CONG. BUDGET OFFICE, CBO’S ANALYSIS OF THE MAJOR HEALTH CARE LEGISLATION ENACTED IN MARCH 2010 18 (2011) [hereinafter CBO 2011 ANALYSIS].

¹¹⁶ CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION TABLE 1 (2012) [hereinafter CBO 2012 ESTIMATE].

substantive requirements for covered benefits and policy terms, especially in the individual market but also to some degree for Medicare and Medicaid. These requirements give definition to the meaning of this expanded right to health care, creating a more consistent baseline of coverage among all insured. In essence, PPACA implicitly asserts what is substantively core to an American right to health care.

PPACA's coverage regulations do not apply uniformly to all insurance plans but should nonetheless address the greatest sources of current variability in benefits among different types of plans. For example, as part of the compromise necessary to enact the law, plans in place before September 23, 2010 are considered "grandfathered"¹¹⁷ and exempted from certain PPACA regulations so long as they make only limited changes to existing benefits and cost-sharing structures.¹¹⁸ But it is expected that many plans will relinquish grandfathered status over time and become bound by more of PPACA's regulations.¹¹⁹

One key substantive policy is a new floor of mandated benefits for non-grandfathered health plans sold in the individual or small group markets. These "Essential Health Benefits" (EHBs) include categories such as emergency services, mental health and substance use disorder services, prescription drugs, and rehabilitative services and devices.¹²⁰ New Medicaid enrollee plans must also cover EHBs.¹²¹ Large group and self-insured employer plans are not required to cover EHBs,¹²² but since most of these plans already do cover them, the regulations in effect align other plans with these large group policies.¹²³

In addition, all non-grandfathered health insurance plans must cover certain preventive care without any cost-sharing obligations, such as screenings for breast, cervical, and colorectal cancer or alcohol-misuse and tobacco-use counseling. First dollar coverage can be understood as defining certain services as so central to a right to health care that insurance should cover them in full to ensure everyone access.¹²⁴ As of March 2011, PPACA also eliminated copayments for certain preventive services for Medicare and Medicaid beneficiaries.¹²⁵ PPACA is expected to result in first-dollar coverage of preventive services for about one-half of all Americans by 2013, and more over time as plans relinquish grandfathered status.¹²⁶

Finally, the law restricts the total cost sharing a plan might impose on an insured in order to avoid erosion of insurance plan value through cost shifting. The law caps annual out-of-pocket limits for *all* private health insurance policies.¹²⁷ These caps are set at the dollar value limits in the tax code for allowable out-of-pocket spending for high-deductible health plans,¹²⁸

¹¹⁷ PPACA § 1251, 42 U.S.C. § 18011 (2012).

¹¹⁸ *Id.* See also Preservation of Right to Maintain Existing Coverage, 45 C.F.R. § 147.40 (2010).

¹¹⁹ Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 41,726, 41,732 (July 19, 2010) (estimating the number of people in grandfathered plans) [hereinafter Interim Final Rules for Preventive Services].

¹²⁰ PPACA § 1302, 42 U.S.C. § 18022(b)(1) (2012). The Secretary of Health and Human Services must define which benefits must be covered under each of these broad categories.

¹²¹ *Id.* § 2001, 42 U.S.C. § 1396a(k)(1) (2012).

¹²² *Id.* § 1201, 42 U.S.C. § 18022 (2012).

¹²³ PPACA § 1302, 42 U.S.C. § 18022(b)(2)(A) (2012).

¹²⁴ *Id.* § 1001, 42 U.S.C. § 300gg-13 (2012); See Interim Final Rules for Preventive Services, *supra* note 119, at 41,741-41,743; Koh & Sebelius, *supra* note 105, at 1296-97.

¹²⁵ PPACA §§ 4104-4108, 42 U.S.C §§ 1395-1396 (2012); see also DENAVAS-WALT ET AL, *supra* note 14, at 71 tbl.C-1 (reporting ninety-three million Americans had public health insurance in 2009).

¹²⁶ 78 million in non-grandfathered plans plus 90 million publically insured will initially be covered.

¹²⁷ PPACA § 1302(c), 42 U.S.C § 18022(c) (2012).

¹²⁸ *Id.*; I.R.C. § 223(c)(2)(A)(ii) (2011).

which were USD \$6,050 for individual and USD \$12,100 for family coverage in 2012.¹²⁹ In addition, PPACA prevents certain health plans from imposing annual or lifetime spending limits on EHBs.¹³⁰ Finally, all plans offered by an insurer participating in a state exchange must have at least a 60% actuarial value with respect to EHBs, even for policies sold by that insurer outside of the exchange,¹³¹ meaning that the plan must pay on average for 60% of total expenses for EHBs covered under a policy. These restrictions on out-of-pocket spending ensure that insurance coverage will indeed finance a significant part of covered benefits so that beneficiaries will be able to afford and access medical care, even in cases when their medical needs are intensive.

All of these changes, together, redefine private markets as a situ for realizing more equitable access to medical care. The law requires that private insurance policies be widely available, reasonably priced, and high-value, and then provides subsidies for low-income enrollees to buy them. As was previously the case for public insurance, private insurance will take on more of the characteristics found in social insurance programs of other countries, such as tax-based financing, broad risk spreading, and access to a fairly rich range of benefits with limited cost sharing.¹³² With greater similarities between the functions and characteristics of public and private coverage, the lines between and the goals of each may start to blend – both in effect and perhaps in the public’s imagination. Both become key parts of a plan to guarantee a more equitable right to health care among Americans.

C. Limitations of PPACA

PPACA attempts to accomplish a significant expansion in health care equity, but it falls short in several respects. As noted above, even PPACA’s provisions that serve to reshape private market coverage apply to only some policies and some benefits. In addition, PPACA ensures access to insurance, not necessarily to medical care, and could result in shortages of available physicians to treat the newly insured,¹³³ as occurred in Massachusetts after the state enacted a similar coverage expansion in 2006.¹³⁴ Medicaid enrollees might have particular difficulty accessing care if providers, especially specialists, increasingly refuse to care for patients because of low reimbursement rates.¹³⁵

Finally, the reform does not realize a universal right. The Congressional Budget Office (CBO) estimates the law will insure about 30 million more Americans within a decade; yet, millions will remain uninsured.¹³⁶ Future uninsured include about one-third “unauthorized immigrants,” who are ineligible for Medicaid or subsidies through the exchanges, one-quarter of individuals eligible for Medicaid who do not enroll, and those who are exempted from or choose not to comply with the individual mandate.¹³⁷ Despite these limitations, PPACA does take a

¹²⁹ Internal Revenue Service, REV. PROC. 2011-32, at <http://www.irs.gov/pub/irs-drop/rp-11-32.pdf> (2012).

¹³⁰ PPACA § 1001, 42 U.S.C. § 300gg-11 (2012). “Grandfathered” plans are subject to the lifetime limit rule but not the annual limit rule. Self-funded plans are subject to both.

¹³¹ PPACA § 1302, 42 U.S.C § 18022(d) (2012) (describing levels of coverage available on an exchange).

¹³² Richard B. Saltman, *supra* note 19, at 3.

¹³³ Suzanne Sataline & Shirley S. Wang, *Medical Schools Can’t Keep Up*, WALL ST. J., April 12, 2010.

¹³⁴ Robert Pear, *Shortage of Doctors an Obstacle to Obama Goals*, N.Y. TIMES, April 26, 2009, at A1; MASSACHUSETTS MEDICAL SOCIETY, PHYSICIAN WORKFORCE STUDY: SEPTEMBER 2009 2-3 (2009).

¹³⁵ See e.g., Joanna Bisgaier & Karin Rhodes, *Auditing Access to Specialty Care for Children with Public Insurance*, 364 NEW ENG. J. MED. 2324 (2011) (finding more appointment denials and longer wait times at specialty clinics for children with Medicaid or CHIP, as compared to privately insured).

¹³⁶ CBO 2012 ESTIMATE, *supra* note 116, at Table 1; CBO 2011 ANALYSIS, *supra* note 115, at 18.

¹³⁷ CBO 2011 ANALYSIS, *supra* note 115, at 1-2.

significant step toward defining a vision for an emerging, albeit not fully realized, right to health care.

PART 4: TESTING THIS VISION FOR AN EMERGING RIGHT TO HEALTH CARE IN THE COURTS OF LAW AND PUBLIC OPINION

Unsurprisingly, in light of the way PPACA alters the distribution of health resources and challenges basic assumptions of private market ordering, the law has prompted early backlash and challenges in both the court of public opinion and courts of law. PPACA has by no means captured the American imagination yet (and may never do so). At any point from the time of passage until now, no more than half of Americans viewed the reform favorably,¹³⁸ although most of its policies, when viewed individually, are highly popular.¹³⁹ Some commentators went as far as to blame PPACA for the Democratic Party's loss of majority control of the House of Representatives in the 2010 mid-term Congressional elections, which occurred shortly after its passage;¹⁴⁰ even if only partially true, such claims reflect the perception of strong negative reactions to the law.

A. Legal Challenges

For the law to have any chance of having a longer impact, it first had to withstand legal challenges. Ironically, in light of the past insignificance of courts in shaping a right to health care in the U.S., the courts took on a critical role: either ratify or veto PPACA's vision of an emerging right to health care. The Supreme Court had the final word and chose to ratify it (mostly).¹⁴¹

The pieces of the law under assault were, not surprisingly, the Medicaid expansion and the individual mandate, two foundational policies for setting new baselines.¹⁴² In fact, the individual mandate is often referred to as the "lynchpin" of the private insurance market reforms because of its role in preventing adverse selection and creating more heterogeneous risk pools, as discussed above.

The challengers claimed that these two provisions of the law were enacted without proper Congressional authority. The states' challenge to the Medicaid expansion succeeded in part. Under a "coercion and commandeering" theory, half of the states claimed that PPACA's Medicaid policies placed untenable conditions on the states.¹⁴³ The Supreme Court has held in the past that Congress can condition states' receipt of federal funds so long as the conditions are unambiguous and don't rise to the level of compulsion.¹⁴⁴ The states claimed the requirement for a state to cover all individuals up to 133% of the FPL or lose *existing* Medicaid funding rises to

¹³⁸ Kaiser Health Tracking Poll: Views of Health Reform Law Remain Unchanged, THE HENRY J. KAISER FAMILY FOUNDATION (2011), at <http://healthreform.kff.org/scan/2011/may/may-kaiser-health-tracking-poll-views-of-health-reform-law-remain-unchanged.aspx> (last visited Jul 27, 2012).

¹³⁹ Michael J. Saks, What Do Polls Really Tell Us About The Public's Views of The Affordable Care Act?, Health Affairs Blog, at <http://healthaffairs.org/blog/2012/09/21/what-do-polls-really-tell-us-about-the-publics-view-of-the-affordable-care-act/> (September 21, 2012).

¹⁴⁰ See, e.g., Jonathan Weisman, *Loyalty to Obama Costs Democrats*, WALL ST. J., September 30, 2010.

¹⁴¹ Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

¹⁴² CBO 2011 ANALYSIS, *supra* note 115, at 18.

¹⁴³ Florida *ex rel.* Bondi v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256 (N.D. Fla. 2011).

¹⁴⁴ South Dakota v. Dole, 483 U.S. 203 (1987).

the level of compulsion.¹⁴⁵ In other words, they claimed states had no choice but to expand their programs.

Although the expansion will be mostly federally funded (90-100% in the first decade), it does place burdens on the states, particularly given how thinly stretched states' budgets have been throughout the recent recession. Most importantly, to qualify for federal expansion funding, PPACA requires states to maintain pre-reform eligibility standards ("maintenance of effort").¹⁴⁶ Furthermore, it requires a state to pay its full matching share for new enrollees who had been eligible under old rules but had not previously enrolled. Finally, the federal share of expansion funding could decrease over time, leaving states responsible for a growing share of the costs.

In a decision surprising to many, the Supreme Court agreed with the states' arguments, striking the provision of the law that would strip states of existing federal Medicaid funding if they failed to expand eligibility to 133% of FPL. No lower federal court had found these arguments compelling. Even a conservative judge dismissed the Medicaid claim as having "simply no support."¹⁴⁷ Nonetheless, the Supreme Court found the fact that states would lose all existing funding if opting against the expansion to rise to the level of compulsion.¹⁴⁸ The remedy, however, was mild. The court simply struck the provision that said that states that failed to expand would lose current federal funding, leaving the rest of the expansion and related conditions intact.¹⁴⁹ The result is that states can keep their current programs and decline federal money for expansion or expand in compliance with all of the conditions in the law and get the federal expansion funding. Because of the high value of the federal matching dollars, most states are expected to expand eligibility,¹⁵⁰ despite early grumbling to the contrary.¹⁵¹

Also unexpected by many, the individual mandate survived completely unscathed.¹⁵² Furthermore, its survival turned on a different legal argument and court majority than anticipated. The challengers – uninsured individuals, a federation of small businesses, and 26 states – asserted that Congress didn't have the authority under its enumerated powers to compel individuals to buy insurance they would not have otherwise purchased. In contrast, the Administration argued that Congress had the power under its authority (1) to regulate interstate commerce ("Commerce Clause" power), (2) to use means necessary and proper to carry out enumerated powers; and (3) to tax and spend for the general welfare.

Most observers thought if the mandate survived it would be based on the Commerce Clause power, which was the argument favored by lower federal courts, scholars, and commentators, as well as explicitly asserted by Congress in the text of PPACA as the grounds for its authority.¹⁵³ The Commerce Clause power provides that Congress can regulate activities

¹⁴⁵ See I. Glenn Cohen & James Blumstein, *The Constitutionality of the ACA's Medicaid-Expansion Mandate*, 366 NEW ENG. J. MED. 103 (2012).

¹⁴⁶ PPACA § 2001, 42 U.S.C. § 13966(y)(2)(A) (2012).

¹⁴⁷ See *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256 (N.D. Fla. 2011).

¹⁴⁸ *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2603 (2012)

¹⁴⁹ *Id.* at 2607.

¹⁵⁰ CBO 2012 ESTIMATE, *supra* note 116, at 9-11.

¹⁵¹ Michael Muskal, TEXAS REJECTS TWO PILLARS OF NEW FEDERAL HEALTHCARE OVERHAUL, LOS ANGELES TIMES (2012), <http://www.latimes.com/news/nation/nationnow/la-na-nn-texas-rejects-federal-healthcare-20120709,0,5870338.story> (last visited Jul 25, 2012).

¹⁵² Amy Bingham, HEALTH CARE GAMES: THE ODDS ARE NOT IN OBAMACARE'S FAVOR, ABC NEWS (2012), http://abcnews.go.com/Politics/OTUS/health-care-games-odds-obamacares-favor/story?id=16652833#.T_v19fVKU1Q (last visited Jul 25, 2012).

¹⁵³ PPACA § 1501(a), 42 U.S.C. § 18091 (2012).

when it has a “rational basis” to conclude that the activities “taken in the aggregate, substantially affect interstate commerce.”¹⁵⁴ The plaintiffs argued that the Commerce Clause power does not allow Congress to regulate *inactivity*. That is, an individual’s decision *not* to purchase insurance is not activity contemplated by the Commerce Clause’s legislative reach. The lower federal courts came to mixed decisions on this argument.¹⁵⁵

In a decision surprising to many, based on lower court decisions and general buzz, the court rejected the Commerce Clause argument,¹⁵⁶ agreeing with the plaintiffs’ inactivity/activity distinction, but found the mandate constitutional under Congress’s taxing power.¹⁵⁷ To come to this decision, the court had to find that the mandate, which was called a “penalty” in PPACA, is in fact a tax. It did so based on the fact that the mandate is directed at taxpayers and the enforcement mechanism occurs through the tax system, to the dismay of some Democrats who for political reasons resisted the characterization of the mandate as a new tax.¹⁵⁸

Not only was the legal reasoning unexpected, but the makeup of the majority also came as a surprise. Many anticipated Justice Kennedy to cast the deciding vote;¹⁵⁹ Chief Justice Roberts instead played this role, joining with the four liberal Justices to uphold the mandate, despite his own conservative leanings. Although it is impossible to know why Roberts upheld the mandate, some posit he was balancing a long-term strategy to erode Congress’ Commerce Clause power with a short-term desire to protect the institutional integrity of the Court, which might have been compromised if the court overturned a major social reform law in a seemingly political decision. Regardless of his motivation, the court affirmed a law that serves to expand more meaningful insurance coverage to over 30 million more Americans.

Thus, the Supreme Court, which has historically played little role in defining or defending a right to health care, has now validated a law that envisions a much broader conception of a right to health care in the U.S. This law – for both normative and political reasons – divided the Supreme Court in charged and unexpected ways. Yet, it survived, perhaps foreshadowing a similar battle ahead in the court of public opinion. Professor Jack Balkin asserted that the court affirmed a new social contract, legitimating the most major change in U.S. social policy by Congress in decades.¹⁶⁰ The open question is whether Americans will eventually accept and perhaps even embrace this social contract.

B. An Opportunity to Build Consensus in the Court of Public Opinion

Formal law, even if validated by the Supreme Court, does not necessarily lead to a change of consciousness among Americans, but it does redefine the status quo and offer a different way to think about insurance institutions. If the law survives continued legal challenges throughout implementation, political calls for repeal, and Americans’ current ambivalence, as

¹⁵⁴ *Gonzalez v. Raich*, 545 U.S. 1, 22 (2005).

¹⁵⁵ For summary of litigation in federal courts, see ACA Litigation Blog, <http://acalitigationblog.blogspot.com/> (last accessed Sept. 15, 2012).

¹⁵⁶ *Nat’l Fed’n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2591 (2012).

¹⁵⁷ *Id.* at 2598. See Jack M. Balkin, TAX POWER: THE LITTLE ARGUMENT THAT COULD - CNN.COM (June 30, 2012), at <http://www.cnn.com/2012/06/28/opinion/balkin-health-care/> (last visited Jul 19, 2012).

¹⁵⁸ *Id.*

¹⁵⁹ Greg Stohr, KENNEDY’S PIVOTAL VOTE FOCUSES ON FREEDOM AS COURT RULING LOOMS (June 13, 2012), <http://www.bloomberg.com/news/2012-06-14/kennedy-s-pivotal-vote-focuses-on-freedom-as-court-ruling-looms.html> (last visited Jul 19, 2012).

¹⁶⁰ Jack M. Balkin, *The Court Affirms Our Social Contract*, THE ATLANTIC, June 29, 2012, available at <http://www.theatlantic.com/national/archive/2012/06/the-court-affirms-our-social-contract/259186/>.

discussed below, it has the potential to begin to reshape public conceptions about the appropriate level of access to medical care for all Americans.

In particular, PPACA, over time, could change what Americans expect from private health insurance. In the past, private insurance, especially in the individual market, operated so that market forces allocated access to medical care on the basis of ability and willingness to pay. PPACA redefines private insurance so that it becomes a locus for more affordable and meaningful coverage and thus asserts that health insurance markets are fundamentally different than other private markets.

In light of these transformative changes to the private insurance system and the expansion of public coverage, it is possible that Americans might embrace – or at least accept – the idea that public and private insurance can and should work together to ensure greater health care equity. PPACA asks all Americans to adopt and participate in a system of financing where those who need medical care can access it. This law could help develop a new norm of universal access to care and broader sharing of health resources, as commonly exists in countries with universal coverage.¹⁶¹ The universal social insurance programs of Medicare and Social Security have only become more popular over time as Americans see the benefit of such programs for themselves, friends, or family members.¹⁶² PPACA creates the structure for a solidarity-based system of health care financing for all Americans. The question is whether the public consciousness will grow to accept this solidaristic norm and support a notion of sharing of health resources more collectively or whether, conversely, the law will face sustained backlash that could erode support for health solidarity. My hopes are that it will create a slow evolution toward the former over time. Of course, even if it succeeds in doing so, as many of the other chapters of this book illustrate, universal access invites second order problems, including managing costs and contentious battles over allocation of resources (i.e. rationing).

CONCLUSION

Even though Americans lack strong ground on which to make legal claims to a right to health care, legislation, including PPACA, has advanced the development of this right. PPACA establishes a structural and conceptual foundation for a broader sharing of health resources. In a country where a fragmented insurance system has resulted in inequitable access to medical care, and where private insurance excluded millions, private insurance might ironically become a strong thread in a more solid fabric of equitable coverage. PPACA's regulation of private insurance recasts it as a market supporting a social mission so that health insurance – public and private alike – can become a foundation for greater health care equity. If enduring, the law has the potential to shape how Americans experience and conceptualize health care rights and the role of public and private insurance in supporting such rights.

To many, the reform is too modest. Some will remain uninsured or underinsured. Even with insurance, some Americans might lack access to health care. And costs will continue to rise, putting increasing pressure on the system. While clearly not the end of the story, PPACA is nonetheless an important chapter, outlining a vision for an emerging American right to health care. The question remains whether public consciousness will follow this vision and whether Americans might eventually espouse widespread support for a right to health care.

¹⁶¹ Saltman, *supra* note 19, at 3.

¹⁶² See *supra* note 103.