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### Rights to Health Care in the United States: Inherently Unstable

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# Rights to Healthcare in the United States: Inherently Unstable

David Orentlicher<sup>†</sup>

## I. INTRODUCTION

Although international covenants have long recognized a fundamental right to healthcare,<sup>1</sup> and other countries provide healthcare coverage for all of their citizens, rights to healthcare in the United States have been adopted only grudgingly, and in a manner that is inherently unstable.<sup>2</sup> While a solid right to healthcare would provide much benefit to individuals and society, the political and judicial branches of the U.S. government have granted rights that are incomplete and vulnerable to erosion over time.<sup>3</sup>

Unfortunately, enactment of the Patient Protection and Affordable Care Act (ACA) does not change these fundamental weaknesses in the regime of U.S. healthcare rights. Millions of Americans will remain uninsured after ACA takes full effect, and rather than creating a more stable right to healthcare, ACA gives unstable rights to more people. As a result, even if ACA survives its constitutional challenges, access to healthcare still will be threatened by the potential for attrition of the rights that ACA provides.

## II. CONSTITUTIONAL RIGHTS

Historically, rights to healthcare in the United States have been weak because courts have rejected the possibility of “positive” rights under the Constitution.<sup>4</sup>

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<sup>1</sup> Eleanor D. Kinney, *Recognition of the International Human Right to Health and Health Care in the United States*, 60 RUTGERS L. REV. 335, 338-39 (2008) (describing the right to healthcare in the 1948 constitution of the World Health Organization and in the 1948 Universal Declaration of Human Rights).

<sup>2</sup> See *id.* at 348-52 (discussing debate over whether U.S. federal government should sponsor national health insurance legislation, including President Truman’s and President Clinton’s efforts for health reform).

<sup>3</sup> See James Monroe, *American Political Culture and the Search for Lessons from Abroad*, 15 J. HEALTH POL. POL’Y & L. 129 (1990), for a summary of the impact of American political culture and institutions on health policy.

<sup>4</sup> *Wideman v. Shallowford Cmty. Hosp.*, 826 F.2d 1030, 1033 (11th Cir. 1987) (“The Constitution is ‘a charter of negative rather than positive liberties.’”) (quoting *Jackson v. City of Joliet*, 715 F.2d 1200, 1203 (7th Cir. 1983)).

Rather, constitutional rights are largely limited to “negative” rights.<sup>5</sup> In other words, while the Constitution may preclude government from interfering with the autonomous choices of people, it does not require government to facilitate the exercise of individual autonomy.<sup>6</sup> Thus, for example, legislatures may not prohibit women from obtaining an abortion before their fetuses are viable, but they need not provide funding for women who cannot afford the cost of an abortion.<sup>7</sup> Similarly, legislatures may not prevent patients from receiving treatment for their illnesses or injuries, but nothing in the Constitution imposes a duty on government to ensure that patients can in fact obtain needed care.<sup>8</sup>

To be sure, a duty to provide healthcare attaches when the government confines people in prisons, psychiatric facilities, or other institutions, since the individuals are not free to seek healthcare on their own.<sup>9</sup> But for most people, the Constitution is not helpful.<sup>10</sup> Accordingly, when people are unable to afford medical treatment, they have had to rely on common law or statutory rights to healthcare.<sup>11</sup>

### III. STATUTORY RIGHTS TO HEALTHCARE

#### A. THE GRUDGING NATURE OF U.S. HEALTHCARE RIGHTS

Statutory rights are the primary source of rights to healthcare in the United States, but they have been adopted only grudgingly.<sup>12</sup> Consider, for example, the history of Medicare and Medicaid.

##### 1. The Passage of Medicare and Medicaid

Medicare and Medicaid grew out of a five-decade history of efforts to enact national health insurance in the United States.<sup>13</sup> The effort began around 1912 during the Progressive Era.<sup>14</sup> Germany and other European countries had adopted

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<sup>5</sup> *Id.*

<sup>6</sup> *Id.* (“[The Constitution] tells the state to let people alone; it does not require the federal government or the state to provide services . . .”) (quoting *Bowers v. DeVito*, 686 F.2d 616, 618 (7th Cir. 1982)).

<sup>7</sup> *Harris v. McRae*, 448 U.S. 297 (1980)

<sup>8</sup> *Wideman*, 826 F.2d at 1033. As the abortion example indicates, a refusal by government to provide coverage for care can effectively mean a denial of care. Medicare policy also illustrates this connection between funding and access. If the Medicare program decides not to reimburse physicians for a particular treatment, the treatment will not be available for the great majority of Medicare recipients. *Cf.* *N.Y. State Ophthalmological Soc’y v. Bowen*, 854 F.2d 1379 (D.C. Cir. 1988) (preventing physicians from billing Medicare recipients for the cost of an assistant surgeon during cataract surgery without prior approval by the Medicare program).

<sup>9</sup> MARK A. HALL, MARY ANNE BOBINSKI & DAVID ORENTLICHER, *HEALTH CARE LAW AND ETHICS* 120 (7th ed. 2007) (discussing institutional responsibilities of mental hospitals).

<sup>10</sup> *Wideman*, 826 F.2d at 1032 (“[W]e can discern no general right, based upon either the Constitution or federal statutes, to the provision of medical treatment and services by a state or municipality.”).

<sup>11</sup> See HALL, BOBINSKI & ORENTLICHER, *supra* note 9, at 120 n.5.

<sup>12</sup> A number of states recognized a right to receive emergency care at a hospital by common law. *Id.* at 106-09, 114.

<sup>13</sup> See JONATHAN OBERLANDER, *THE POLITICAL LIFE OF MEDICARE* 18-22 (2003), for a general discussion of national health insurance between 1912 and 1952.

<sup>14</sup> *Id.* at 18.

government healthcare plans by then,<sup>15</sup> and Teddy Roosevelt championed healthcare reform in his losing presidential campaign of 1912. When Roosevelt lost to Woodrow Wilson, the cause was taken up by the American Association for Labor Legislation, which supported healthcare coverage for industrial workers.<sup>16</sup> Interestingly, the national healthcare movement was supported by the American Medical Association (AMA) at that time.<sup>17</sup> Indeed, a committee of the AMA reasoned that physicians' "blind opposition, indignant repudiation, bitter denunciation of these laws is less than useless; it leads nowhere and it leaves the profession in a position of helplessness as the rising tide of social development sweeps over it."<sup>18</sup>

By 1920, the effort to enact government-sponsored coverage had stalled, in part because more conservative elements at the AMA led to a reversal of the association's support for government-sponsored healthcare coverage.<sup>19</sup> Opposition also came from the insurance industry, the pharmaceutical industry, employers, and labor unions.<sup>20</sup> (The labor leader Samuel Gompers apparently feared that benefits gained through legislation rather than negotiation would be vulnerable to later repeal or limitation.<sup>21</sup> He probably also felt that benefits won by negotiation would make workers more likely to support unions.<sup>22</sup>)

Timing often matters to the success of legislative reform, and opponents of a right to healthcare could exploit U.S. involvement in World War I against Germany and the Russian Revolution of 1917. Critics of national health insurance were able to discredit the policy by connecting it with Germany, which was the first country to enact a national healthcare plan.<sup>23</sup> The link to Russia and its right to healthcare allowed opponents to argue that national health insurance was a first step toward socialism.<sup>24</sup>

The next push for national health insurance came during the Franklin Delano Roosevelt administration, and the Social Security bill that was ultimately passed in 1935 originally included a provision for healthcare coverage.<sup>25</sup> The combination of physician opposition and the desire not to compromise the passage of Social Security, however, led FDR to drop his support for national health insurance.<sup>26</sup>

The Truman administration initiated the third effort for national health coverage, but the United States was embroiled in the Cold War, and the AMA again waved the flag of socialism to mobilize public opposition.<sup>27</sup> In addition to the AMA's important influence, Truman faced a recalcitrant Congress that at the time was dominated by a conservative coalition of Republicans and southern Democrats.<sup>28</sup>

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<sup>15</sup> Germany was the first country to establish a government plan, doing so in 1883. Other European countries followed, with England adopting a plan in 1911. *Id.* (citing RONALD NUMBERS, *ALMOST PERSUADED: AMERICAN PHYSICIANS AND COMPULSORY HEALTH INSURANCE* 11 (1968)).

<sup>16</sup> The American Association for Labor Legislation included academics, labor activists, and lawyers. *Id.*

<sup>17</sup> *Id.* at 19.

<sup>18</sup> *Id.* (citing ROBERT J. MYERS, *MEDICARE* 5 (1970)).

<sup>19</sup> *Id.* (citing BEATRIX HOFFMAN, *THE WAGES OF SICKNESS: THE POLITICS OF HEALTH INSURANCE IN PROGRESSIVE AMERICA* 2 (2001)).

<sup>20</sup> *Id.* at 19-20.

<sup>21</sup> THEODORE R. MARMOR, *THE POLITICS OF MEDICARE* 5 (2d ed. 2000).

<sup>22</sup> *Id.*

<sup>23</sup> OBERLANDER, *supra* note 13, at 18.

<sup>24</sup> *Id.* at 20.

<sup>25</sup> *Id.* at 21.

<sup>26</sup> MARMOR, *supra* note 21, at 5-6; OBERLANDER, *supra* note 13, at 20-21.

<sup>27</sup> OBERLANDER, *supra* note 13, at 21-22.

<sup>28</sup> MARMOR, *supra* note 21, at 8-9; OBERLANDER, *supra* note 13, at 21-22.

After four decades of failure to enact a universal healthcare program, advocates decided to refine their approach in the 1950s, and the strategy that ultimately led to the passage of Medicare and Medicaid was formulated.<sup>29</sup> Wilbur Cohen and I.S. Falk recognized that a health insurance plan focused on Social Security beneficiaries would be much easier to sell than a plan for all Americans.<sup>30</sup> By limiting its benefits to the elderly, Medicare could be portrayed as a program for people who met two important criteria:<sup>31</sup> they had greater need for healthcare coverage and they were especially deserving of public assistance.<sup>32</sup> Because of their age, seniors have relatively high medical costs—when Medicare was passed, average healthcare expenses for people sixty-five or older were twice the average expenses for younger persons.<sup>33</sup> At the same time, the elderly were less able to afford healthcare bills.<sup>34</sup> Medicare would kick in when people no longer were working and were experiencing a greatly reduced income.<sup>35</sup> Moreover, their reduced income did not reflect a lack of initiative or an attempt to exploit the system. Rather, they had made their contributions to society and moved into a well-deserved retirement.<sup>36</sup> Cohen and Falk further restricted their proposal by limiting it to hospital costs (and only sixty days of hospitalization a year).<sup>37</sup>

The Medicare proposal was refined further by making it a form of social insurance rather than public welfare. People qualified themselves and their spouses for Medicare in the same way that they qualified themselves and their spouses for Social Security—by making payments to the Social Security system during their working lives.<sup>38</sup> In other words, while a public assistance program for younger persons might stifle initiative and promote dependence, the Medicare program became available for persons who were not expected to be active workers and who in fact had earned their eligibility.<sup>39</sup> Medicare recipients would truly be “deserving” of their benefits.<sup>40</sup>

Still, even with a much narrower and politically more appealing range of coverage, it was not possible to pass Medicare until President Lyndon Johnson’s

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<sup>29</sup> OBERLANDER, *supra* note 13, at 22-23.

<sup>30</sup> Cohen later became Secretary of the U.S. Department of Health, Education and Welfare under President Lyndon Baines Johnson. Falk served in senior positions at the Social Security Administration and had a distinguished academic career at the University of Chicago and Yale University. See MARMOR, *supra* note 21, at 9 nn.2-3; *Isidore Sydney Falk*, SOCIAL SECURITY ONLINE: SOCIAL SECURITY HISTORY, <http://www.ssa.gov/history/ifalk.html> (last visited Feb. 25, 2012).

<sup>31</sup> OBERLANDER, *supra* note 13, at 23-24.

<sup>32</sup> *Id.*

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> *Id.* at 24.

<sup>36</sup> MARMOR, *supra* note 21, at 11-12; OBERLANDER, *supra* note 13, at 23-24.

<sup>37</sup> OBERLANDER, *supra* note 13, at 25.

<sup>38</sup> Medicare includes four major components. Part A covers hospital services and is financed by a payroll tax, equally shared by employers and employees. Currently, employers and employees each pay a payroll tax of 1.45% of the employee’s earnings. Part A is a mandatory program. KAISER FAM. FOUND., MEDICARE: A PRIMER 1, 14 (2010), available at [www.kff.org/medicare/upload/7615-03.pdf](http://www.kff.org/medicare/upload/7615-03.pdf). Part B covers physicians’ services, is voluntary (and taken by ninety-five percent of those who are eligible), and requires a monthly premium (which is deducted from Social Security payments). The monthly premium covers about twenty-five percent of costs, with the remainder covered by general federal revenues. *Id.* at 1-2, 14. Part C offers beneficiaries the option of receiving their care from a private Medicare Advantage healthcare plan. *Id.* at 1. Part D was added in 2006 and provides a prescription drug benefit. *Id.*

<sup>39</sup> MARMOR, *supra* note 21, at 15-16, 96.

<sup>40</sup> OBERLANDER, *supra* note 13, at 24-25.

landslide victory at the polls in November 1964.<sup>41</sup> With his election and the election of a strong majority of Democrats in Congress, conservative Republicans and southern Democrats were no longer able to block the legislation.<sup>42</sup>

By that time, a few proposals were being floated. There was the Cohen-Falk idea of hospital coverage for the elderly, with mandatory participation for workers (just as participation in the Social Security system is required).<sup>43</sup> Republicans offered a counterproposal for a voluntary program that would subsidize the purchase of comprehensive private insurance by the elderly.<sup>44</sup> The Republicans, then, drew three important contrasts with the Cohen-Falk proposal.<sup>45</sup> Their program would be optional rather than required, involve coverage by private companies rather than by government, and cover all medical services rather than just hospitalization.<sup>46</sup> The third main proposal came from the AMA and involved a federal-state program to subsidize the purchase of private health insurance for the elderly poor.<sup>47</sup> Like the Republicans, the AMA wanted a plan that was more reliant on the private sector.<sup>48</sup> The AMA also argued for a means-tested program, on the theory that the government should not be subsidizing healthcare coverage for elderly persons who could afford to purchase their own insurance.<sup>49</sup>

As healthcare reform worked its way through the legislative process, U.S. Representative Wilbur Mills, Chair of the Ways and Means Committee, came up with legislation that essentially combined the three proposals:<sup>50</sup>

The Cohen-Falk bill became Part A of Medicare, a mandatory program to cover hospital costs and that would be funded by employer and employee payroll taxes.<sup>51</sup>

The Republican proposal became Part B of Medicare, a voluntary program for physicians' services (funded by general revenues and individual premiums).<sup>52</sup>

The AMA proposal was modified from a proposal to cover the elderly poor to a program that would cover children and some adults under the age of sixty-five who were unable to afford private health care coverage.<sup>53</sup> Thus was born Medicaid.

## B. THE LIMITED NATURE OF FEDERAL HEALTHCARE STATUTORY RIGHTS

After more than fifty years, the United States finally came in 1965 to accept a right to healthcare, but even then it was a highly limited right. All seniors would be eligible for coverage under Medicare, and many of the poor would be eligible for

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<sup>41</sup> *Id.* at 29.

<sup>42</sup> MARMOR, *supra* note 21, at 56-57; OBERLANDER, *supra* note 13, at 29.

<sup>43</sup> OBERLANDER, *supra* note 13, at 24.

<sup>44</sup> Two-thirds of the costs would be covered by general revenues and one-third by individual premiums. *Id.* at 30.

<sup>45</sup> *Id.* at 30-31.

<sup>46</sup> *Id.* at 30.

<sup>47</sup> *Id.*

<sup>48</sup> *Id.*

<sup>49</sup> MARMOR, *supra* note 21, at 46-47.

<sup>50</sup> OBERLANDER, *supra* note 13, at 30-31.

<sup>51</sup> *Id.*

<sup>52</sup> *Id.*

<sup>53</sup> *Id.*

coverage under Medicaid.<sup>54</sup> But rather than recognizing a right to healthcare for all persons, Congress opted to enact a right for those who “deserved” such a right.<sup>55</sup>

As indicated, Medicare beneficiaries were seen as deserving of their new program because they had earned it through a lifetime of work and financial contributions.<sup>56</sup> The adoption of the Medicaid program illustrated another way in which Americans could be seen as deserving of healthcare coverage. Some people, it was thought, lacked health insurance through no fault of their own.<sup>57</sup> One could not blame children, for example, for their failure to afford coverage. Medicaid was enacted as a program for poor persons who did not seem responsible for their lack of insurance.<sup>58</sup> Children, single parents with children, and persons with disabilities would qualify if their family incomes fell below an eligibility threshold.<sup>59</sup> All of these persons were seen as not responsible for their predicament, either because of age or infirmity or because of their childcare obligations.<sup>60</sup>

Thus, while the public commonly thinks of the Medicaid program as providing universal coverage for the poor, it never was designed to insure all of the indigent. The Medicaid program requires coverage only for poor people who fall into one of the mandatory coverage categories (“categorical eligibility”).<sup>61</sup> The mandatory groups include pregnant women, children, parents with dependent children, and persons with serious disabilities.<sup>62</sup> Medicaid categories are defined not only by family status or disability, but also by income.<sup>63</sup> Thus, for example, children usually are covered when family incomes are no more than 200% of the federal poverty level, while parents may not be eligible even when family income is below fifty percent of the federal poverty level.<sup>64</sup>

Initially, Medicaid eligibility was tied to eligibility for one of the federal welfare programs (e.g., the old Aid to Families with Dependent Children, now Temporary Aid to Needy Families (TANF)).<sup>65</sup> Thus, Medicaid originally did not cover families where a father was in the home and working, and other than in a few states operating under Medicaid waivers, it still does not cover any able-bodied adults who do not have children.<sup>66</sup> With reforms in the Medicaid statute, states have been allowed to

<sup>54</sup> *Id.* at 31.

<sup>55</sup> *Id.* at 32. I use the term “deserving” not to indicate my own view, but to characterize what I believe is a real social ethic in the United States.

<sup>56</sup> *Id.* 23-24.

<sup>57</sup> *Id.* at 24.

<sup>58</sup> See Cindy Mann & Tim Westermoreland, *Attending to Medicaid*, 32 J.L. MED. & ETHICS 416, 418 (2004) (“The Medicaid program began by focusing narrowly on . . . children, their ‘caretaker relatives,’ and the ‘aged, blind and disabled’—all persons deemed too vulnerable to provide insurance for themselves.” (quoting Social Security Amendments of 1965, Pub. L. No. 980369, 98 Stat. 494 (codified as amended in scattered sections of 42 U.S.C.))).

<sup>59</sup> KAISER FAM. FOUND., MEDICAID: A PRIMER 8 (2010), available at <http://www.kff.org/medicaid/upload/7334-04.pdf> [hereinafter KAISER FAM. FOUND., MEDICAID].

<sup>60</sup> See Mann & Westermoreland, *supra* note 58, at 418.

<sup>61</sup> KAISER FAM. FOUND., MEDICAID, *supra* note 59, at 8.

<sup>62</sup> *Id.*

<sup>63</sup> *Id.*

<sup>64</sup> *Id.* at 8-9. Indigent seniors also qualify for Medicaid benefits to cover the costs of their Medicare premiums and co-payments.

<sup>65</sup> JONATHAN ENGEL, POOR PEOPLE’S MEDICINE: MEDICAID AND AMERICAN CHARITY CARE SINCE 1965, at 48 (2006). 42 U.S.C. § 1396u-1 creates the link between TANF and Medicaid. In addition to covering families with children and a single parent, the federal welfare programs also provide aid to the blind and others with permanent disabilities. *Id.* at 48. States have the option to extend Medicaid coverage to other poor persons, but their freedom to do so is limited. *Id.*

<sup>66</sup> *Id.* at 49; KAISER FAM. FOUND., MEDICAID, *supra* note 59, at 8, 12.

provide coverage to both adults in a two-parent family, and most states do so.<sup>67</sup> In 2014, barring a Supreme Court override of ACA, Medicaid finally will become a program for all of the poor (defined as families earning no more than 133% of the federal poverty level).<sup>68</sup>

Medicaid falls short of covering all of the poor for another reason; it has not covered many of those who are eligible for it. While virtually all seniors sign up for Medicare, many individuals who qualify for Medicaid fail to enroll.<sup>69</sup> As with other public benefit programs that are “means-tested,” Medicaid must screen applicants to make sure they qualify, and that can discourage people from filing for benefits.<sup>70</sup> Qualified persons may be unaware of their eligibility or find it difficult to navigate the application process.<sup>71</sup> The screening process can be daunting, especially for poorly educated persons. ACA will simplify the application process, but some persons eligible for public programs wish to avoid the embarrassment of being a recipient.<sup>72</sup> Having to rely on governmental benefits can be demeaning, and some individuals prefer to maintain their dignity, even at the cost of forgoing important services.<sup>73</sup> Universal programs like Medicare, on the other hand, do not carry the problem of stigma. If everyone receives healthcare through the same program, poor individuals do not need to feel that participation in the program automatically identifies them as being poor.<sup>74</sup> For all of these reasons, programs targeted at the poor do not achieve universal coverage of the indigent. Among those eligible for food stamps, for example, only two-thirds sign up for the benefit.<sup>75</sup>

The stinginess of Medicaid is reflected in ways other than its past failure to reach all of the poor. While eligibility for a federal welfare program has been necessary to qualify for Medicaid, it has not been sufficient.<sup>76</sup> Medicaid does not cover everyone who qualifies for a federal welfare program.<sup>77</sup> The income threshold at which one loses eligibility for Medicaid is lower than the income threshold at which one loses eligibility for cash assistance.<sup>78</sup> Thus, one can be viewed as so poor as to need payments from the government to make ends meet, but not so poor as to need government subsidies for healthcare coverage.<sup>79</sup> With its many limitations, Medicaid has reached less than half of those whose income falls below the poverty line; according to recent data, Medicaid covers forty-five percent of those with family incomes below the federal poverty level.<sup>80</sup>

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<sup>67</sup> MATTHEW BROADDUS ET AL., CTR. FOR BUDGET & POLICY PRIORITIES, EXPANDING FAMILY COVERAGE: STATES' MEDICAID ELIGIBILITY POLICIES FOR WORKING FAMILIES IN THE YEAR 2000, at 36 (2002), <http://www.cbpp.org/1-2-02health.pdf>.

<sup>68</sup> KAISER FAM. FOUND., MEDICAID, *supra* note 59, at 8.

<sup>69</sup> *Id.* at 13.

<sup>70</sup> *Id.* at 8-9.

<sup>71</sup> *Id.* at 13.

<sup>72</sup> *Id.* at 30.

<sup>73</sup> PETER K. EISINGER, TOWARD AN END TO HUNGER IN AMERICA 51-52 (1998).

<sup>74</sup> See generally Lawrence D. Brown & Michael S. Sparer, *Poor Program's Progress: The Unanticipated Politics of Medicaid Policy*, 22 HEALTH AFF. 31 (2003).

<sup>75</sup> USDA Food Stamp Program: Food Stamps Make America Stronger, FOOD & NUTRITION SERV., U.S. DEP'T OF AGRIC., <http://www.fns.usda.gov/cga/FactSheets/SNAP.htm> (last visited Feb. 26, 2012).

<sup>76</sup> See LIZ SCHOTT, STACY DEAN & JOCELYN GUYER, THE CENTER ON BUDGET AND POLICY PRIORITIES, COORDINATING MEDICAID AND FOOD STAMPS 5-6 (2001), available at <http://www.cbpp.org/archiveSite/9-14-01fs.pdf>.

<sup>77</sup> See *id.*

<sup>78</sup> See *id.*

<sup>79</sup> ENGEL, *supra* note 65, at 51.

<sup>80</sup> KAISER FAM. FOUND., MEDICAID, *supra* note 59, at 7.



Besides being grudging in terms of how long it took to be enacted and in terms of how many of the poor would receive coverage, Medicaid was grudging even in the way it provided coverage to those who qualified for the program. While Medicare is fully funded with federal dollars, Medicaid relies on a combination of state and federal funding. Under Medicaid, the federal government offers matching dollars to states that provide their own funding.<sup>81</sup> Thus, state governments determine the amount of Medicaid spending in their states, and marked variations in Medicaid programs exist from state to state.<sup>82</sup> For example, the number of persons eligible for Medicaid differs from one state to another. One study found that Colorado's Medicaid program reached twenty-eight percent of the low-income uninsured, while the Massachusetts Medicaid program reached fifty-nine percent.<sup>83</sup>

The shortcomings of Medicaid can be measured not only in terms of the number of people covered, but also in terms of the quality of coverage. For example, Medicaid pays physicians at lower levels than does Medicare, making it much more difficult for Medicaid recipients to find a doctor who will take care of them.<sup>84</sup> According to a national survey from 1998-2003, Medicaid's reimbursement rates for physicians averaged sixty-two percent of Medicare rates in 1998, rising to sixty-nine percent of Medicare rates by 2003.<sup>85</sup> Some states fall well below the average. In Maryland in 2001, Medicaid reimbursed physicians at thirty-six percent of the rate that Medicare reimbursed physicians.<sup>86</sup> Thus, while researchers in one study found that dermatologists would accept as new patients eighty-five percent of Medicare beneficiaries (and eighty-seven percent of persons with private insurance), they would take on only thirty-two percent of Medicaid recipients.<sup>87</sup>

Critics also have observed that Medicaid tries to shoehorn poor persons into a healthcare model that is better tailored for wealthier persons.<sup>88</sup> Simply giving people an insurance card and relying on them to find a healthcare provider ignores issues of access for poor persons. They often live in areas underserved by physicians and hospitals, and they may not have automobiles or public transportation to get them to areas adequately served by the healthcare system.<sup>89</sup> In addition, lower-income

<sup>81</sup> ENGEL, *supra* note 65, at 48.

<sup>82</sup> KAISER FAM. FOUND., MEDICAID, *supra* note 59, at 5.

<sup>83</sup> Mann & Westermoreland, *supra* note 58, at 418 (citing JOHN HOLAHAN, URBAN INST., VARIATIONS AMONG STATES IN HEALTH INSURANCE COVERAGE AND MEDICAL EXPENDITURES: HOW MUCH IS TOO MUCH? (2002), available at [http://www.urban.org/UploadedPDF/310520\\_DP0207.pdf](http://www.urban.org/UploadedPDF/310520_DP0207.pdf)). This reflects data before Massachusetts adopted its 2006 healthcare reform.

<sup>84</sup> See *id.* at 420.

<sup>85</sup> Stephen Zuckerman et al., *Changes in Medicaid Physician Fees, 1998-2003: Implications for Physician Participation*, W4 HEALTH AFF. 374, 379 (2004), available at <http://content.healthaffairs.org/content/early/2004/06/23/hlthaff.w4.374.full.pdf>.

<sup>86</sup> In 2005, the differential narrowed significantly, but Medicaid in Maryland still reimbursed at only sixty-eight percent of the Medicare rate. MD. HEALTH CARE COMM'N, REPORT ON INCREASING REIMBURSEMENT RATES FOR PHYSICIANS PARTICIPATING IN THE MARYLAND MEDICAL ASSISTANCE PROGRAM AND MARYLAND CHILDREN'S HEALTH PROGRAM 2 (2006), available at [http://mhcc.maryland.gov/legislative/increasereimburserpt\\_0506.pdf](http://mhcc.maryland.gov/legislative/increasereimburserpt_0506.pdf).

<sup>87</sup> Jack Resneck, Jr., Mark J. Pletcher & Nia Lozano, *Medicare, Medicaid, and Access to Dermatologists: The Effect of Patient Insurance on Appointment Access and Wait Times*, 50 J. AM. ACAD. DERMATOLOGY 85, 88 (2004). This was not always the case. In its first years, Medicaid reimbursed doctors at higher rates than did private insurers. See ENGEL, *supra* note 65, at 63. As states found their Medicaid budgets unaffordable, they began to reduce reimbursement rates. See *id.* at 62-63.

<sup>88</sup> See CONG. BUDGET OFFICE, THE LONG-TERM BUDGET OUTLOOK 25 (June 2009).

<sup>89</sup> ENGEL, *supra* note 65, at 52. My own medical experience validates this concern. At one time, I took care of patients at Wayne County Medical Center (which has since closed). The hospital was located in one of the western suburbs of Detroit but served patients throughout Wayne County,

persons are less likely to seek medical care even when cost and transportation barriers do not exist.<sup>90</sup>

Medicaid's problems can be traced in large part to the lack of a strong constituency at its inception. Conservatives in Congress disliked the idea of the federal government assuming responsibility for a program that they believed was a local and state responsibility, and liberals in Congress recognized, for the reasons discussed above, that Medicaid was poorly designed to meet the healthcare needs of the poor.<sup>91</sup> Those who were involved in drafting the Medicaid legislation and other staunch proponents of healthcare reform believed that Medicaid would soon be supplanted by comprehensive reform and therefore did not dwell long on the program's shortcomings.<sup>92</sup>

In recent years, Medicaid programs have fared even worse, as tight budgets force states to curtail their Medicaid spending.<sup>93</sup> Nationally, Medicaid consumes more than fifteen percent of state spending, and it has been the fastest-growing component of state budgets.<sup>94</sup> In the past, some states implemented cost-cutting measures that reduced the enrollment in their Medicaid programs.<sup>95</sup> More recently, as federal rules prohibited restrictions on eligibility, states have eliminated or restricted access to particular services, like dental or vision benefits.<sup>96</sup>

To be sure, some states have tried to expand their Medicaid programs to cover more of the uninsured, and there are some important examples of reform.<sup>97</sup> But even these programs remain underfunded.<sup>98</sup> When Indiana passed its "Healthy Indiana Plan" to provide coverage to uninsured individuals, it did not create an entitlement to coverage for those who lacked insurance and were not covered under another government plan. Rather, it offered affordable coverage on a first-come, first-served basis to uninsured persons, with the number of available slots determined by the amount of funding raised by an increase in the cigarette tax. According to estimates at the time of passage, the new plan was expected to provide coverage for 130,000 people, about twenty percent of the number of uninsured persons in the state.<sup>99</sup> However, it only reached about a third of its projected enrollment before ACA was enacted, and Governor Mitch Daniels restricted enrollment—with the passage of ACA, the Indiana plan will be phased out by 2013.<sup>100</sup>

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including residents of Detroit, the county seat. Many of the patients from Detroit lived more than ten miles from the hospital, and it was common for them to miss their follow-up appointments in the outpatient clinic because they had no good way to get to the hospital.

<sup>90</sup> See *id.* at 52-53.

<sup>91</sup> Emily Friedman, *The Compromise and the Afterthought: Medicare and Medicaid After 30 Years*, 274 JAMA 278, 278-80 (1995).

<sup>92</sup> See ENGEL, *supra* note 65, at 49-50, 60; see Friedman, *supra* note 91, at 280.

<sup>93</sup> KAISER FAM. FOUND., MOVING AHEAD AMID FISCAL CHALLENGES: A LOOK AT MEDICAID SPENDING, COVERAGE AND POLICY TRENDS 22-23 (2011), available at <http://kff.org/medicaid/upload/8248.pdf>.

<sup>94</sup> *Id.* at 11.

<sup>95</sup> *Id.* at 7.

<sup>96</sup> *Id.* at 38, 46-47.

<sup>97</sup> *Id.* at 7.

<sup>98</sup> *Id.* at 22.

<sup>99</sup> KAISER COMM'N ON MEDICAID FACTS, SUMMARY OF HEALTHY INDIANA PLAN: KEY FACTS AND ISSUES (2008), available at <http://www.kff.org/medicaid/upload/7786.pdf>.

<sup>100</sup> Dan Carden, *State Enrolling More in Health Plan*, NW. IND. TIMES, Aug. 8, 2011, [http://www.nwtimes.com/news/local/lake/gary/article\\_50744e52-9e45-58c6-9d94-d02011be62a2.html](http://www.nwtimes.com/news/local/lake/gary/article_50744e52-9e45-58c6-9d94-d02011be62a2.html).

In addition to Medicare and Medicaid, there is an additional important statutory right to healthcare under federal law.<sup>101</sup> In 1986, Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA).<sup>102</sup> Under EMTALA, emergency departments at hospitals cannot deny care to indigent persons (or anyone else) who are in active labor or experiencing an emergent need for care.<sup>103</sup> While valuable to the indigent, who no longer can be refused all care, there also are serious limits to EMTALA. The emergency department only must stabilize the patient's medical condition.<sup>104</sup> There is no duty to fully treat the condition, nor is there any obligation to provide care in non-emergency circumstances.<sup>105</sup>

### C. ACA AND THE EXPANSION OF THE U.S. RIGHT TO HEALTHCARE

ACA provides an important improvement of the Medicaid program. Starting in 2014, all individuals with family incomes up to 133% of the federal poverty level will be eligible for coverage.<sup>106</sup> Moreover, families with incomes between 133 and 400% of the federal poverty level will be eligible for subsidies to help offset the costs of their healthcare coverage.<sup>107</sup>

But ACA does not address important problems with Medicaid. For example, it will remain a federal-state partnership, and that means that reimbursement rates and the availability of a physician willing to treat Medicaid patients will still vary from state to state.<sup>108</sup> And even at 133% of the federal poverty level, Medicaid leaves many families without coverage who cannot afford to purchase it on their own.<sup>109</sup> To be sure, ACA provides subsidies for low (and even some middle) income families who earn too much to qualify for Medicaid, but the subsidies may not be adequate to make private healthcare coverage affordable. Thus, projections indicate that millions of Americans will remain uninsured after ACA fully kicks in.<sup>110</sup>

To this point, I have discussed the grudging nature of healthcare rights. They have been very slow coming, they have generally not reached all in need, and even those who qualify for coverage are unable to have their healthcare needs adequately met. There is another important problem with healthcare rights in the United States: they are formulated in a way that leaves them inherently unstable.

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<sup>101</sup> Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2006) [hereinafter EMTALA].

<sup>102</sup> *Id.*

<sup>103</sup> *Id.*

<sup>104</sup> CONG. RESEARCH SERV., EMTALA: ACCESS TO EMERGENCY MEDICAL CARE 1-3 (2010), <http://aging.senate.gov/crs/medicare20.pdf>.

<sup>105</sup> HALL, BOBINSKI & ORENTLICHER, *supra* note 9, at 126-27.

<sup>106</sup> Medicaid: Eligibility, CTRS. FOR MEDICARE & MEDICAID SERVS., <http://www.medicaid.gov/AffordableCareAct/Provisions/Eligibility.html> (last visited Mar. 2, 2012).

<sup>107</sup> *Saving Money for Families and Small Businesses*, U.S. DEP'T OF HEALTH & HUMAN SERVS., <http://www.healthcare.gov/blog/2011/01/saving-money.html> (last visited Mar. 2, 2012).

<sup>108</sup> See KAISER FAM. FOUND., MEDICAID COVERAGE AND SPENDING IN HEALTH REFORM: NATIONAL AND STATE-BY-STATE RESULTS FOR ADULTS AT OR BELOW 133% FPL 1 (2010), available at <http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf> (different participation rates key to variable analysis).

<sup>109</sup> See *id.* (different participation rates imply different amounts of families who can afford to purchase health insurance after subsidies).

<sup>110</sup> *Id.* at 2.

## D. THE INHERENT INSTABILITY IN U.S. HEALTHCARE RIGHTS

The instability of healthcare rights can be traced to three important features of those rights. First, they are rights to payment for healthcare costs, but not rights to receive healthcare. Second, the poor must rely on the willingness of the wealthy to fund their healthcare costs, and the willingness of the wealthy to do so diminishes as the availability of a public program generates unanticipated demand for healthcare services and drives the costs of the program well above initial projections. Third, other than Medicare, healthcare programs entail federal-state partnerships rather than programs run solely by the federal government.

### 1. A Right to Coverage, Not to Care

As discussed earlier, healthcare rights generally recognize a right to payment for the costs of care, but not a right to receive healthcare. EMTALA ensures that patients receive healthcare to stabilize their emergency medical conditions, but under Medicare, Medicaid, and ACA, patients only gain access to insurance to cover their medical expenses.<sup>111</sup> They still must find a physician who is willing to accept payment from their plans. Medicaid patients have long found it difficult to find willing physicians, and Medicare patients are finding it increasingly difficult too.<sup>112</sup> As healthcare costs continue to rise and health plans contain costs by cutting their reimbursement rates, difficulties finding physicians will likely get worse.<sup>113</sup>

In fact, ACA almost guarantees that Medicare will cut reimbursement rates. ACA created the Independent Payment Advisory Board ("Board"), which will develop proposals to keep Medicare spending within strict targets established by ACA.<sup>114</sup> The Board's proposals will automatically take effect unless Congress adopts substitute provisions.<sup>115</sup> The proposals may not ration healthcare, raise costs to recipients, restrict benefits, or modify eligibility criteria.<sup>116</sup> As a result, ACA leaves the Board with few options other than reductions in reimbursement rates. With reductions in reimbursement, physicians will be more inclined to shrink their Medicare practices and expand their care of privately insured patients.<sup>117</sup>

Many patients not only will find it harder to find a physician who will accept their coverage, they also will find it harder to afford care once they find a willing physician. While the Medicaid statute protects its recipients from high out-of-pocket costs, persons who will rely on the ACA subsidies for private healthcare insurance will have greater difficulty affording the out-of-pocket costs of their care. In recent years, employers and insurers have addressed the rising cost of healthcare by making

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<sup>111</sup> EMTALA, *supra* note 101.

<sup>112</sup> See, e.g., Lisa Zamosky, *Medicare Guidance Is Here*, L.A. TIMES (July 11, 2011), <http://articles.latimes.com/2011/jul/11/health/la-he-health-411-20110711> ("You're not alone when it comes to having difficulty finding a doctor who will accept Medicare, the government health insurance program for seniors. People have long complained that doctors have either dropped out of the program or are no longer accepting new Medicare patients into their practice.").

<sup>113</sup> See *id.*

<sup>114</sup> Nancy-Ann DeParle, *The Facts About the Independent Payment Advisory Board*, THE WHITE HOUSE BLOG (Apr. 20, 2011, 5:46 PM), <http://www.whitehouse.gov/blog/2011/04/20/facts-about-independent-payment-advisory-board>.

<sup>115</sup> See *id.*

<sup>116</sup> *Id.*

<sup>117</sup> See Timothy Jost, *The Independent Payment Advisory Board*, 363 NEW ENG. J. MED. 103, 104 (2010); David Orentlicher, *Cost Containment and the Patient Protection and Affordable Care Act*, 6 FIU L. REV. 67, 82 (2010).

patients responsible for a larger share of the costs.<sup>118</sup> Employers are requiring workers to bear higher payments for their insurance premiums, and they are offering healthcare plans with higher deductibles and co-payments.<sup>119</sup> Patients face a double whammy. With the higher premium costs, which can total in the thousands of dollars a year, patients have less money to pay their deductible and co-payments. And the higher levels for deductibles and co-payments make it more costly to see a physician. With less money to pay greater fees, many patients are likely to delay or forgo needed care.

## 2. The Divergence of Interests Between Rich and Poor

Rights to healthcare in the United States are unstable for a second important reason. Under Medicaid and ACA (but not Medicare), the interests of the poor are divorced from the interests of the well-to-do. When Medicaid and ACA expanded healthcare access, they did so primarily for the poor or lower-income families.<sup>120</sup> The financially secure generally receive healthcare coverage from their employers, or can afford to purchase it on their own.<sup>121</sup> Thus, those who are better off see Medicaid and ACA as programs that serve the poor at the expense of themselves.<sup>122</sup> But with governmental programs like this in the United States, there generally is not sufficient political support to ensure adequate funding over time.<sup>123</sup> The poor have little influence in the halls of Congress or the statehouses, and the wealthy are inclined to disfavor programs that benefit only the poor. Thus, for example, programs like Social Security and Medicare that serve recipients at all income levels are far more successful than programs like Medicaid, which target the indigent.<sup>124</sup> ACA preserves Medicare's broad base of support and improves Medicaid by imposing a federal standard for eligibility.<sup>125</sup> ACA's expansion of access to healthcare coverage, however, depends on adding millions more of the poor to Medicaid, and providing subsidies for the purchase of insurance for those not poor enough for Medicaid but not wealthy enough to afford healthcare coverage on their own. Thus, the expansion in coverage depends to a substantial extent on the willingness of persons with political influence to fund programs for other people. Experience suggests that their willingness to do so over the long run will be limited.

An important feature of ACA may compromise the willingness of the politically influential to support adequate funding for ACA's expansion of access. As mentioned, Medicaid under ACA will cover all of the poor, not just the poor that

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<sup>118</sup> See Walecia Konrad, *When Choosing Health Care, Know What You'll Owe*, N.Y. TIMES (July 9, 2010), <http://www.nytimes.com/2010/07/10/health/10patient.html>.

<sup>119</sup> KAISER FAM. FOUND., EMPLOYER HEALTH BENEFITS: 2011 ANNUAL SURVEY 67, 101-02, 116 (2011), available at <http://ehbs.kff.org/pdf/2011/8225.pdf>. While employees are assuming greater costs, the percentage share of the costs has not necessarily increased. *Id.* at 66.

<sup>120</sup> See KAISER FAM. FOUND., MEDICAID, *supra* note 59, at 7 (explaining that Medicaid covers mostly low-income and high-need populations).

<sup>121</sup> See *id.* (displaying the various means of coverage by poverty level).

<sup>122</sup> See WILLIAM JULIUS WILSON, *THE TRULY DISADVANTAGED: THE INNER CITY, THE UNDERCLASS, AND PUBLIC POLICY* 119 (1987) (noting that taxpayers viewed Medicaid as paying for services provided to welfare recipients but not to themselves).

<sup>123</sup> *Id.* at 118-20.

<sup>124</sup> See *id.* at 118 ("[O]nly programs based on the principle of equality of life chances are capable of substantially helping the truly disadvantaged.").

<sup>125</sup> See KAISER FAM. FOUND., MEDICAID, *supra* note 59, at 1 ("[T]he law creates a national framework for near-universal coverage and also outlines a comprehensive set of strategies to improve care and contain costs.").

have historically been viewed as “deserving.”<sup>126</sup> From the perspective of justice, this is an important change, and it may reflect a broad view that most of the uninsured lack coverage because healthcare costs have risen so high. Indeed, during the debate over ACA, proponents successfully cited the frequency with which unpaid medical bills contributed to personal bankruptcy filings.<sup>127</sup> But to the extent that voters begin to see the expanded Medicaid as a program that rewards people who lack initiative and are responsible for their uninsured status, support for Medicaid funding may diminish.

The inadequacy of public benefit programs serving the poor is a phenomenon not only with healthcare programs but also with other public benefit programs. The food stamps program is able to stave off malnutrition for the most part, but many poor families suffer from food “insecurity,”<sup>128</sup> and the level of food stamp benefits is not sufficient to cover the costs of a healthy diet.<sup>129</sup> Fresh fruits and vegetables, for example, can easily overwhelm the grocery budget of a food stamp recipient.<sup>130</sup> Similarly, housing subsidies for the indigent have not been adequate to reach all those who need a home, and many Americans have to rely on families, friends, or homeless shelters for a place to reside.<sup>131</sup>

The problem with programs targeted only at the poor can be illustrated further by the decline in the federal housing program as it became more focused on serving the indigent. When public housing was developed in the 1930s during the Great Depression,<sup>132</sup> the federal government did not engage in means-testing, so tenants came from the solid working class, as well as the unemployed.<sup>133</sup> The housing was

<sup>126</sup> See *id.* at 8 (“Under the new health reform law, nearly everyone under age 65—regardless of category—with income below a national ‘floor’ will be eligible for Medicaid . . .”).

<sup>127</sup> See, e.g., David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741 (2009); Catherine Arnst, *Study Links Medical Costs and Personal Bankruptcy*, BLOOMBERG BUSINESSWEEK (June 4, 2009, 8:45 AM), [http://www.businessweek.com/bwdaily/dnflash/content/jun2009/db2009064\\_666715.htm](http://www.businessweek.com/bwdaily/dnflash/content/jun2009/db2009064_666715.htm); Nicholas D. Kristof, *Until Medical Bills Do Us Part*, N.Y. TIMES, Aug. 30, 2009, at 8WK. Ironically, ACA may not in fact reduce bankruptcies driven by medical costs. Many of those who file for bankruptcy carry insurance, but cannot afford their share of the costs. See David U. Himmelstein, *Medical Bankruptcy in Massachusetts: Has Health Reform Made a Difference?*, 124 AM. J. MED. 224 (2011) (finding healthcare reform in Massachusetts did not reduce number of medical bankruptcies).

<sup>128</sup> ALISHA COLEMAN-JENSEN ET AL., U.S. DEP’T OF AGRIC., HOUSEHOLD FOOD SECURITY IN THE UNITED STATES IN 2010 (2011), available at [www.ers.usda.gov/Publications/ERR125/err125.pdf](http://www.ers.usda.gov/Publications/ERR125/err125.pdf).

<sup>129</sup> See, e.g., *id.* at 25; Melanie Mason, *Food Stamps for Good Food*, THE NATION, Mar. 28, 2011, at 21.

<sup>130</sup> See Mason, *supra* note 129, at 21.

<sup>131</sup> Housing subsidies may be inadequate for the poor, but they are very generous for the well-to-do. See GILLIAN REYNOLDS, THE URBAN INSTITUTE, OPPORTUNITY AND OWNERSHIP FACTS NO. 6, FEDERAL HOUSING SUBSIDIES: TO RENT OR TO OWN? (2007), available at [http://www.urban.org/UploadedPDF/411592\\_housing\\_subsidies.pdf](http://www.urban.org/UploadedPDF/411592_housing_subsidies.pdf). There are important federal income tax deductions for home mortgage interest and state property taxes. *Id.* Moreover, the value of these deductions is greater for the wealthy. See *id.* Those with larger mortgages, higher property taxes because of higher home values, or higher marginal tax rates realize the larger deductions. See Stanley S. Surrey, *Tax Incentives as a Device for Implementing Government Policy: A Comparison with Direct Government Expenditures*, 83 HARV. L. REV. 705, 722-23 (1970). Overall, nearly eighty percent of federal housing subsidies go to homeowners and only about twenty percent to subsidize rental payments for the indigent. See Peter Dreier, *Federal Housing Subsidies: Who Benefits and Why?*, in A RIGHT TO HOUSING: FOUNDATION FOR A NEW SOCIAL AGENDA 106-07 (Rachel G. Bratt et al. eds., 2006).

<sup>132</sup> There had been earlier, temporary programs for housing, such as a housing program tied to the war effort in WWI. FROM TENEMENTS TO THE TAYLOR HOMES: IN SEARCH OF AN URBAN HOUSING POLICY IN TWENTIETH-CENTURY AMERICA 19-20 (John F. Bauman et al. eds., 2000).

<sup>133</sup> Gail Radford, *The Federal Government and Housing During the Great Depression*, in FROM TENEMENTS TO THE TAYLOR HOMES, *supra* note 132, at 102, 104-06.

created under the auspices of the Public Works Administration (PWA), which built or financed fifty-eight housing developments with approximately 25,000 units. The housing was functional, attractive, and accompanied by community facilities like parks, libraries, and child-care facilities; hence its appeal to people who could afford private housing.<sup>134</sup>

While the PWA housing was desirable, public housing that followed and that was reserved for the poor was especially unappealing. The PWA was a temporary agency, so housing advocates sought legislation that would authorize a permanent housing agency.<sup>135</sup> In 1937, Congress passed the Wagner-Steagall bill over the objections of industry, particularly from the private housing sector that feared competition from the government. While they could not block the bill, industry and its allies succeeded in shaping the legislation in a way that severely limited its potential for success.<sup>136</sup>

Far from launching a universal program for public housing, Wagner-Steagall targeted its benefits to those with very low incomes, on the theory that a public program should be reserved only for those whose needs could not be met by the private market.<sup>137</sup> The Act limited eligibility on the basis of income in two ways. First, the rent paid, plus utility costs, had to exceed twenty percent of household income.<sup>138</sup> Thus, families that earned more than five times their housing costs were not eligible for public housing. In addition, the federal housing agency was authorized to set absolute income caps, and they were set at levels below the poverty line.<sup>139</sup>

With public housing now reserved for the indigent, Congress imposed constraints that eventually doomed the quality of public housing. For example, public housing projects had to be linked to the clearance of slums—the construction of new dwelling units had to be matched by the elimination of an equal amount of slum property.<sup>140</sup> The need to clear slum properties led to high land acquisition costs, leaving fewer resources for the construction of the public housing that would replace the condemned houses.<sup>141</sup>

At the same time that higher land acquisition costs were imposed, Congress included spending caps in the legislation, further squeezing construction budgets.<sup>142</sup> There were limits on how much could be spent in construction costs for an apartment or even a single room, and public housing projects could not include “elaborate or expensive design or materials.”<sup>143</sup> In addition, public housing projects had to fall within strict cost limits.<sup>144</sup> These factors alone ensured austerity, but the U.S. Housing Authority went even further in containing costs, on the theory that keeping costs to a minimum would help generate public support and allow the government to maximize the number of housing units it could create.<sup>145</sup>

<sup>134</sup> *Id.* By 1936, Congress established income limits for the housing projects. *Id.*

<sup>135</sup> *Id.* at 108-09.

<sup>136</sup> *Id.* at 112.

<sup>137</sup> R. ALLEN HAYS, *THE FEDERAL GOVERNMENT AND URBAN HOUSING: IDEOLOGY AND CHANGE IN PUBLIC POLICY* 93 (1995).

<sup>138</sup> *Id.* For families with three or more children, rent could not exceed seventeen percent of income. See LEONARD FREEDMAN, *PUBLIC HOUSING: THE POLITICS OF POVERTY* 105-06 (1969).

<sup>139</sup> FREEDMAN, *supra* note 138, at 106-07.

<sup>140</sup> Radford, *supra* note 133, at 111.

<sup>141</sup> *Id.*

<sup>142</sup> *Id.* (citing per unit spending caps of \$5000).

<sup>143</sup> FREEDMAN, *supra* note 138, at 116.

<sup>144</sup> See Radford, *supra* note 133, at 111-12 (citing per unit spending caps of \$5000).

<sup>145</sup> *Id.* at 111-12; see also FREEDMAN, *supra* note 138, at 115.

With all of this belt-tightening, public housing became a failed policy. New projects in New York City cost half as much per apartment as projects built in the city by the PWA, and they conjured up images of Soviet-style drabness and cheapness.<sup>146</sup> Out of this era came the much-discredited public housing high-rise developments that concentrated poor, mostly minority, residents in the new urban ghettos.<sup>147</sup> To minimize real estate acquisition costs, planners preferred high-rise apartments, which could maximize the number of housing units per acre of land.<sup>148</sup> But high-rise apartments made little sense for families with children.<sup>149</sup> Parents found it difficult to keep their eyes on children playing many stories below them, and gangs could readily find members among the large numbers of teenagers clustered together.<sup>150</sup> Notorious among these projects were the Robert Taylor Homes ("Homes") in Chicago, which comprised the largest public housing project in the world when completed in 1962.<sup>151</sup> The Homes housed 27,000 people in buildings that were claustrophobic and noisy. Moreover, they were located in a community that lacked green space, that was surrounded by littered streets and few stores or civic amenities, and that was plagued by gangs, drug dealing, and other crime.<sup>152</sup> The Homes, whose residents were nearly all black and poor, also reinforced existing patterns of residential segregation.<sup>153</sup> Ultimately, high-rise public housing projects had to be torn down.<sup>154</sup>

We can look not only to the federal government for evidence that public programs are difficult to sustain when they only serve the poor. The same has been true for state-run programs. The Oregon Health Care Plan provides a useful example.<sup>155</sup> In the 1990s, Oregon decided to expand its Medicaid program to reach all of its poor residents (i.e., those with a family income up to one hundred percent of the federal poverty level).<sup>156</sup> Instead of providing generous benefits for a limited number of the poor, Oregon would provide limited benefits for all of the poor.<sup>157</sup> At first, the program was well-funded, and the percentage of uninsured in the state dropped from seventeen percent to eleven percent.<sup>158</sup> As the Oregon economy stalled and government revenues dropped, however, Oregon raised eligibility thresholds, and within ten years of the plan's implementation Oregon's rate of uninsured had risen to pre-plan levels.<sup>159</sup>

As the Oregon experience indicates, economic pressures make it very difficult to maintain public programs that primarily serve lower-income persons, and

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<sup>146</sup> See Radford, *supra* note 133, at 113 (citing *New Yorker's* review of first two public housing complexes in Brooklyn, which describes them as displaying "Leningrad formalism").

<sup>147</sup> See *id.* at 115.

<sup>148</sup> See FREEDMAN, *supra* note 138, at 115-16.

<sup>149</sup> See *id.* at 116.

<sup>150</sup> See *id.*

<sup>151</sup> Roger Biles, *Public Housing and the Postwar Urban Renaissance, 1949-1973*, in FROM TENEMENTS TO THE TAYLOR HOMES, *supra* note 132, at 143, 149.

<sup>152</sup> *Id.*

<sup>153</sup> *Id.*

<sup>154</sup> Roger Biles, *Epilogue to TENEMENTS TO THE TAYLOR HOMES*, *supra* note 132, at 265.

<sup>155</sup> See Lawrence Jacobs et al., *The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics Have Claimed and What Oregon Did*, 24 J. HEALTH POL. POL'Y & L. 161, 163 (1999); David Orentlicher, *Controlling Health Care Costs Through Public, Transparent Processes: The Conflict Between the Morally Right and the Socially Feasible*, 36 J. CORP. L. 807, 813-14 (2011).

<sup>156</sup> Orentlicher, *supra* note 155, at 813-14.

<sup>157</sup> *Id.*

<sup>158</sup> Jacobs et al., *supra* note 155, at 165-68.

<sup>159</sup> David Orentlicher, *supra* note 155, at 814.



economic pressures are a particular concern in healthcare. Although President Barack Obama recognized the need for ACA to include cost-containment provisions, the bill falls far short of what is needed to bend the healthcare cost curve.<sup>160</sup> Indeed, once the law is fully implemented, it is expected to barely slow the rate of healthcare inflation, dropping it from 6.8% to 6.7%.<sup>161</sup>

The willingness of financially secure persons to sustain ACA's coverage provisions for the poor may be tested further because ACA maintains a dual healthcare system, with both public and private coverage, rather than switching to a system based primarily on public coverage.<sup>162</sup> In this dual U.S. healthcare system, the new public benefits may "crowd out" private coverage, making public coverage even more expensive for state and federal governments, and therefore less sustainable over time. That is, people who now have unsubsidized private healthcare coverage may switch to the expanded Medicaid program or qualify for subsidized private healthcare coverage.

Of particular concern is the possibility that ACA's subsidies for the purchase of insurance will encourage employers to drop their healthcare benefits. Currently, if an employer stops offering healthcare coverage, employees expect the employer to offset the loss of coverage by raising salaries.<sup>163</sup> That way, workers have funds to purchase their own healthcare plans.<sup>164</sup> But many employees may be able to purchase their replacement coverage with governmental subsidies through the healthcare insurance exchanges that will be created under ACA. In that case, the employer can effectively shift the costs of employee healthcare coverage onto the government.<sup>165</sup> If this crowd out of employer-based coverage occurs to a significant extent, it will drive the costs of the subsidies much higher than expected and make it difficult to sustain ACA for the long term.

How likely is it that employers will drop healthcare coverage and send their employees to the exchanges? There are a few factors that will discourage employers from doing so. First, many of their employees may earn too much money to qualify for meaningful subsidies.<sup>166</sup> Hence, they would have to foot the bill themselves for policies purchased on the exchanges, and they would expect their employers to raise their salaries accordingly. Employers would end up paying more for healthcare benefits. Consider, for example, the costs to employers to provide \$10,000 in healthcare coverage for an employee. If the employer provides the coverage, then it costs the employer \$10,000. If, on the other hand, the employee has to purchase the coverage on a healthcare exchange, the employer will have to pay the employee

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<sup>160</sup> See *id.* at 110.

<sup>161</sup> See Andrea M. Sisko et al., *National Health Spending Projections: The Estimated Impact of Reform Through 2019*, 29 HEALTH AFF. 1933, 1936 (2010).

<sup>162</sup> See *id.* at 1938-40 (describing projected future growth in the distinct areas of public and private healthcare coverage under the ACA).

<sup>163</sup> See Amy Monahan & Daniel Schwarcz, *Will Employers Undermine Health Care Reform by Dumping Sick Employees?*, 97 VA. L. REV. 125, 182-83 (2011).

<sup>164</sup> See *id.*

<sup>165</sup> See Richard S. Foster, *Estimated Financial Effects of the "Patient Protection and Affordable Care Act," as Amended*, CTRS. FOR MEDICARE & MEDICAID SERVS., 7-8 (2010), available at [http://www.cms.gov/ActuarialStudies/Downloads/PPACA\\_2010-04-22.pdf](http://www.cms.gov/ActuarialStudies/Downloads/PPACA_2010-04-22.pdf) ("[S]ome smaller employers would be inclined to terminate their existing coverage, and companies with low average salaries might find it to their—and their employees'—advantage to end their plans, thereby allowing their workers to qualify for heavily subsidized coverage through the Exchanges."); David A. Hyman, *PPACA in Theory and Practice: The Perils of Parallelism*, 94 VA. L. REV. IN BRIEF 83, 84 (2011) (referencing Monahan & Schwarcz, *supra* note 163, at 127-29).

<sup>166</sup> See Hyman, *supra* note 165, at 102-03. For high-wage workers, the ACA provides only modest subsidies for obtaining coverage through an exchange. *Id.*

\$12,000-\$13,000 or more in salary. Because of taxes owed on income, employees need to receive more than \$10,000 in income to have \$10,000 to spend. The employer also may incur additional costs. If some of their employees purchase healthcare on an ACA exchange with a governmental subsidy, then the company must pay a fine.<sup>167</sup> For many employers, it clearly will be worthwhile to maintain healthcare insurance as an employee benefit. Hence, researchers have not projected a significant loss of coverage from employers dropping healthcare benefits.<sup>168</sup>

Still, that might change as healthcare costs continue to rise, and especially so for employers with predominantly low-income workforces. Low-income employees will qualify for Medicaid or receive substantial subsidies to buy private healthcare insurance, so will not need an increase in salary to compensate for the loss of healthcare coverage from their employers.<sup>169</sup> At the same time, the fines that will be levied under ACA's employer mandates are much smaller than the costs of providing healthcare coverage.<sup>170</sup> Even if cost pressures do not lead employers to drop healthcare coverage as an employee benefit, the cost pressures still will make it difficult to sustain the federal subsidies for Medicaid and for policies purchased on the healthcare exchanges by lower-income individuals.

In sum, ACA's right to healthcare will suffer from the fact that those who are financially secure must be willing to pay for the healthcare of the poor, and they must maintain that willingness even as healthcare costs rise further.

### 3. Federal-State Partnerships Make for Weaker Programs

The third major cause of instability in healthcare rights lies in the fact that they often entail partnerships between the federal and state governments. The Medicaid program provides a useful illustration.<sup>171</sup> The federal government sets minimum standards and reimburses most of the costs, but the states determine eligibility and reimbursement levels for their own residents.<sup>172</sup> As a result, the percentage of uninsured varies widely from state to state, depending on a state's wealth and the willingness of its legislators to fund Medicaid coverage. In Texas, for example, twenty-five percent of the public is uninsured, while only five percent are uninsured in Massachusetts.<sup>173</sup>

The deficiencies of federal-state partnerships are seen in other public benefit programs. When Congress created a permanent food stamp program in 1964 after some temporary programs, coverage was limited.<sup>174</sup> States could choose whether to participate in the program, they were allowed to set their own eligibility standards, and they could implement the program in some parts of the state but not other parts.<sup>175</sup> Hence, wide variations existed across and within states. In 1970, eligibility was limited in South Carolina to persons who earned no more than thirty-eight percent of the federal poverty level, while New Jersey extended its program to

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<sup>167</sup> See Monahan & Schwarcz, *supra* note 163, at 129 n.8.

<sup>168</sup> Christine Eibner et al., *The Effects of the Affordable Care Act on Workers' Health Insurance Coverage*, 363 NEW ENG. J. MED. 1393, 1394 (2010).

<sup>169</sup> See *id.*

<sup>170</sup> Monahan & Schwarcz, *supra* note 163, at 157-58.

<sup>171</sup> ENGEL, *supra* note 65, at 48-49.

<sup>172</sup> *Id.*

<sup>173</sup> *Health Coverage & Uninsured*, KAISER FAM. FOUND., <http://www.statehealthfacts.org/comparecat.jsp?cat=3> (last visited Mar. 2, 2012).

<sup>174</sup> See EISINGER, *supra* note 73, at 39.

<sup>175</sup> *Id.*

persons who earned up to eighty-six percent of the federal poverty level.<sup>176</sup> Because states could choose not to offer food stamps or offer them only in some counties, only fifty-nine percent of the population lived in counties with a food stamp program in 1969.<sup>177</sup>

Congress responded to the access problems with amendments to the original act.<sup>178</sup> These amendments established uniform, national standards of eligibility, and if states participated in the food stamp program, they were required to include residents of every county. "By 1975 food stamps were available in every . . . [U.S.] county."<sup>179</sup>

Public housing provides another example of the problems with federal-state partnerships. This Article previously discussed how housing policy declined in effectiveness in the transition from the Public Works Administration to the Wagner-Steagall Act.<sup>180</sup> There was another important change under Wagner-Steagall. While the federal government decided the location of public housing projects under the PWA, site selection under Wagner-Steagall was left to local housing authorities.<sup>181</sup> This policy ensured that public housing would be built in inner city settings, as middle and upper income residents exercised their political strength to prevent the building of public housing in their neighborhoods.<sup>182</sup> In doing so, local decision-making resolved an important debate in a way harmful to the future of public housing. As many advocates argued, the housing should have been built on cheap, vacant lots at the periphery of cities, and in the form of low-density, scattered site units.<sup>183</sup> That would allow for healthier, safer, and less expensive housing, as well as increase the chances that urban ghettos could be eliminated rather than recreated.<sup>184</sup> Locating the new units in the poor areas of cities, however, left them with a stigma from the outset.<sup>185</sup> The working poor with dreams and prospects of upward mobility avoided the new housing, leaving behind a high concentration of the poorest of the poor, who had no place else to go.<sup>186</sup> Moreover, to the extent that residents of public housing did work hard and move up the economic ladder, they were likely to lose their eligibility for public housing.<sup>187</sup> Once they exceeded the income limits, they were subject to eviction.<sup>188</sup> As the economically successful families left public housing, they left behind an ever-increasing "culture of poverty."<sup>189</sup> The tenants who left because of rising incomes "tended to be the more energetic, ambitious, and 'responsible' tenants" who played leadership roles in the structure and organization of the public housing communities.<sup>190</sup>

As indicated, ACA addresses the state-to-state variation in healthcare coverage under Medicaid to some extent by imposing uniform eligibility standards, but it still

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<sup>176</sup> *Id.*

<sup>177</sup> *Id.*

<sup>178</sup> *Id.*

<sup>179</sup> *Id.*

<sup>180</sup> See *supra* notes 135-54 and accompanying text.

<sup>181</sup> FREEDMAN, *supra* note 138, at 39-40.

<sup>182</sup> HAYS, *supra* note 137, at 92-93.

<sup>183</sup> Roger Biles, *Nathan Straus and the Failure of US Public Housing*, 53 HISTORIAN 33, 39, 45 (1990).

<sup>184</sup> See *id.* at 39.

<sup>185</sup> HAYS, *supra* note 137, at 93.

<sup>186</sup> *Id.*

<sup>187</sup> FREEDMAN, *supra* note 138, at 107.

<sup>188</sup> *Id.*

<sup>189</sup> *Id.* at 108.

<sup>190</sup> *Id.*

leaves management of the program to the states. There still will be different Medicaid programs in the different states, each with their own administrative structures and rules.

#### IV. THE EROSION OF ACA

While much of my concern lies with the future instability of ACA, it has started to unravel even before its real implementation. For example, ACA was designed to address an important shortcoming in the Medicare program—the failure to cover the costs of long-term care for patients with dementia or other debilitating conditions who require residence in a nursing home.<sup>191</sup> With the aging of the U.S. population and its baby boom bulge, the demand for long-term care will continue to reach new highs in the coming years.<sup>192</sup> Yet most Americans do not carry insurance for the costs of long-term care, and they often end up relying on Medicaid for coverage after depleting their savings.<sup>193</sup> During the drafting of ACA, provisions were added from the CLASS Act, a legislative proposal from previous years, to establish government-sponsored long-term insurance.<sup>194</sup> While the CLASS Act provisions were enacted, it did not take long for government officials to recognize that the program would not be adequately funded.<sup>195</sup> The U.S. Department of Health and Human Services (HHS) announced in 2011 that it would not be able to implement the act, and the long-term care problem remains unsolved.<sup>196</sup>

In a second potentially significant erosion of ACA, HHS decided that it would let each state determine the “essential benefits” package required for healthcare plans sold through the insurance exchanges.<sup>197</sup> This compromises one of the key features of ACA—the extent to which it adopted federal standards rather than state-by-state standards.

As discussed, public programs are much more likely to be successful when they follow federal standards than when they are based on state standards. Medicaid beneficiaries in many parts of the country have suffered from the fact that states set eligibility standards and determine reimbursement rates for physicians and hospitals.<sup>198</sup> Thus, the poor fare much better in states like Massachusetts or New Jersey than in states like Texas in gaining access to healthcare.<sup>199</sup> Similarly, the food stamps program failed to meet the needs of the poor in many states until the federal

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<sup>191</sup> Gardiner Harris & Robert Pear, *Still No Relief in Sight for Long-Term Needs*, N.Y. TIMES, Oct. 25, 2011, at D1.

<sup>192</sup> Robert Pear, *Long-Term Care Is Latest Issue in Health Care Debate*, N.Y. TIMES, Dec. 14, 2009, at A21.

<sup>193</sup> Harris & Pear, *supra* note 191.

<sup>194</sup> Robert Pear, *Health Law to Be Revised by Ending a Program*, N.Y. TIMES, Oct. 15, 2011, at A10.

<sup>195</sup> *Id.*

<sup>196</sup> *Id.*

<sup>197</sup> Robert Pear, *Health Care Law Will Let States Tailor Benefits*, N.Y. TIMES, Dec. 17, 2011, at A1.

<sup>198</sup> See MICHAEL S. SPARER, *MEDICAID AND THE LIMITS OF STATE HEALTH REFORM* 8-9 (1996); Eleanor D. Kinney, *Rule and Policy Making for the Medicaid Program: A Challenge to Federalism*, 51 OHIO ST. L.J. 855, 857 (1990) (suggesting lack of uniformity in state implementation of Medicaid eligibility requirements may be inequitable).

<sup>199</sup> See Kinney, *supra* note 198, at 857 (“[I]n 1985, New York with over 16 million people spent \$7.5 billion on its Medicaid program and Texas, with a population of comparable size, spent only \$1.4 billion.”).

government established uniform eligibility standards for that program.<sup>200</sup> ACA has done much to ensure uniformity by requiring Medicaid programs in every state to cover all persons earning no more than 133% of the federal poverty level.<sup>201</sup>

ACA was supposed to promote more uniformity through a federal standard for the essential benefits that healthcare plans would have to provide. A right to healthcare is insufficient if it gives access to inadequate coverage, so ACA requires that health plans meet minimally decent standards of coverage.<sup>202</sup> With its decision to let states determine the essential benefits package, HHS has invited states to differ in the extent to which they ensure adequate coverage to their residents.<sup>203</sup> While ACA cabins the authority of states in defining essential benefits in important ways,<sup>204</sup> we once again must worry that residents of some states will end up with a limited right while residents of other states will end up with a sufficient right.

## V. MAKING A RIGHT TO HEALTHCARE MORE STABLE

If ACA provides an unstable right to healthcare or if ACA is found to be unconstitutional, what alternatives would provide a stable right? Three possibilities come to mind:

1. The federal government could choose to employ or contract with hospitals, physicians, and other professionals to treat citizens who need medical care. Under this British model, the government would act not simply as an insurer but as a provider of healthcare.<sup>205</sup> The Veterans Affairs (VA) healthcare system takes this approach in the United States.<sup>206</sup> By implementing a fully federal program for all persons that provides care rather than just coverage, VA-healthcare-for-all would address all of the causes of instability in U.S. healthcare rights. However, even though the VA healthcare system has become a model for implementing reforms to promote quality and reduce cost,<sup>207</sup> such an approach is infeasible—it would quickly come under attack as entailing socialized medicine.

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<sup>200</sup> See EISINGER, *supra* note 73, at 39 (summarizing amendments Congress made to the food stamp program in the 1970s that led to availability in every state and county by 1975).

<sup>201</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(a)(1)(C), 124 Stat. 119, 271 (2010).

<sup>202</sup> Patient Protection and Affordable Care Act § 1302(b), 124 Stat. at 163; Pear, *supra* note 197, at A1.

<sup>203</sup> Pear, *supra* note 197, at A1.

<sup>204</sup> Essential benefits must include coverage for hospitalization, emergency care, out-patient services, maternity and newborn care, mental health and substance abuse services, prescription drugs, laboratory testing, preventive and wellness care, pediatric services (including dental and vision examinations), rehabilitative care, and habilitative care such as services for children with developmental disabilities. Patient Protection and Affordable Care Act § 1302(b), 124 Stat. at 163. In addition, coverage must be comparable to those offered in a typical employer plan, with states required to look for guidance to one of the following plans: (1) one of the three largest small group plans in the state; (2) one of the three largest state employee health plans; (3) one of the largest federal employee health plan options; or (4) the largest HMO plan offered in the state's commercial market. Pear, *supra* note 197, at A1.

<sup>205</sup> Uwe E. Reinhardt, *Reforming the Health Care System: The Universal Dilemma*, 19 AM. J.L. MED. 21, 22-23 (1993).

<sup>206</sup> See *About VHA*, U.S. DEP'T OF VETERANS AFF., <http://www.va.gov/health/aboutVHA.asp> (last visited Mar. 5, 2012) (explaining structure of Veteran's Health Administration and describing it as "the nation's largest integrated health care system").

<sup>207</sup> See *id.* ("VHA will continue to be the benchmark of health care and value in health care and benefits by providing exemplary services that are both patient centered and evidence based.").

In two options for universal coverage, the federal government would act as insurer, but not as a provider, of healthcare.

2. In one option, the government would provide healthcare coverage to everyone, paying hospital, physician, and pharmacy bills, but leaving it to individuals to choose their physicians and other healthcare professionals, who would be privately or publicly employed. Medicare follows this single-payer, Canadian healthcare model.<sup>208</sup> While programs that provide coverage rather than care can leave some beneficiaries with inadequate access to care, the universality of a Medicare-for-all program would likely ensure sufficient political support for adequate funding over time. However, the debate about a single-payer system during the passage of ACA indicates the current political infeasibility of enacting a Medicare-for-all system.<sup>209</sup>
3. Alternatively, the government could provide a voucher to everyone for the purchase of healthcare insurance, and each person would then find a private plan for coverage. The voucher would be worth the full cost of the lowest-cost plan in the market that meets minimum federal standards. In other words, just as healthcare plans have to meet federal standards to participate in the Federal Employees Health Benefits Program,<sup>210</sup> so would insurers have to meet federal standards for their plans before Americans could use their vouchers for the plans. Insurers would not be able to charge higher rates for persons with pre-existing medical conditions, and they would have to accept vouchers from all comers. While the voucher would be worth the full cost of the lowest-priced plan, individuals would have to pay out of pocket for the extra cost of a higher-priced plan. Thus, insurers would have a strong incentive to offer the lowest-cost plan. While such a program does not exist in the United States, it has been proposed by scholars like Alain Enthoven and Victor Fuchs and adopted as a policy recommendation by the Committee for Economic Development.<sup>211</sup>

A voucher-for-all reform also is the most promising path to universal coverage in terms of its political feasibility. Republicans like U.S. Senator John McCain and U.S. Representative Paul Ryan have proposed vouchers, albeit in a weak form,<sup>212</sup> in

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<sup>208</sup> Reinhardt, *supra* note 205, at 23.

<sup>209</sup> Robert Pear & Jackie Calmes, *Obama Advances His Case; Health Bill's Cost Challenged*, N.Y. TIMES, June 16, 2009, at A1 (reporting Obama's assurances to the AMA that he would not propose a single-payer healthcare system).

<sup>210</sup> COMM. FOR ECON. DEV., QUALITY, AFFORDABLE HEALTH CARE FOR ALL: MOVING BEYOND THE EMPLOYER-BASED HEALTH-INSURANCE SYSTEM 54 (2007), available at [http://www.ced.org/images/library/reports/health\\_care/report\\_healthcare07.pdf](http://www.ced.org/images/library/reports/health_care/report_healthcare07.pdf); see also Keith J. Mueller et al., *The Federal Employees Health Benefits Program: A Model for Competition in Rural America?*, 21 J. RURAL HEALTH 105, 106 (2005).

<sup>211</sup> COMM. FOR ECON. DEV., *supra* note 210, at 5-6; Victor R. Fuchs, *Health System Reform: A Different Approach*, 272 JAMA 560 (1994); Alain C. Enthoven, *Consumer-Choice Health Plan—A National-Health-Insurance Proposal Based on Regulated Competition in the Private Sector*, 298 NEW ENG. J. MED. 609 (1978).

<sup>212</sup> The McCain and Ryan vouchers would be inadequate because they do not cover the full cost of healthcare insurance. In addition, insurers would not be required to accept all applicants and therefore could try to “cherry-pick” younger, healthier subscribers. See Clive Crook, *The Trouble with McCain's Health Care Plan*, NAT'L J., May 3, 2008, available at [http://www.nationaljournal.com/njmagazine/wn\\_20080503\\_8652.php](http://www.nationaljournal.com/njmagazine/wn_20080503_8652.php); Robert Pear, *G.O.P. Blueprint Would Remake Health Policy*, N.Y. TIMES, Apr. 5, 2011, at A1.

large part because vouchers allow for reform that minimizes the role of government in managing the U.S. healthcare system.

## VI. CONCLUSION

The Patient Protection and Affordable Care Act was an important step forward in the effort to establish meaningful rights to healthcare in the United States. There is much more to be done, however, before Americans can rely on their healthcare rights to receive the healthcare that they need.