

2013

Developing a Durable Right to Health Care

Erin C. Fuse Brown

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Recommended Citation

Erin C. Fuse Brown, *Developing a Durable Right to Health Care*, 14 MINN. J.L. SCI. & TECH. 439 (2013).
Available at: <http://scholarship.law.umn.edu/mjlst/vol14/iss1/10>

The Minnesota Journal of Law, Science & Technology is published by the University of Minnesota
Libraries Publishing.



Developing a Durable Right to Health Care

Erin C. Fuse Brown*

ABSTRACT

The Patient Protection and Affordable Care Act's (ACA) signature accomplishment was the creation of a statutory right to health care for the uninsured. This is a momentous change in policy, addressing one of the most vexing social issues of our time and affecting millions of people and billions of dollars of the U.S. economy. This ambition and the degree of societal and political debate leading up to the Act's passage suggests that it is a "superstatute," a rare breed of statute that can, among other things, create rights and institutions more typically thought to be the province of constitutional undertaking. Nevertheless, the structure of the ACA's right to health care makes it fragile and reduces its chances of becoming a durable right. The ACA may end up as a "quasi-superstatute:" a statute that aspires but fails to become a superstatute through a failure of political and public entrenchment. The problem is that the right to health care is to be delivered largely through changes to the private health insurance market, requiring the collective action of many reluctant actors, including unwilling states and recalcitrant individuals. Even though it survived legal challenge before the Supreme Court, the ACA's right to health care faces significant political and market challenges that threaten to retrench rather than entrench its benefits in the public's mind. The vulnerability of this right to health care is concentrated early in its lifespan, and if it survives these early years, forces such as the endowment effect may strengthen the right's durability as its

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benefits take hold. The fragility of the ACA's right to health care and its uncertain path to durability provide lessons to future framers of a right to health care regarding the long timeframe for implementation, uncertainty, complexity, and structure. The risk of becoming a "quasi-superstatute" highlights the importance of how such social reforms ought to be structured to achieve entrenchment and durability after the ink is dry on the new legislation.

INTRODUCTION	440
I. CURRENT LANDSCAPE OF THE RIGHT TO HEALTH CARE IN THE UNITED STATES	445
A. Absence of a Federal Constitutional Right to Health Care.....	448
B. Existing Federal Statutory Rights to Health Care...	451
C. The Right to Health Care under the Affordable Care Act.....	455
II. DURABILITY OF THE AFFORDABLE CARE ACT'S RIGHT TO HEALTH CARE	461
A. Using Superstatutes to Create Durable Statutory Rights	461
B. The Affordable Care Act's Fragile Right to Health Care	465
1. Political Challenges	467
2. Legal Challenges.....	471
3. Market Challenges.....	473
C. Quasi-Superstatutes	476
III. DEVELOPING A DURABLE RIGHT TO HEALTH CARE.....	480
A. The Affordable Care Act's Path to Durability.....	480
B. Implications for Efforts to Establish a Durable Right to Health Care	485
IV. CONCLUSION.....	490

INTRODUCTION

Nikki White had aspired to become a physician when she was diagnosed with lupus at the age of twenty-one. After her diagnosis, she set that ambition aside, but she found work at a hospital trauma unit that came with health insurance benefits. After becoming too ill to continue her job, she lost her health insurance coverage and moved back home to live with her parents. For the next few years, she struggled to gain coverage

through TennCare, her state's Medicaid system, gaining coverage only to lose it again when the program suffered cuts. No private insurance company would cover her with a preexisting medical condition. Although the vast majority of lupus patients live a normal lifespan, it is an illness that requires extensive medical management.¹ Nikki was not so lucky; she was rushed to the hospital after collapsing at home and succumbed to her illness at the age of thirty-two in severe pain, bleeding internally, and suffering multiple organ failure. Her physicians believe that she would not have died had she had health insurance and been able to receive proper care for her disease. Instead, she joined the approximately 18,000 Americans who die every year from a lack of health care coverage.²

Had she lived long enough, Nikki could have obtained health care coverage under the Patient Protection and Affordable Care Act of 2010 (ACA). Among its many provisions, the ACA's most significant is one that creates a right to health care in this country for the uninsured.³ Having largely survived legal challenge at the Supreme Court, this right is a momentous change in American health policy. The practical question for most people like Nikki White, however, is if they lose their job or their health insurance, will the ACA provide a meaningful right to health care that they can count on in the future? The answer turns on whether the right to health care created by the Act is durable. A durable right is a right that will last for a long time without deterioration.

Analyzing the durability of the ACA's right to health care requires an evaluation of what makes a right durable. The quintessential durable right is a constitutional right, which, once established, is entrenched against political or partisan attack through the difficult amendment process of the U.S. Constitution. That may be one of the reasons scholars and advocates alike look to the Constitution—a constitutional right

1. Jane Zhang, *Amid Fight for Her Life, Lupus Patient Fights for Insurance*, POST-GAZETTE (Dec. 5, 2006, 12:00 AM), <http://www.post-gazette.com/pg/06339/743713-84.stm>.

2. Nicholas D. Kristof, *The Body Count at Home*, N.Y. TIMES, Sept. 12, 2009, at WK18.

3. Barry Furrow, *Health Reform and Ted Kennedy*, *The Art of Politics and Persistence*, 14 N.Y.U. J. LEGIS. & PUB. POL'Y 445, 447 (2011) ("The ACA is . . . a reform of private employment insurance, intended to increase coverage for those who are currently uninsured.").

comes with a level of structural entrenchment through Article V amendment requirements, which makes the right resilient against the political whims of the time. Contrary to the popular and scholarly bias toward locating a right to health care in the Constitution, there is no federal constitutional right to health care.⁴ Instead the federal right to health care is largely a creature of statute, which does not automatically come with political protection or structural entrenchment.

In the context of a statutory right to health care, there is a patchwork of federal statutes that cover various groups: Medicare, Medicaid, the Veterans Administration health system, TRICARE for active duty military and their families, the Emergency Medical Treatment and Active Labor Act (EMTALA), and, most recently, the ACA. The right to health care under the Medicare program, in particular, is an example of a durable statutory right that has become a cherished and politically entrenched right.⁵ The problem with the statutory right to health care until now has been its patchwork nature, covering only certain subpopulations and leaving in excess of 50 million uninsured.⁶ The ACA purports to fill in the gap by extending a statutory right to health care to those previously not covered by an existing federal statutory right or through private health insurance. It is uncertain, however, whether the ACA's right to health care will become a durable right like the right under Medicare, or whether it will fall short of its promise of assuring access to health care for the uninsured.

The statutory nature of the right to health care in this country is consistent with theories of sub-constitutionalism, which posit that much of the constitutional work in this country, namely creation of rights and governmental institutions, is accomplished through statutory or regulatory law.⁷ According to one vein of sub-constitutional scholarship

4. Puneet K. Sandhu, Comment, *A Legal Right to Health Care: What Can the United States Learn from Foreign Models of Health Rights Jurisprudence?*, 95 CALIF. L. REV. 1151, 1162 (2007) ("Despite the moral, citizenship, and equal opportunity rationales for a right to health care, the Supreme Court has not recognized health care as a constitutional right.").

5. Furrow, *supra* note 3, at 452–453.

6. *Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2009*, U.S. CENSUS BUREAU, http://www.census.gov/hhes/www/cpstables/032010/health/h05_000.htm (last visited Nov. 17, 2012).

7. See generally Mark Tushnet, *Subconstitutional Constitutional Law:*

popularized by William Eskridge, Jr. and John Ferejohn, the heavy lifting of sub-constitutionalism is accomplished through a breed of federal statutes called “superstatutes.”⁸ Superstatutes address serious social problems and gain such broad public support that they are entrenched against future political attack.⁹ Three features distinguish superstatutes from ordinary statutes: first, the statute must substantially alter the existing regulatory baseline with a new principle or policy; second, the statute is generated after a long period of public deliberation; and third, the new principle or policy “sticks” in the public culture such that it becomes a fundamental or axiomatic legal norm.¹⁰

One way to create a durable right via statute is through a superstatute. The same features that make a superstatute “super,” namely public support and the entrenchment that follows, also make the rights created by such a statute durable. The ACA has the pedigree of a superstatute, achieving a significant change from existing coverage baselines and the largest expansion of health care access in a generation.¹¹ The legislation was undertaken to address the serious social problem of lack of universal access to health care, following a period of intense public and political debate and deliberation. Nevertheless, the ACA is in a particularly vulnerable period, and its prospects for creating a durable right to health care are, at best, uncertain.

One limitation of the superstatutes theory is that it does not describe how to predict whether a statute will be a superstatute. Applying the criteria for superstatutes, it is unknown at the outset whether a statute will become a superstatute (and thus whether the rights it creates become durable rights) until it has withstood the test of time. Some statutes address important social problems and undergo

Supplement, Sham, or Substitute?, 42 WM. & MARY L. REV. 1871 (2001) (providing a commentary on the use of subconstitutional doctrines).

8. WILLIAM N. ESKRIDGE JR. & JOHN FERREJOHN, A REPUBLIC OF STATUTES: THE NEW AMERICAN CONSTITUTION 26 (2010) [hereinafter A REPUBLIC OF STATUTES].

9. William N. Eskridge, Jr. & John Ferejohn, *Super-Statutes*, 50 DUKE L.J. 1215, 1216 (2001).

10. *Id.* at 1230–31.

11. See Furrow, *supra* note 3, at 453–54 (“The ACA will harmonize health care in the United States with the idea of universal coverage of all citizens as a right, in large part by moving private health insurance closer to quasi-social insurance.”).

serious public deliberation, but somehow fail to live up to their promise of solving the social challenge. These statutes may reflect the aspirational characteristic of superstatutes, but fail to become entrenched through widespread public support. I propose that these would-be, but failed, superstatutes occupy their own category called “quasi-superstatutes.” Quasi-superstatutes fall short of their “super” aspirations because the rights or new legal norms they create are not fully accepted by the public, either because the public does not agree with the norm or because not enough of the public experiences the benefits of the new right or legal norm before it is rolled back by courts or future Congresses. Given that entrenchment is the key to durability, assessing the aspects of a statute that will make it more or less likely to become entrenched help predict whether a statute will be a superstatute or quasi-superstatute.

This Article’s central claim is that although the ACA creates a new right to health care for the uninsured, the structure of this right to health care makes it fragile and more likely to end up as a quasi-superstatute than a superstatute. In particular, the ACA’s right to health care may be structurally weaker than the right under other federal programs like Medicare. Rather than creating a federally-funded and administered benefit program that can rapidly deliver benefits to wide population and gain support, the ACA bases its right on private health insurance reforms with the following vulnerabilities: (1) the right faces a long time-frame for implementation without delivering benefits while susceptible to political attacks; (2) judicial challenges to the individual mandate and Medicaid provisions created uncertainty that delayed implementation; and (3) the right depends on the creation of a private insurance market through the collective action of a host of potentially reluctant private actors, states, and individuals.

The ACA’s uncertain path to durability depends largely on whether it survives the long time period prior to implementation of its benefits. Once its benefits begin, a diverse interest group may emerge to defend the ACA’s right to health care, including not only individuals who gain benefits, but also the insurance companies and health care providers who gain new customers and patients. The greater the sunk costs by those implementing the reforms, the greater the incentive to maintain the current arrangement rather than

abandoning it for a new approach. If the fragility of the ACA's right to health care relegates it to the quasi-superstatute category, its weaknesses provide several strategic lessons for those continuing to seek a durable right to health care. In particular, efforts to develop a durable right should deliver benefits quickly, while avoiding statutory complexity that makes it difficult for the public to understand its benefits and legal uncertainty that inhibits implementation and confidence among stakeholder groups.

This Article proceeds in three parts. Part I describes the current landscape of the federal right to health care in the United States, tracing the absence of a broad, federal constitutional right to health care and the statutory efforts to fill the constitutional gaps, including how the ACA creates a right to health care. Part II analyzes the durability of the ACA's right to health care, drawing on and expanding upon the sub-constitutionalism literature and theory of superstatutes to add a new category called "quasi-superstatutes" to capture those that aspire to be, but fail to achieve the entrenchment required to become a superstatute. Part III explores how the ACA's right to health care could survive despite its fragility as well as the implications of the ACA's prospects as a quasi-superstatute for efforts to develop a durable right to health care in the United States.

I. CURRENT LANDSCAPE OF THE RIGHT TO HEALTH CARE IN THE UNITED STATES

To understand what makes a right to health care durable, the "right to health care" must be defined. The right to health care is the non-excludable right to access and receive some minimum level of health care services.¹²

The right to health care is distinct from the right to health. Conceptually, a right to health is broader than a right to health care, because a right to health encompasses all the actions government can take to ensure the health of the population, which would include not just health care services, but also

12. See Mark Earnest & Dayna Bowen Matthew, *A Property Right to Medical Care*, 29 J. LEGAL MED. 65, 69 (2008) (recognizing a property interest in health care, defined as "the medical goods and services that hospitals, physicians, and other providers deliver"); Sandhu, *supra* note 4, at 1160 ("A right to health care . . . entitles right-holders to the "goods and services" that aid in the achievement of health and, consequently, obligates the government to ensure access to these goods and services.").

adequate provision for the myriad social, economic, and environmental determinants of health, such as housing, education, employment, nutrition, and clean air and water.¹³ Such a right to health is often cast in the framework of human rights and, due to the impossibility of guaranteeing the health of all persons, is aspirational.¹⁴ As a precatory guiding principle, such a broadly conceived right to health is nowhere to be found in the U.S. Constitution and, as has been observed in states with constitutional rights to health, is of limited utility in terms of enforcement, justiciability, or delivery.¹⁵

This Article focuses on the narrower, legal right to health care, rather than the right to health. Even the narrower conception of a right to health care is difficult to define without grappling with the normative and practical judgment of defining what substantively ought to be included in a minimum benefits package constrained by limited resources and capacity of the health care delivery system. A minimum benefits package to which everyone would have a basic right will also be ever-evolving as new technologies and scientific discoveries

13. U.N. Committee on Economic, Social, and Cultural Rights, General Comment, *The Right to the Highest Attainable Standards of Health*, General Comment, U.N. Doc. No. 14. CESCR, E/C. 12/2000/4, available at [http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En) (“The Committee interprets the right to health . . . as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.”).

14. William P. Kratzke, *Tax Subsidies, Third-Party-Payments, and Cross-Subsidization: America's Distorted Health Care Markets*, 40 U. MEM. L. REV. 279, 390 (2009) (“Obviously, no system can guarantee any particular level of health.”); Sandhu, *supra* note 4, at 1160 (“A right to health implies that every person is entitled to perfect health. Although perfect health may be achievable at some point in the future, it is not a realistic benchmark against which to adjudicate a right.”).

15. See Elizabeth Weeks Leonard, *State Constitutionalism and the Right to Health Care*, 12 U. PA. J. CONST. L. 1325, 1392 (2010) (“More than a dozen states give constitutional imprimatur to health. Judicial decisions in the seven states examined demonstrate a general reluctance to recognize affirmative, enforceable health rights. Indeed, there is not a single provision or case supporting a universal right to publicly funded health care.”); see also Sandhu, *supra* note 4, at 1158 (“[T]he problem of defining and implementing a right to health is three-fold: indeterminacy (how to characterize it), justiciability (how to enforce it), and progressive realization (how to raise the standard over time).”).

change the scope of medical care.¹⁶ Some have argued that the right to health care should be defined as the amount of health care that can be delivered in an equal manner, given the country's resources, to all of its citizens.¹⁷ Others propose that the right ought to be defined by the level of care that society may use its collective coercive power to make universally accessible.¹⁸ In practice, the right to health care is often defined in categorical terms, by types of services, level of coverage, and consumer obligations and protections. This was the approach taken by Congress in the ACA, defining an "essential benefits package" as including items and services in certain general categories.¹⁹ While development of the ACA's definition of an essential benefits package may have been informed by ethical or human rights considerations, the essential benefits package was based on what a typical U.S. employer-based health benefits package covers.²⁰ This fact underscores the point that

16. Daniel Callahan, *What is the Reasonable Demand on Health Care Resources? Designing a Basic Package of Benefits*, 8 J. CONTEMP. HEALTH L. & POL'Y 1, 2 (1992) ("It has proven impossible, however, to use 'medical need' as a single meaningful criterion for a basic health care package. Instead, that package must be grounded in an array of ingredients—medical, ethical, social, and political. More importantly, there must be a political dimension to the idea of a basic package or at least some role for the public to express its own values about what it believes is a minimally adequate level of care.")

17. See Sandhu, *supra* note 4, at 1160 ("A right to health care may be defined as equality of access: whatever health care resources society provides must be provided to everyone on an equal basis."); Kratzke, *supra* note 14, at 391–92 ("Disagreement over the extent of an entitlement to health care does not focus on a minimum level of care but on what is an acceptable level of (in)equality.")

18. See Paul T. Menzel, *The Cultural Moral Right to a Basic Minimum of Accessible Health Care*, 21 KENNEDY INST. ETHICS J. 79, 90 (2011).

19. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1302, 124 Stat. 119, 163–68 (2010) (including in the essential benefits package the following services: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care). The task of further explicating the details of the minimum benefits package is left, like much of the ACA's implementation, to the Secretary of the Department of Health and Human Services (HHS).

20. Patient Protection and Affordable Care Act § 1302(b)(2)(A). The Institute of Medicine recommends the essential benefits package be modeled after a typical small-group plan rather than large-group plan due to concerns regarding affordability. See INST. OF MED., *ESSENTIAL HEALTH BENEFITS: BALANCING COVERAGE AND COST* 86 (Cheryl Ulmer et al. eds., 2011).

any practical definition of a right to health care in the United States is inextricably tied to the health care delivery system currently in existence, such that a right to health care is often framed as a right to a basic level of health insurance. For all but the extremely wealthy or supremely healthy, meaningful access to health care services in the U.S. requires financing through health insurance.²¹ Thus, the right to health care can take the form of a right to non-excludable access to a minimum level of health services that is financed through affordable health insurance coverage.

This Part sets forth the current state of the federal right to health care in this county, identifying the absence of a federal constitutional right to health care and the existing federal statutes that create rights to health care for a variety of sub-populations. It then examines the right to health care created by the ACA and how its structure differs from other federal rights to health care.

A. ABSENCE OF A FEDERAL CONSTITUTIONAL RIGHT TO HEALTH CARE

It is generally agreed that there is no broad right to health or health care under the federal constitution.²² As other

21. See Mark A. Hall, *Approaching Universal Coverage With Better Safety-Net Programs for the Uninsured*, 11 YALE J. HEALTH POL'Y, L. & ETHICS 9, 9 (2011); Eleanor D. Kinney, *Recognition of the International Human Right to Health and Health Care in the United States*, 60 RUTGERS L. REV. 335, 356 (2008) ("Health insurance coverage is the most important means for assuring that individuals have access to expensive health care services."); Kratzke, *supra* note 14, at 281 ("Health insurance is a payment system through which Americans receive their medical care, even the predictable routine health care, the cost of which should not be beyond the means of most of them."). While the right to health insurance is a proxy for the right to health care for most, it remains conceivable that a right to health care could be fulfilled through the direct provision of health care services, such as the services provided through publicly funded clinics and safety-net hospitals. See Hall, *supra* note 21, at 9 ("Insurance, after all, is not an end in itself; it is the best means of access to affordable care. But, if other means to minimally acceptable access exist, they may provide a form of non-insurance, direct-access coverage that helps to fill the remaining coverage gap for the uninsured.")

22. See Leonard, *supra* note 15, at 1329 ("[T]he U.S. Constitution does not explicitly or implicitly recognize health as a right."); Tom Stacy, *The Courts, the Constitution, and a Just Distribution of Health Care*, 3 KAN. J.L. & PUB. POL'Y 77, 82, 91 & n. 64 (1993–94) ("The Supreme Court has now rejected the notion of a constitutional welfare right to health care and other basic goods, such as education."); Kenneth Wing, *The Right to Health Care in the United*

scholars have argued extensively, the U.S. Constitution provides neither a textual nor structural basis for such a right.²³ Health is never mentioned in the Constitution, a document that is often described as providing a charter of negative rights that limit government action rather than impose any affirmative obligation of the government to provide for the health or welfare of its citizens.²⁴ Scholars have often pointed to (and criticized) this feature of American constitutionalism, comparing it to other countries' or states' constitutional obligations to provide their citizens health care or other social and economic goods.²⁵ Despite the limitations of a conceptual dichotomy between positive rights (e.g., entitlements to social goods) or negative rights (e.g., liberties or freedom from interference),²⁶ this distinction is a useful description of the federal constitutional posture toward a right to health.²⁷ For example, the Supreme Court has recognized

States, 2 ANNALS HEALTH L. 161, 162 (1993) (“[T]he United States Constitution does not require the federal government, the state governments, or any other level of government to protect the health of its citizens collectively or individually.”).

23. See Leonard, *supra* note 15, at 1329 (“By contrast to several state constitutions, the federal constitution does not expressly reference the word “health” in any provision.”); Wing, *supra* note 22, at 162; see also Kinney, *supra* note 21, at 353 (“The Federal Constitution is silent on the matters of health and health care.”).

24. See *DeShaney v. Winnebago Cnty. Dep’t of Soc. Servs.*, 489 U.S. 189, 195 (1989) (“[N]othing in the language of the Due Process Clause itself requires the State to protect the life, liberty, and property of its citizens against invasion by private actors. The Clause is phrased as a limitation on the State’s power to act, not as a guarantee of certain minimal levels of safety and security.”); *Barksy v. Bd. of Regents*, 347 U.S. 442, 472–73 (1954) (Douglas, J., dissenting) (“The Bill of Rights does not say . . . what government must give, but rather what it may not take away.”); *Jackson v. City of Joliet*, 715 F.2d 1200, 1203 (7th Cir. 1983) (“[T]he Constitution is a charter of negative rather than positive liberties. The men who wrote the Bill of Rights were not concerned that government might do too little for the people but that it might do too much to them.”); see also, Helen Hershkoff, “*Just Words*”: *Common Law and the Enforcement of State Constitutional Social and Economic Rights*, 62 STAN. L. REV. 1521, 1524 (2010) (“American constitutionalism consistently is seen as excluding social and economic rights.”).

25. See Sandhu, *supra* note 4, at 1154; see also Leonard, *supra* note 15, at 1391–92.

26. RONALD DWORKIN, *TAKING RIGHTS SERIOUSLY* 266–71 (1978).

27. Abigail Moncrieff, *The Freedom of Health*, 159 U. PA. L. REV. 2209, 2211 (2011) (“Unlike the international human right to health, this American freedom of health would operate primarily as a restriction on—rather than as an obligation for—governmental regulation of medical decision-making.”).

certain negative rights involving health or health care under the Due Process Clause: including the freedom of health care decision-making, privacy, and access in the context of end of life, health information privacy, and abortion under the Due Process Clause.²⁸ When government does provide health care under benefit programs such as Medicare or Medicaid, the benefits must be administered in accordance with the Equal Protection Clause.²⁹ Nevertheless, the Court has not recognized a generally applicable positive right to health care, and it seems unlikely ever to do so.³⁰

An affirmative constitutional right to health care has been recognized only in very limited circumstances, such as where persons have lost the liberty to care for themselves. For example, the Eighth Amendment's prohibition against cruel and unusual punishment requires provision of medical treatment to prisoners,³¹ and the Due Process Clause of the Fourteenth Amendment requires the state to ensure the

28. *Roe v. Wade*, 410 U.S. 113, 115 (1973); *Eisenstadt v. Baird*, 405 U.S. 438, 443 (1972); *see also* *Washington v. Glucksberg*, 521 U.S. 702, 723 (1997). *Cf.* *Cruzan v. Mo. Dep't of Health*, 497 U.S. 261, 286-87 (1990) (finding a Due Process liberty interest in patient's right to refuse life-sustaining treatment but upholding state law requiring clear and convincing evidence of patient's wishes).

29. *See Stacy*, *supra* note 22, at 83 ("[W]hen government spends its resources on goods that greatly influence a person's life opportunities, such as health care, it must do so in a way that[] promotes rough equality of access to at least some minimally adequate level of opportunity."); *Wing*, *supra* note 22, at 164 ("In authorizing or implementing such programs as Medicaid, Medicare, or any of the other federal, state, or local health care financing or service activities, the government must comply with important constitutionally-imposed constraints, particularly the nondiscrimination requirements of equal protection and the 'fairness' requirements of due process as imposed by the Fifth and Fourteenth Amendments.").

30. *See Harris v. McRae*, 448 U.S. 297, 318 (1980); *Maher v. Roe*, 432 U.S. 464, 469 (1977); *Dandridge v. Williams*, 397 U.S. 471, 487 (1970) (declining to find welfare rights in the Constitution); *Leonard*, *supra* note 15, at 1330 ("Setting aside well-meaning proposals, the likelihood of a federal constitutional amendment identifying health as a right is all but unimaginable."); *see also Stacy*, *supra* note 22, at 77 ("[A]nother unquestioned premise holds that legislatures are the sole forum for any reform of the distribution of health care, and that the Constitution, as interpreted and enforced by the judiciary, has virtually nothing to say. It is understandable that this premise should be taken for granted. As a practical matter, the current Supreme Court will not significantly involve itself in this issue, and any reform must emerge from Congress.").

31. *Estelle v. Gamble*, 429 U.S. 97, 103 (1976).

reasonable safety of the involuntarily committed.³² Scholars have also advanced arguments for a constitutionally protected property interest in health care from a federally-funded and -subsidized delivery system or a constitutional right to access potentially life-saving but non-FDA approved drugs or human organs as a form of medical self-defense.³³ These are narrow exceptions (or proposed exceptions) to the general maxim that the Constitution does not guarantee a broad right to health care.

Perhaps the reason scholars and advocates continue to try to locate a right to health care in the Constitution is that constitutional recognition makes a right seem more permanent or durable. Constitutional rights are structurally entrenched against political encroachment because of the supremacy of the Constitution relative to the laws of the political branches of government and because of the difficult Article V amendment process.³⁴ Recognizing a constitutional right to health care also conveys a normative message about the value of such a right to the American people, consistent with the canonical reverence with which Americans regard their founding document.³⁵ From a practical standpoint, those lamenting the legislature's longstanding political inability to act may be attracted to a judicial recognition of a constitutional right to health care because it would command the legislature to effectuate the right.³⁶ Despite this scholarly and popular bias toward constitutional rights, existing federal rights to health care are almost entirely statutory in derivation.

B. EXISTING FEDERAL STATUTORY RIGHTS TO HEALTH CARE

In the absence of a constitutional right to health care,

32. *Youngberg v. Romeo*, 457 U.S. 307, 324 (1982).

33. See Earnest & Matthew, *supra* note 12 at 69; Eugene Volokh, Essay, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. 1813, 1835 (2007).

34. See A REPUBLIC OF STATUTES, *supra* note 8, at 115.

35. John F. Preis, *Constitutional Enforcement By Proxy*, 95 VA. L. REV. 1663, 1665–67 (2009) (noting that “Americans love their Constitution,” and arguing that contrary to this constitutional preference, sub-constitutional law may also be constitutive of the national order).

36. See Sandhu, *supra* note 4, at 1169 (“A constitutional right to healthcare in the United States, or perhaps even the threat of a constitutional amendment, would force political action to break the special interest logjam that has bedeviled efforts at healthcare reform by obligating Congress to address healthcare comprehensively.”).

Congress has provided health care to various subgroups of the U.S. population through statutes. These statutes create a right to health care for those who fall within the covered categories, primarily by creating a federally-funded benefit program and committing to the provision or financing of health care services for those eligible to participate.

The Medicare program provides coverage to citizens and legal residents sixty-five and older, the disabled, those with end-stage renal disease or amyotrophic lateral sclerosis (Lou Gehrig's disease), and individuals exposed to certain environmental health hazards.³⁷ Medicaid and the Children's Health Insurance Program (CHIP) are administered and funded through federal-state cooperation to provide health care services to eligible poor.³⁸ Medicaid eligibility varies by state, but currently extends only to a subgroup of the poor, including children, pregnant women, the blind, and certain disabled and elderly.³⁹ The federal government also provides health care coverage and services to active duty military members, retirees, and their families under the TRICARE program⁴⁰ and to disabled and low-income veterans under the Veterans Health Administration.⁴¹ According to 2009 census data, these governmental programs collectively cover approximately thirty-one percent of the United States population.⁴² In other words, about one-third of the population has a statutory right to

37. Social Security Act of 1965, Pub. L. No. 89-384, 80 Stat. 99, 99-106 (codified at 42 U.S.C. § 1395 (2006)); Pub. L. No. 110-27, 121 Stat. 111 (codified at 42 U.S.C. § 426 (2006)); Pub. L. No. 111-148, 124 Stat. 119, 119-1024 (codified at 42 U.S.C. § 1395rr-1 (2006)) (providing Medicare coverage and medical screening services to individuals exposed to environmental health hazards as a result of a public health emergency declaration under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980 (CERCLA)).

38. Social Security Act of 1965, 42 U.S.C. § 1396 (2006). CHIP was created as part of the Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4901, 111 Stat. 251, 552 (codified at 42 U.S.C. §§ 1397aa-1397jj); see also Children's Health Insurance Program Reauthorization Act of 2009, Pub. L. No. 111-3, 123 Stat. 8 (2009) (codified as amended in scattered sections of 42 U.S.C.) (financing CHIP through 2013).

39. Social Security Act, 42 U.S.C. §§ 1396r-1.

40. 10 U.S.C. §§ 1071-1110 (2006).

41. 38 U.S.C. §§ 1710(a), 1722(a) (2006).

42. *Table HI05. Health Insurance Coverage Status and Type of Coverage by State and Age for All People: 2009*, U.S. CENSUS BUREAU, http://www.census.gov/hhes/www/cpstables/032010/health/h05_000.htm (last visited Nov. 17, 2012) [hereinafter *Insurance Coverage Status*].

health care from one of these government programs. An additional fifty-two percent of the population is covered through some form of private insurance, whether employer-based or direct-purchased.⁴³ As of 2009, the approximate remaining seventeen percent of the population (50,674,000 persons) were uninsured.⁴⁴

The statutory language of these benefit programs provides the right to health care for covered individuals by either (1) creating the benefit program and providing that eligible individuals are entitled to enroll or (2) creating an obligation of third parties (such as state governments or private actors) to provide financing or services to eligible persons. For example, the Medicare statute creates a right by stating that every eligible individual “shall be entitled to hospital insurance benefits” under Medicare’s hospital benefits program (Part A) without having to pay hospital insurance premiums.⁴⁵ All those who are enrolled in Medicare Part A are eligible to enroll in Part B,⁴⁶ which covers non-hospital expenses such as physicians’ and outpatient services. The Medicaid statute requires state plans to provide “medical assistance” payments for covered medical services to all eligible persons.⁴⁷ Under TRICARE’s statute, all members of a uniformed service are entitled to medical and dental care in any military facility.⁴⁸

43. *Id.* The 2009 census data report that sixty-four percent of the population has some form of private health insurance, but of these, approximately twelve also have government health insurance through Medicare or Medicaid. *Id.*

44. *Id.*

45. Social Security Act, Pub. L. No. 89-384 § 226 (codified at 42 U.S.C. § 426 (2006)); Social Security Act § 226A. Medicare hospital benefits (Part A) are available without premiums to all those over age sixty-five who are eligible for Social Security. For those who are not eligible for Social Security benefits because, for example, they never worked or have never been married to someone who worked, Medicare is available but requires payment of premiums. For those who must pay premiums to obtain coverage, the statute states that all such persons “shall be eligible to enroll” in Medicare Part A. Social Security Act § 1818; Social Security Act § 1818A.

46. Social Security Act § 1836.

47. 42 U.S.C. § 1396a(a)(10)(A)–(B) (2006). Eligible persons include those who fall into mandatory categories of eligibility (e.g., certain pregnant women and children) and other optional categories determined by the state. Medicaid also contains a nondiscrimination requirement that the medical assistance provided to one person “shall not be less in amount, duration, or scope than the medical assistance made available to any other such individual . . .” 42 U.S.C. § 1396a(a)(10)(A)–(B).

48. 10 U.S.C. § 1074(a)(1) (2006). Dependents of members of the

EMTALA creates a right to emergency health care for persons with an emergency medical condition, regardless of the patient's ability to pay.⁴⁹ EMTALA embodies the non-excludable nature of the right to health care, because emergency care must be provided to anyone who shows up to an emergency room with an emergency medical condition in hospitals participating in Medicare. The right, however, is limited in scope because it only requires hospitals to provide enough care to stabilize a person's emergency condition⁵⁰ and thus falls short of even the most ungenerous conception of the minimum benefits package. It does not, for example, cover preventive care, primary care, prenatal care, care for chronic conditions, follow-up care, or tertiary care (such as surgery or invasive diagnostic tests) that are not necessary to stabilize the patient's emergency medical condition. However, for the uninsured, the right to emergency medical care is the only right to health care universally available, which may, in part, explain why care is increasingly sought in emergency rooms in the United States.⁵¹ Unlike the federal benefit programs, EMTALA does not create a government-funded health care program or state that all individuals have a right to emergency medical care that the government will pay for or provide. Instead, it requires that hospitals, as a condition of participating in Medicare, provide emergency care in a nondiscriminatory manner to all who present at their

uniformed services are also covered under TRICARE, but the statutory language granting them access is weaker, requiring that the Secretary of Defense to contract with managed care or other health plans to provide medical and dental services for military members' dependents, but only to the extent that the Secretary considers appropriate. 10 U.S.C. § 1079(a).

49. Emergency Treatment and Active Labor Act, 42 U.S.C. § 1395dd. An "emergency medical condition" is defined as:

[A] medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part

42 U.S.C. § 1395dd(e)(1)(A).

50. *Id.* § 1395dd(b)–(c) (2006).

51. See Menzel, *supra* note 18, at 84; Stephen R. Pitts et al., *Where Americans Get Acute Care: Increasingly, It's Not at Their Doctor's Office*, 29 HEALTH AFF. 1620,1624–25 (2010).

emergency room.⁵²

C. THE RIGHT TO HEALTH CARE UNDER THE AFFORDABLE CARE ACT

This patchwork of federal programs discussed above provides a statutory right to health care for certain subgroups of the population. These programs, however, leave uncovered approximately 43 million uninsured working-age adults and 7.5 million uninsured children.⁵³ Congress responded to this growing population of uninsured by creating a health insurance coverage scheme to accomplish near-universal coverage for those without health insurance. The ACA contains several provisions that, when considered together, create a statutory right to health care for the population not eligible for an existing federal benefit program nor covered through employer-sponsored or other private insurance.⁵⁴ However, an affirmative statement that all Americans have a right to health care is nowhere to be found in the ACA.

The right to health care under the ACA is different than the other federal statutory rights because it does not create a government program to provide health care or health insurance. Other than a significant (now optional) expansion of Medicaid,⁵⁵ Congress declined to structure the right to health

52. Emergency Treatment and Active Labor Act, 42 U.S.C. § 1395dd.

53. *Insurance Coverage Status*, *supra* note 42.

54. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

55. The right to health care accomplished through expansion of Medicaid to nearly all persons up 133% of the federal poverty level was originally estimated to account for about half of the 32 million of those of those to be newly insured under the ACA. The other half are covered through the right to health care accomplished through the private insurance reform provisions discussed in this Part I. After the Supreme Court ruled that the expansion must be optional to states to be constitutional, it is unclear how many of the states will opt-out of the expansion, leaving much of their population of poor uninsured. Following the ruling, the Congressional Budget Office estimated that 6 million fewer individuals will be covered by Medicaid because their states opt out of the expansion. Of those, 3 million will obtain coverage through the Exchanges, leaving a net of 3 million additional uninsured as a result of the Supreme Court's decision. *See* CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION (2012), *available* at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>; *see also* Nat'l Fed'n of Indep. Bus. v. Sebelius, No. 11-393, slip op. (U.S. June 28, 2012); Letter from Peter Elmendorf, Director, Cong. Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives

care in the ACA through governmental provision of health care or health insurance when the so-called “public option” was defeated in earlier versions of the bill.⁵⁶ Thus, unlike the statutory language establishing an entitlement to health care or health insurance under Medicare, Medicaid, or other federal programs, the right to health care in the ACA is derived from a combination of nondiscrimination and guaranteed issue provisions applicable to private health insurers and the creation of an accessible private health insurance market. The choice to structure the right this way had the political advantage of expanding existing private markets, and it relies on competing private actors and the states to administer health care coverage in a meaningful and cost-effective manner.

The health insurance nondiscrimination portions of the right to health care are designed to prohibit health plans from engaging in practices that have previously barred individuals from obtaining coverage, such as denying coverage for preexisting health conditions or prior medical history, charging higher premiums based on gender or age, or finding technical reason to rescind coverage when a person develops a health condition.⁵⁷ Health insurance companies employ these

(Mar. 18, 2010), available at http://www.cbo.gov/sites/default/files/cbofiles/attachments/hr4872_0.pdf [hereinafter, CBO Estimate]; John V. Jacobi, Sidney D. Watson & Robert Restuccia, *Implementing Health Reform at the State Level: Access and Care for Vulnerable Populations*. 39 J.L. MED. ETHICS (special supplement) 69, 69 (2011).

56. Affordable Health Care for America Act, H.R. 3962, 111th Cong. (2009) (enacted); see also Robert Pear & Jackie Calmes, *Senators Battle Over Two Public Insurance Proposals and Reject Both*, N.Y. TIMES, Sept. 30, 2009, at A18.

57. H.R. 3962 §§ 1001, 1201 (codified at 42 U.S.C. § 300gg (2006)) (going into effect January 1, 2014 and prohibiting health plans in the group and individual markets from: (1) excluding persons from coverage on the basis of a preexisting condition; (2) setting eligibility rules based on health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability or other health status-related factors determined by the Secretary of the Department of HHS; (3) engaging in discriminatory premium pricing; and, (4) except for individual health plans, imposing waiting periods for coverage in excess of ninety days). See S. REP. NO. 111-89, at 3–4 (2009) (“For the millions of Americans who don’t have employer-sponsored coverage, cannot afford to purchase coverage on their own, or who are denied coverage by health insurance companies due to a pre-existing condition, the [bill] reforms the individual and small-group markets, making health coverage affordable and accessible. These market reforms would require insurance companies to issue coverage to all individuals regardless of health status, prohibit insurers from limiting coverage based on

underwriting practices to avoid higher-risk and higher-cost beneficiaries.⁵⁸ As a result, an individual with an existing health condition or unfavorable medical history may find she is unable to qualify for a health insurance policy or one that is affordable.⁵⁹ Or she may lose coverage for medical expenses if she hits an annual or lifetime cost-limit imposed by the plan or find herself terminated from coverage following the development of a high-cost condition, such as breast cancer.⁶⁰ In addition, the ACA's guaranteed issue provisions require health plans to accept every employer or individual in the state that applies for coverage and offer the essential benefits package, so all persons will have access to basic, comprehensive health insurance.⁶¹

The ACA's nondiscrimination and guaranteed issue provisions remove blockades to accessing health insurance by forcing health plans to accept all prospective consumers and engage in fair pricing and underwriting practices regardless of health status, gender, or genetic predisposition. Removing roadblocks only establishes part of the right to health care. The right would remain relatively empty without affordable health insurance products available to those for whom coverage was

pre-existing conditions and allow only limited variation in premium rates.”).

58. Nat'l Fed'n of Indep. Bus. v. Sebelius, No. 11–393, slip op. at 9–10 (U.S. June 28, 2012) (Ginburg, J., dissenting) (“Because individuals with preexisting medical conditions cost insurance companies significantly more than those without such conditions, insurers routinely refused to insure these individuals, charged them substantially higher premiums, or offered only limited coverage that did not include the preexisting illness.”); SUSAN JAFFE, HEALTH AFF., HEALTH INSURANCE REFORMS: SHOULD THERE BE A NEW FEDERAL LAW AND REGULATIONS TO BROADEN COVERAGE AND MAKE THE MARKET WORK BETTER FOR INDIVIDUALS AND SMALL BUSINESSES? (2009), available at http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_12.pdf.

59. See, e.g., David Hilzenrath, *Acne, Pregnancy Among Disqualifying Conditions*, WASH. POST, Sept. 19, 2009, at A3.

60. Christopher Lee, *More Hitting Cost Limit on Health Benefits: Consumers Forced To Explore Options*, WASH. POST, Jan. 27, 2008, at A3; Murray Waas, *WellPoint Routinely Targets Breast Cancer Patients*, REUTERS (Apr. 23, 2010, 7:28 PM), <http://www.reuters.com/article/2010/04/23/us-wellpoint-breastcancer-idUSTRE63M5D420100423>.

61. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1201, 124 Stat. 119, 183–84 (2010). Section 1201 also imposes affirmative requirements on individual and group health plans to accept every employer or individual in the state that applies for coverage; guarantee renewability of coverage in the individual and group markets (other than self-insured group plans); for all small group and individual plans, provide the essential benefits package; and, for all group plans, meet cost-sharing limits requirements.

previously beyond reach. This accessible health insurance market is achieved through the creation of state-based health insurance exchanges (Exchanges) and through subsidies for those unable to afford coverage.⁶² Health insurance exchanges are state-based marketplaces for “qualified health plans” that offer the essential benefits package and meet affordability and consumer protection requirements (including the nondiscrimination and guaranteed issue requirements) for qualified individuals and employers to compare information and purchase health insurance.⁶³ For those who cannot afford to purchase health insurance from the Exchange but make too much income to qualify for Medicaid, the ACA offers individual subsidies for those earning up to 400 percent of the federal poverty level.⁶⁴

The role premium subsidies play in actualizing the right to health care is highlighted by a strange outcome of the Supreme Court’s ACA decision. The decision creates a hole in the right to health care for those persons who would have been newly eligible for Medicaid under the expanded program, but whose state declines to pursue the ACA’s Medicaid expansion. Pursuant to the Court’s ruling, states may opt out of the Medicaid expansion to cover all non-retired persons up to 133% of the federal poverty level without forfeiting the federal dollars

62. *Id.* § 1311 (creating health insurance exchanges) and § 1401 (providing for premium subsidies for individuals to purchase health insurance).

63. *Id.* § 1311–12. A “qualified individual” is defined as an individual who (1) is seeking to enroll in a qualified health plan in the individual market offered through the Exchange, (2) is a citizen or lawful resident of the United States, and (3) resides in the state that established the Exchange (other than incarcerated individuals). Qualified employers initially include only small employers with fewer than 100 employees that elect to offer Exchange-based qualified health plans to full time employees, but expand to large employers after 2017. *Id.*

64. *Id.* § 1401, *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1001 [hereinafter HCERA]. The sliding-scale subsidies take the form of refundable tax credits for premium costs and limits to cost-sharing amounts and are designed to limit an individual’s out-of-pocket expenses to affordable levels, ranging from 2 percent for individuals with income up to 133 percent of the federal poverty level (FPL) to 9.5 percent for those at 400 percent of FPL. *See* S. REP. NO. 111-89, at 4 (2009) (“To ensure that health coverage is affordable, the [bill] would provide an advanceable, refundable tax credit for low and middle-income individuals (between 100–400 percent of FPL) to help offset the cost of private health insurance premiums”).

that help fund the state's existing Medicaid program.⁶⁵ If, however, a state opts-out of Medicaid, no premium subsidies would be available for those who are not eligible for Medicaid, such as childless adults, and who earn less than 100% of the federal poverty level, almost ensuring that these individuals would be left uninsured.⁶⁶

To the extent that remedies are intrinsic to the existence of a right, the ACA's right to health care, specifically the nondiscrimination provisions applicable to insurance plans are enforceable by individuals through federal regulations setting forth requirements for appeals of adverse health plan decisions and actions.⁶⁷ If a health plan fails to meet the federal requirements for the appeals process, the claimant may immediately seek judicial review.⁶⁸ What is less apparent is whether individuals seeking to purchase a health plan on the Exchanges have a remedy if their state does properly administer an Exchange or if no affordable health plans are offered in the Exchange. Such individuals, if they fall under 400% of the federal poverty limit, may be protected to some degree by availability of the subsidies to make purchase of health plans affordable.⁶⁹

The closest the ACA comes to affirmatively recognizing a right to health care is set forth in section 1312 of the ACA, which provides, "A qualified individual may enroll in any qualified health plan available to such individual and for which such individual is eligible."⁷⁰ On its face, this right appears to be limited by health plan availability and individual eligibility.

65. See Nat'l Fed'n of Indep. Bus. v. Sebelius, No. 11-393, slip op. at 50 (U.S. June 28, 2012).

66. See, e.g., Sarah Kliff, *What Happens if a State Opts Out of Medicaid, In One Chart*, WASH. POST WONK BLOG (July 5, 2012, 10:25 AM), <http://www.washingtonpost.com/blogs/ezra-klein/wp/2012/07/05/what-happens-if-a-state-opts-out-of-medicaid-in-one-chart/>.

67. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1401, 124 Stat. 119, 213-20 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1001; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Internal Claims and Appeals and External Review Processes Under the Patient Protection and Affordable Care Act, 75 Fed. Reg. 43330, 43334 (July 23, 2010) (to be codified at 26 C.F.R. pts. 54 and 602, 29 C.F.R. pt. 2590, and 45 C.F.R. pt. 147).

68. *Id.*

69. See *supra* note 64.

70. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1312, 124 Stat. 119, 182-84, amended by § 10104(i)(I).

The modifier “for which such individual is eligible” does not appear to create additional limitations because qualified individuals are, by definition, “qualified” and thus eligible to purchase health insurance made available in their own state Exchange.⁷¹ Qualified health plans must issue health insurance policies to any individual in the state who applies. Thus, a qualified individual arguably has a statutory right to obtain health insurance from a qualified health plan in their state Exchange. The availability of health plans may, however, pose a limitation. Health insurers are not required to offer qualified health plans in the Exchanges. It is assumed that health insurers will want to participate in this new market, which largely replaces and expands the individual and small group insurance markets currently in existence. There is, however, no guarantee that sufficient options will be offered by health plans in the Exchanges.

Taken together, these health insurance reforms create a negative right to health care—the right to be free from discrimination on the basis of health status when seeking coverage. The ACA’s right to health care is available for most, but not all, of the uninsured⁷² by providing non-excludable access to all individuals who seek to purchase health insurance, creating a market for these health insurance products, and subsidizing the costs of premiums for those who cannot afford coverage. Unlike the Medicare, VA or TRICARE programs, the federal government is not in charge of financing or administering the health care services to which eligible persons are entitled. The right is instead more akin to the right to emergency care under EMTALA, creating an affirmative obligation for private actors to provide coverage or care to all who need services. As with EMTALA, when government is not itself paying for or providing the health care, the right to health

71. See *supra* note 63 for the definition of a “qualified individual”.

72. The uninsured are those who are not covered by existing federal health care programs, employer-based or other private health insurance. Note, however, certain uninsured persons are left out of the ACA’s right to health care: illegal immigrants are not eligible for Medicaid or premium subsidies for the purchase of private insurance through the Exchanges. After the Supreme Court’s decision, poor adults and others who make less than 100% of the federal poverty level will not be eligible for premium subsidies because Congress believed they would be covered by the expanded Medicaid program. Such individuals in states that opt out of the Medicaid expansion will continue to be uninsured.

care is structured in terms of imposing obligations on private entities to accept all comers.

II. DURABILITY OF THE AFFORDABLE CARE ACT'S RIGHT TO HEALTH CARE

The ACA follows a line of statutes providing health care coverage to an increasing proportion of the population. In addition to health care benefits for the aged, disabled, certain poor, members of the military, and veterans, the question remains whether Americans will similarly embrace extending such a right to the uninsured. The problem with the ACA's right to health care for the uninsured is that it is structured in a way that weakens its prospects for durability. This part explores what makes a right durable, drawing on and expanding upon the sub-constitutionalism literature and theory of superstatutes to add a new category called "quasi-superstatutes" to capture those that aspire to be, but fail to achieve the entrenchment and social change required to become a superstatute.

A. USING SUPERSTATUTES TO CREATE DURABLE STATUTORY RIGHTS

Durable rights are rights that the public accepts as fundamental legal norms for society and thus persist over time without deterioration. Their widespread acceptance by the public makes them resistant to erosion or political attack when honoring the right is difficult, such as in challenging economic circumstances or when the right is applied to an unpopular group. A quintessential example of a durable right is the right to freedom of speech. The right is accepted as a fundamental norm for society's functioning, so the right remains protected even when the speech involves deeply offensive and unpopular speech.⁷³ This type of entrenchment makes a right durable and allows individuals to be able to count on the protection of and benefits of the right over time. Although constitutional rights are the traditional examples of durable rights, entrenched through the difficult Article V amendment process and constitutional supremacy, many of the positive rights in this country are created via statute rather than the Constitution.

73. See *e.g.*, *Snyder v. Phelps*, 131 S. Ct. 1207, 1218–19 (2011) (upholding the First Amendment right of members of the Westboro Baptist Church to protest at military funerals).

According to a growing body of literature that can be referred to collectively as “sub-constitutionalism,” it is unsurprising that the right to health care in this country would be accomplished via statute rather than through the Constitution. According to this account, many of the laws that create important legal norms in this country exist largely outside the four corners of the Constitution.⁷⁴ Rather, many of the functions usually thought to be of a “constitutional” nature, specifically the establishment of individual rights and governmental institutions, are accomplished through sub-constitutional laws.⁷⁵ The inflexibility and structural limitations of the Constitution drive Americans to utilize statutes to articulate and protect most of the positive rights that are guaranteed by law.⁷⁶

The problem with statutory rights is that they do not automatically come with the political protection and structural entrenchment that endow constitutional rights. Even if legislators muster the political will to create a new right, more is required to make it durable. Here, the sub-constitutional theory of superstatutes is useful because the same features

74. A REPUBLIC OF STATUTES, *supra* note 8; Bruce Ackerman, *The Living Constitution*, 120 HARV. L. REV. 1737, 1741 (2007); Ernest A. Young, *The Constitution Outside the Constitution*, 117 YALE L.J. 408, 410 (2007); Eskridge & Ferejohn, *supra* note 9, at 1215; Karl N. Llewellyn, *The Constitution as an Institution*, 34 COLUM. L. REV. 1, 3–4 (1934); *see also*, Preis, *supra* note 35.

75. A REPUBLIC OF STATUTES, *supra* note 8, at 1, 7 (“Some of the nation’s entrenched governance structures and normative commitments are derived directly from the Constitution, but most are found in *superstatutes* enacted by Congress, executive-legislative partnerships, and consensus of state legislature.”); Young, *supra* note 74, at 416 (citing society’s commitments to environmental stewardship, intergenerational responsibility, and free market economy as embodied by statutes such the Clean Water Act, Social Security and Medicare regimes, and the Sherman Antitrust Act, rather than the Constitution); *see also* Preis, *supra* note 35, at 1663 (arguing that enforcement of constitutional norms often occurs by proxy through sub-constitutional statutes that elaborate on constitutional guarantees).

76. A REPUBLIC OF STATUTES, *supra* note 8, at 25 (describing the weaknesses of the Constitution that explain the rise of sub-constitutional law: first, the Constitution is old and difficult to amend making it rigid and non-adaptive to changing norms and social problems; second, the Constitution’s largely structural and process-orientation limits its ability to respond to the substantive values and commitments important to the polity; third the Constitution primarily addresses state actors and says little to nonpublic sources of authority and power); Young, *supra* note 74, at 424 (“[M]any rights that are fundamental for individuals in modern America are entirely creatures of statute.”).

that make a statute “super” will also make a statutory right durable.

Statutory rights can be durable because they are contained within entrenched superstatutes. According to Eskridge and Ferejohn, a superstatute is a relatively rare breed of statute that is similar to, and shares the work of, constitutions—by articulating fundamental legal norms that become so embraced by both public and institutional culture that they become “deeply embedded in our national aspirations.”⁷⁷ Examples of superstatutes that have provided individual rights include: the Social Security Act, the Fair Labor Standards Act, the Voting Rights Act, and Title VII of the Civil Rights Act.⁷⁸

Three features distinguish superstatutes from ordinary statutes.⁷⁹ The statute: (1) embodies a new principle or policy that displaces common law baselines and responds to important social or economic challenges facing the country; (2) is enacted after a process of publicized institutional deliberation; and (3) sticks in the public culture, after a period of implementation and formal confirmation by Congress after further public discussion.⁸⁰ The first two features of superstatutes align with Bruce Ackerman’s concept of a “constitutional moment,” which describes the particular confluence of a strong social movement and public deliberation to address a particular injustice or problem in a way that establishes new fundamental legal norms.⁸¹ The involvement of the public and the underlying effort to address social problems give superstatutes weight and legitimacy beyond ordinary statutes.⁸² Nevertheless, the third feature, entrenchment through public support, is the most salient feature of

77. Eskridge & Ferejohn, *supra* note 9, at 1273. *Cf.* Ackerman, *supra* note 74, at 1742 (describing the role of “landmark statutes” such as the Social Security Act in transforming constitutional norms).

78. *See* Ackerman, *supra* note 74, at 1742.

79. A REPUBLIC OF STATUTES, *supra* note 8, at 26.

80. *Id.*

81. Ackerman, *supra* note 74, at 1765.

82. *See* A REPUBLIC OF STATUTES, *supra* note 8, at 27–28. Ordinary statutes may become entrenched, but because they do not address an important social problem or lack public deliberation, they do not express the fundamental values of society the way superstatutes do. For example, statutes like ERISA or certain provisions of the tax code may be entrenched through institutional inertia and political capture by certain interest groups, but such entrenchment alone, without the public engagement and normative objectives, may not classify such statutes as superstatutes.

superstatutes.

The type of entrenchment statutes achieve is a functional entrenchment that occurs when a legal norm has widespread popular support across an array of interests that makes it resistant to political challenge.⁸³ Unlike the “formal” entrenchment process required by Article V of the Constitution, where difficult procedural hurdles tie the hands of future policymakers, popular support of superstatutes leads to entrenchment through reaffirmation, continued expansion, implementation, and refinement by subsequent legislatures, executive agencies, and courts.⁸⁴ To achieve the strong constituency of support necessary for functional entrenchment, implementation of the statute must overcome the challenges predicted by the statute’s critics and deliver sufficient value to a politically significant and growing group of the population.⁸⁵ As a result, functionally entrenched statutory rights may be just as important to Americans as certain formally entrenched constitutional rights.⁸⁶

One weakness of the superstatute theory is that the application of the superstatute criteria does not predict at the outset whether a particular statute will become a superstatute. Thus, it is not certain whether the rights created by the statute will ever become durable rights until the statute has stood the test of time.⁸⁷ Although this article does not purport to solve this theoretical vacuum, it does assume that the optimal way to forecast the fate of a would-be superstatute is to look to the features of a statute that make it more or less likely to become entrenched. These features of entrenchment include not only the breadth of public support the statute has amassed upon passage, but the ability of the statute to effectively deliver tangible benefits to a wide swath of constituents while garnering support from its opponents.⁸⁸

83. See *id.* at 13; Young, *supra* note 74, at 458.

84. See Eskridge & Ferejohn, *supra* note 9, at 1230–31.

85. A REPUBLIC OF STATUTES, *supra* note 8, at 17.

86. See Young, *supra* note 74, at 412.

87. Eskridge & Ferejohn, *supra* note 9, at 1273 (“One test of a superstatute is that whatever the circumstances of its enactment, it instantiates a principle that passes the test of time: it works, it appeals to multiple generations, and it sticks in the public culture.”).

88. See A REPUBLIC OF STATUTES, *supra* note 8, at 28.

B. THE AFFORDABLE CARE ACT'S FRAGILE RIGHT TO HEALTH CARE

The ACA is a statute that aspires to be a superstatute. Nevertheless, the right to health care for the uninsured created by the ACA is structured in a way that weakens its prospects for durability. The ACA differs in significant ways from other federal statutory rights to health care that have become entrenched. The ACA's right relies upon reformation and creation of a private health insurance market for the uninsured rather than a government-administered and funded program. The ACA's vulnerabilities are revealed when compared to Medicare.

In the health care context, Medicare is a primary example of a durable right created by a superstatute. Like most superstatutes, Medicare addresses an important social problem.⁸⁹ Prior to its passage, most of the increasing population of persons over age sixty-five lacked health insurance and consequently were at risk for destitution, increased infirmity, or even premature death.⁹⁰ The New York Times reported that by 1960 the question of medical insurance for persons sixty-five years of age and older had become one of the hottest political issues in the nation.⁹¹ The passage of Medicare changed the existing baseline by extending federally administered health care coverage to all persons over sixty-five years of age.⁹² Similarly, the ACA addresses the pressing social and economic problem that over fifty million nonelderly Americans are uninsured.⁹³ The push to cover these uninsured and reform the health care system became the most pressing political issue in the 2008 election.⁹⁴ Nearly fifty years after Congress created Medicare, the New York Times reported that "five months after [President Obama's] inauguration, health care dominates the domestic agenda on both ends of

89. See *id.* at 26 (discussing how superstatutes address important social or economic problems).

90. See SHERI I. DAVID, *WITH DIGNITY, THE SEARCH FOR MEDICARE AND MEDICAID* 5 (1985) (discussing a 1959 finding that only forty-three percent of senior citizens had any hospital or health policy).

91. See Edwin L. Dale Jr., *Congress Facing Issues Renewing Battle of Budget*, N.Y. TIMES, April 11, 1960, at 1.

92. See A REPUBLIC OF STATUTES, *supra* note 8, at 197–98.

93. See KAISER COMMISSION, *MEDICAID AND THE UNINSURED* 1–2 (2012), available at <http://www.kff.org/uninsured/upload/1420-14.pdf>.

94. See KAISER FAM. FOUND., *HEALTH CARE AND THE 2008 ELECTIONS* 1–4 (2008), available at <http://www.kff.org/uninsured/upload/7813.pdf>.

Pennsylvania Avenue.”⁹⁵

Moreover, the legislation establishing Medicare followed a period of extensive public and political deliberation. In the five years prior to Medicare’s passage in 1965, both Presidents Kennedy and Johnson had repeatedly championed several of Medicare’s unsuccessful predecessors.⁹⁶ Efforts to provide health care coverage for the elderly date back even earlier, to the origins of the Social Security Act itself.⁹⁷ As with the problem of covering the elderly that led to the passage of Medicare, public debate over health reform and the problem of the uninsured has persisted for decades.⁹⁸ Several administrations and Congresses have tried unsuccessfully to extend coverage to the uninsured and reign in health care costs.⁹⁹ The most recent attempt, President Clinton’s Health Security Act, would have accomplished near-universal coverage through a combination of individual and employer mandates, “managed competition” between health plans, and increased government regulation.¹⁰⁰

A significant difference between the ACA and Medicare, however, is the degree of public support critical for entrenchment and durability. The ACA’s capacity to attract public support differs not only when measured at the time of passage, but more importantly, in the way the right to health care is structured to attract widespread support and overcome its opponents in the critical period following passage. The ACA’s right has several vulnerabilities that may prevent its right to health care from garnering broad public support.¹⁰¹ The vulnerabilities stem from the structure of the ACA’s right to

95. Kevin Sack, *Health Care Reform’s Moment Arrives (Again)*, N.Y. TIMES, June 19, 2009, at A17.

96. See DAVID, *supra* note 90, at 121; LAWRENCE R. JACOBS, THE HEALTH OF NATIONS: PUBLIC OPINION AND THE MAKING OF AMERICAN AND BRITISH HEALTH POLICY 190 (1993).

97. See A REPUBLIC OF STATUTES, *supra* note 8, at 197.

98. See Lee Igel, *The History of Health Care as a Campaign Issue*, PHYSICIAN EXECUTIVE J. MED. MGMT., June 12, 2008, at 12.

99. See *id.* at 14 (discussing health care attempts under the Nixon administration).

100. Cf. Health Security Act, H.R. 3600, 103d Cong. (1993).

101. See, e.g., Ramesh Ponnuru, *The Flaws that Will Bring Down Obama’s Health Care Plan*, BLOOMBERG.COM (Oct. 1, 2012, 5:30 PM), <http://www.bloomberg.com/news/2012-10-01/the-flaws-that-will-bring-down-obama-s-health-care-plan.html>.

health care, not as a publicly administered benefit program, but rather, from private health insurance market reforms. The ACA's challenges fall into three related categories: (1) political challenges; (2) legal challenges; and (3) market challenges.

1. Political Challenges

Significant political challenges to major social reforms are not unique. Most superstatutes, including Title VII of the Civil Rights Act and Medicare, faced significant political opposition in their early years after passage.¹⁰² But public opinion often drives political opinion, so that if a law does not provide enough of a tangible benefit before the next election, political opposition to new legislation or its implementation may not be checked by rising public support.

Public support leading up to and following the passage of Medicare appears to have been strong.¹⁰³ Although Medicare initially had strong opponents, namely in the American Medical Association, opposition among the medical community dwindled following Medicare's passage.¹⁰⁴ The medical community's opposition was tempered by significant regulatory concessions in the form of generous increases in reimbursement rates that led these opponents to see Medicare as a lucrative source of new business.¹⁰⁵ With the major bloc of opponents disarmed, Medicare's beneficiaries began enjoying its benefits soon thereafter. Medicare was signed into law on July 31, 1965 and the program began paying for hospital insurance benefits (Part A) on July 1, 1966 and nursing home and physicians'

102. See DAVID, *supra* note 90, at 11–12 (describing political opposition to Medicare); Daniel B. Rodriguez & Barry R. Weingast, *The Positive Political Theory of Legislative History: New Perspectives on the 1964 Civil Rights Act and Its Interpretation*, 151 U. PA. L. REV. 1417, 1452–54 (2003) (describing opposition to the expansion of federal civil rights among a large group of legislators from the South); see also ROBERT D. LOEY, *TO END ALL SEGREGATION: THE POLITICS OF THE PASSAGE OF THE CIVIL RIGHTS ACT OF 1964* 153–224, 287–314 (1990).

103. See Julie Ray, *The Gallup Brain: Medicare's Early Days*, GALLUP (May 27, 2003), <http://www.gallup.com/poll/8491/gallup-brain-medicare-early-days.aspx> (finding that in 1964, sixty-one percent of Americans approved of Medicare, thirty-one percent disapproved and eight percent did not know); see also Andrew Kohut, *Would Americans Welcome Medicare if it Were Being Proposed in 2009?*, PEW RESEARCH CENTER (Aug. 19, 2009), <http://pewresearch.org/pubs/1317/would-americans-welcome-medicare-if-proposed-in-2009>.

104. See DAVID, *supra* note 90, at 11–12.

105. See *id.* at 150–51.

payments (Part B) on January 1, 1967.¹⁰⁶ Because participation in Part B is voluntary, the Department of Health, Education and Welfare—the precursor to the Department of Health and Human Services—engaged in an intensive advertising campaign to explain the Part B program to seniors across the country.¹⁰⁷ The Department’s advertising campaign was a great success and achieved enrollment of ninety-five percent of the eligible seniors in Part B within a year of Medicare’s passage.¹⁰⁸ In subsequent years, both Democratic- and Republican-controlled Congresses expanded Medicare to include coverage for ambulatory surgery services, prescription drugs, private managed care plans, and additional classes of eligibility.¹⁰⁹ Even as the baby boomer generation begins to qualify for Medicare and strain Medicare’s fiscal viability, Medicare remains politically strong, and elected officials from both parties who seek to curtail the program do so at their peril.¹¹⁰ Like Social Security, its parent program, Medicare has become fixed in the public’s mind as an essential means to assure economic and medical security in old age, to which Americans feel entitled and value as a fundamental social good for society.¹¹¹

106. *Id.* at 144.

107. *Id.* at 146 (explaining that the department published approximately twenty-million informational kits in twenty-two languages, delivered in some areas by horse or dogsled).

108. *Id.*

109. *See* Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. No. 108-173, § 101, 117 Stat. 2066 (2003) (creating Medicare Part D which expanded coverage to prescription drugs); Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4001, 111 Stat. 251 (1997) (creating Medicare Part C which expanded coverage to managed care); Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972) (expanding eligibility to individuals under 65 with longterm disabilities and individuals with endstage renal disease).

110. *See* Peter H. Schuck, *The Golden Age of Aging and Its Discontents*, 18 *ELDER L.J.* 25, 40 (2010) (“This political entrenchment and inertia are even more pronounced today because *both* political parties, desperate for senior votes, are competing to be perceived as the most stalwart and unequivocal defenders of the current Medicare program.”); *see also* Raymond Hernandez, *Gaining Upset, Democrat Wins New York Seat*, *N.Y. TIMES*, May 25, 2011, at A1 (providing as a recent example of the strength of Medicare’s persistent political support the electoral upset of a GOP House candidate attributed to Congressman Paul Ryan’s fiscal year 2012 budget plan to transform Medicare from a comprehensive public benefit program to a private, fixed cost voucher system).

111. *See* Young, *supra* note 74, at 424–25.

By contrast, when the ACA passed, public opinion was mixed.¹¹² This reaction may be due, in part, to the persisting confusion about the complex content of the ACA and its potential impact on the public.¹¹³ Politically, the right to health care under the ACA faces more formidable opposition than Medicare. Although the ACA was backed by the American Medical Association, not one Republican voted for the Act.¹¹⁴ In this way, the ACA was perhaps more like the Civil Rights Act, which passed amidst bitter partisan division.¹¹⁵ A year and a half after passage, the already divided public support for the ACA continued to wane as the percentage of individuals who believed the ACA would make no difference for them increased.¹¹⁶ The major opponents of the ACA may not be swayed by an administrative compromise, such as the favorable reimbursement rates that won the medical community's support for Medicare. The opponents of the ACA focused less on the practicalities of its effect on their business or income, but rather on a more fundamental opposition to a government mandate for individual participation in the health care market.¹¹⁷

Although millions stand to benefit from the ACA's coverage provisions, most of these provisions do not go into effect until

112. KAISER FAM. FOUND., KAISER HEALTH TRACKING POLL 4 (Mar. 2012), <http://www.kff.org/kaiserpolls/upload/8285-F.pdf> (finding that at the time of passage, forty-six percent of the public had a favorable view, forty percent had an unfavorable view, and fourteen percent did not know); Lydia Saad, *By Slim Margin Americans Support Healthcare Bill's Passage*, GALLUP (Mar. 23, 2010), <http://www.gallup.com/poll/126929/Slim-Margin-Americans-Support-Healthcare-Bill-Passage.aspx> (finding that on the day after the ACA's passage, 49% of national adults polled reported that the passage was a "good thing," 40% reported it was a "bad thing," and 11% did not know).

113. KAISER HEALTH TRACKING POLL, *supra* note 112 (finding that fifty-two percent of the public do not feel they have adequate information to understand how the law will affect them).

114. David M. Herszenhorn & Robert Pear, *Democrats Rally to Obama's Call for Health Vote*, N.Y. TIMES, Mar. 22, 2010, at A16.

115. Rep. James Clyburn (D-S.C.), in describing the ACA, said, "This is the Civil Rights Act of the 21st century." *Id.*

116. KAISER HEALTH TRACKING POLL, *supra* note 112 (finding that as of March 2012, two years after passage, 40% of the public had a unfavorable opinion, 41% percent had a favorable opinion, and 19% did not know, and the percentage of individuals reporting that they do not have enough information to understand the ACA's personal impact was 59%, virtually unchanged from fifty six percent in April 2010, immediately after the Act's passage).

117. See, e.g., Rep. Lamar Smith, *Why I Am Voting to Repeal the New Health Care Law*, FOX NEWS (Jan. 19, 2011), www.foxnews.com/opinion/2011/01/19/rep-lamar-smith-voting-repeal-new-health-care-law/.

January 2014, nearly four years after the passage of the Act and two years after the presidential and congressional elections of 2012. Unlike the seniors who started receiving Medicare benefits within a year of its passage, the uninsured persons who stand to benefit most from the ACA's right to health care remain confused about its amalgam of benefits and requirements more than a year after the ACA's passage.¹¹⁸

Finally, Medicare was supported by seniors, a cohesive political group, that had coalesced into a powerful identity group following the passage of the Social Security Act and under the leadership of the AARP.¹¹⁹ The uninsured, by contrast, do not make up a similarly stable or organized political force. Although an estimated eighteen million will gain insurance through the private insurance reforms,¹²⁰ the group itself may be somewhat fluid as people move between employer-based coverage, coverage through the Exchanges, and coverage through government programs such as Medicaid. Moreover, Medicare's positive entitlement as a valuable government program is easy for its beneficiaries to understand and defend. In contrast, the features of the ACA's right to health care, such as tax credit subsidies, underwriting reforms, and state-based Exchanges, may appear to beneficiaries less like a tangible benefit and more like an amorphous array of private insurance market rules. The ACA's negative right to health care may thus fail to inspire the sort of identity-politics that can powerfully advocate for the ACA's continued survival.¹²¹

118. Drew Altman, *Uninsured But Not Yet Informed*, KAISER FAM. FOUND. (Aug. 2011), http://www.kff.org/pullingittogether/uninsured_informed_altman.cfm (finding in August 2011 Kaiser Health Tracking Poll that 47% of uninsured adults 18–64 believed that the health reform law will not make much difference to them, fourteen percent believed it would hurt them, and seven percent did not know).

119. See ANDREA CAMPBELL, *HOW POLICIES MAKE CITIZENS: SENIOR POLITICAL ACTIVISM AND THE AMERICAN WELFARE STATE 14–64* (2003) (outlining the development of senior citizens as a powerful voting demographic).

120. See CONG. BUDGET OFFICE, *ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION* (2012), available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf>.

121. See Lawrence R. Jacobs, *America's Critical Juncture: The Affordable Care Act and Its Reverberations*, 36 J. HEALTH POL. POL'Y & L. 625, 630 (2011) ("[T]he ACA's reliance on tax credits and decentralized mechanisms (such as state administration of health insurance exchanges) may well diminish its

2. Legal Challenges

Almost as soon as it was passed, legal challenges to the ACA began. The foremost claim by challengers was that the so-called individual mandate provision is unconstitutional because it exceeds Congress' power to regulate interstate commerce.¹²² The individual mandate requires nearly all individuals to maintain minimum essential health insurance by 2014 or face civil penalties.¹²³ In June 2012, the Supreme Court ruled that the individual mandate does exceed Congress' powers under the Commerce Clause, but it upheld the mandate as a valid exercise of the taxing power.¹²⁴

The Supreme Court's decision upholding the individual mandate preserves the right to health care deriving from insurance reforms.¹²⁵ Although the creation of health insurance exchanges and health plan nondiscrimination provisions are not explicitly linked to or statutorily conditioned upon the individual mandate, they are economically intertwined.¹²⁶ Without the mandate, those who do not wish to purchase health insurance while healthy could wait until they needed care to purchase insurance.¹²⁷ Because of the guaranteed issue

political effects. Not all government programs are transparent—or generous—enough to create citizen interest groups in favor of the programs. Today's tax exemptions for home mortgages and employer-sponsored health insurance, for example, are not recognized as government programs. Similarly, while the ACA makes health insurance more secure for all Americans, these protective provisions may not be enough to register with everyday citizens as tangible payoffs.") (footnotes omitted).

122. See, e.g., Randy Barnett, *A Noxious Commandment*, N.Y. TIMES, (June 26, 2012, 11:39 AM), <http://www.nytimes.com/roomfordebate/2010/12/13/a-fatal-blow-to-obamas-health-care-law/an-unconstitutional-commandment>.

123. Patient Protection and Affordable Care Act, Pub. L. No. 111-48, § 1501(b), 124 Stat 242–49 (2010) amended by § 10106 (b) and Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152 § 1002 (discussing exemptions from the mandate for religious objectors, individuals with incomes below the tax filing threshold, individuals for whom premiums would exceed eight percent of household income, and others).

124. Nat'l Fed'n of Indep. Bus. v. Sebelius, No. 11–393, slip op. at 39 (U.S. June 28, 2012) ("Our precedent demonstrates that Congress had the power to impose the exaction of §5000A under the taxing power . . .").

125. See *id.* at 6.

126. See *id.* at 53 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting) ("The whole design of the Act is to balance the costs and benefits affecting each set of regulated parties. Thus, individuals are required to obtain health insurance . . . States are expected to expand Medicaid eligibility and to create regulated marketplaces called exchanges where individuals can purchase insurance.").

127. See *id.* at 11 (Ginsburg, J., concurring) ("[I]ndividuals can wait until

and nondiscrimination provisions, health plans cannot deny coverage or charge more to those who wait until they become sick to purchase health insurance.¹²⁸ Such adverse selection would concentrate unhealthy, high-risk, and high-cost individuals in the health insurance exchanges, making the exchanges increasingly economically untenable to maintain.¹²⁹ Health plans would need to raise premiums to cover this sicker and riskier population without healthier persons to offset the costs of coverage.¹³⁰ The higher premiums would cause more individuals to forego insurance and further concentrate sicker and riskier persons in the insurance pool: the insurance “death spiral.”¹³¹ As with all group insurance models, the low-utilizers’ inclusion in the insurance pool is necessary to subsidize the high-cost members.¹³² Given a broad enough pool, the risk to the insurer becomes more predictable and manageable.¹³³

During the two-year period that legal challenges to the ACA wound their way to the Supreme Court, there was a great deal of uncertainty among health insurance providers and states.¹³⁴ These same actors must mobilize significant resources to implement the new health insurance market created by the ACA’s reforms. As of the day the Supreme Court’s decision was announced, the prediction markets had the odds of the Court striking down the individual mandate at about seventy-five percent.¹³⁵ Even following the Court’s decision resolving the constitutional question, opponents continued to seek political

they become ill to buy insurance.”).

128. *See id.* at 17 (“Congress . . . acted reasonably in requiring uninsured individuals, whether sick or healthy, either to obtain insurance or to pay the specified penalty.”).

129. *See id.* at 11 (“This ‘adverse selection’ problem leaves insurers with two choices: They can . . . raise premiums dramatically to cover their ever-increasing costs or they can exit the market.”).

130. *Id.*

131. *Id.* at 33.

132. *See id.*

133. *Cf.* Marc L. Berk & Alan C. Monheit, *The Concentration of Health Care Expenditures Revisited*, 20 HEALTH AFF. 9, 11 (2001).

134. *Cf.* Bob McConnell & Fred Upton, *Obama Care’s Uncertainty Cripples States and Providers*, INVESTORS.COM (Oct. 17, 2012, 6:49 PM), <http://news.investors.com/ibd-editorials-on-the-right/101712-629730-obamacare-implementation-produces-unanswered-questions.htm?p=full>.

135. *See The U.S. Supreme Court to Rule the Individual Mandate Unconstitutional*, INTRADE, <http://www.intrade.com/v4/markets/contract/?contractId=745353> (last visited Oct. 21, 2012).

overturn of the ACA.¹³⁶ The legal challenge to the individual mandate, which economically undergirds the Act's right to health care, created so much uncertainty that many states delayed taking legislative or administrative action to organize Exchanges.¹³⁷ Insurance companies had been hedging their bets, both proceeding with implementation and bracing themselves for the possibility of rampant adverse selection, death spirals and state-shopping. Some postulated that without a federal mandate, health insurers would exit the market in states that did not impose a state-based mandate.¹³⁸

The legal uncertainty over the ACA's health insurance reforms not only affected the parties required to implement the health insurance reforms, but it also undermined public confidence in the validity and durability of the right to health care. The legal challengers framed the discourse about the ACA as an infringement on individual rights, the right to be free from coerced purchase of unwanted health insurance products.¹³⁹ This libertarian conceptualization of the individual mandate appears to have gained more traction in the public's mind than the communitarian and more conceptually complex relationship between the mandate and the popular nondiscrimination provisions that make up the right to health care.

Although the ACA's right to health care survived its primary legal challenge, it was weakened by the uncertainty, implementation delay, and disapproving public discourse that proliferated while the legal issues were pending.

3. Market Challenges

The ACA's right to health care depends upon the collective action by many different independent actors to create a new universal and affordable private health insurance market.¹⁴⁰

136. See, e.g., Roxana Tiron, *Boehner Says House to Seek Repeal of Health-Care Law*, BLOOMBERG (June 19, 2012, 11:24 AM), <http://www.bloomberg.com/news/2012-06-19/boehner-says-house-to-seek-repeal-of-health-care-law.html>.

137. See *State Actions to Implement Health Insurance Exchanges*, NAT'L CONF. ST. LEGISLATURES, <http://www.ncsl.org/issues-research/health/state-actions-to-implement-the-health-benefit-exch.aspx> (last updated Oct. 2012).

138. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, No.11-393, slip op. at 11 (U.S. June 28, 2012) (Ginsburg, J., concurring).

139. Cf. Abigail Moncrieff, *The Freedom of Health*, 159 U. PA. L. REV. 2209, 2213 (2011).

140. *Sebelius*, No. 11-383, slip op. at 53 (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting) ("[T]he Act attempts to achieve near-universal health

Health insurance companies are not only required to comply with the nondiscrimination and guaranteed issue requirements, but they also must be willing to offer products in the Exchanges.¹⁴¹ The biggest market challenge to the success and sustainability of this new insurance market is ensuring the plans offered through the Exchanges are affordable.¹⁴² The plans offered within the Exchanges must offer the essential benefits package.¹⁴³ To keep plans affordable, the Institute of Medicine recommends the essential benefits be structured after a typical small group plan rather than more expensive and generous large group plan coverage.¹⁴⁴ Moreover, despite the ACA's nondiscrimination and community rating requirements, health plans will still have an incentive to try to attract healthier persons to minimize their insurance risk, and individuals will not necessarily aggregate evenly by their own degree of risk within the options offered.¹⁴⁵ Some degree of risk selection will still persist within the Exchanges where premiums will not reflect the actual risk posed by those with insurance, which can destabilize the insurance market within the Exchanges.¹⁴⁶

In addition to the cooperation of health insurance firms, the states must administer the Exchanges; ideally, they function as a transparent and competitive market.¹⁴⁷ The

insurance coverage by spreading its costs to individuals, insurers, governments, hospitals, and employers . . .”).

141. *Cf. id.* at 60 (“In the absence of federal subsidies to purchasers, insurance companies will have little incentive to sell insurance on the exchanges.”).

142. *See id.* at 59–60 (discussing how federal subsidies are necessary to keep plans offered on the exchanges both available and affordable).

143. *Id.* at 45–46 (majority opinion) (“The Act also establishes a new ‘essential health benefits’ package, which States must provide to all new Medicaid recipients—a level sufficient to satisfy a recipient’s obligations under the individual mandate.”).

144. *See INST. OF MED., supra* note 20, at 6–7 (“[T]he committee endorses . . . using as the cost target the estimated national average premium that would have been paid by small employers in 2014 . . .”); *see also* Patient Protection and Affordable Care Act, Pub. L. 111-148, § 1302, 124 Stat 163, 163–68 (2010).

145. *See* Jonathan P. Weiner et al., *Adjusting for Risk Selection in State Health Insurance Exchanges Will Be Critically Important and Feasible, But Not Easy*, 31 HEALTH AFF. 306, 306–09 (2012).

146. *Cf. id.* at 310.

147. *Cf. Sebelius*, No. 11-393, slip op. at 52 (U.S. June 28, 2012) (Scalia, Kennedy, Thomas, and Alito, JJ., dissenting) (“States are expected to . . .

states play key roles in gathering price and quality data from participating health plans to give consumers enough information to make informed purchasing choices.¹⁴⁸ The Exchanges are also responsible for providing information to the Department of Health and Human Services (HHS) regarding whether individuals are qualified for tax credit subsidies or whether their employer-offered coverage meets affordability requirements.¹⁴⁹ Some states, however, have refused to begin implementing the Exchanges due to political opposition or uncertainty pending the outcome of legal challenges to the ACA.¹⁵⁰

The ACA's right to health care relies upon market competition, an increase in the pool of those with insurance and several other indirect mechanisms to keep premium prices for health insurance offered in the Exchanges under control.¹⁵¹ The removal of a government-offered "public option" health plan from the final bill eliminated an additional tool to foster competition and exert downward pressure on prices in the Exchanges.¹⁵² With Medicare, by contrast, the government is the payer and can set its prices and implement payment and health care delivery reforms to try to keep its costs down.¹⁵³

create regulated marketplaces where individuals can purchase insurance.”).

148. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-48 § 1311, 124 Stat. 119, 173–81 (2010).

149. Patient Protection and Affordable Care Act of 2010 § 1411.

150. *See State Actions to Implement Health Insurance Exchanges*, *supra* note 137 (reporting that as of October 2012, 17 states have not undertaken legislative efforts to begin implementation of Exchanges); Patient Protection and Affordable Care Act § 1321 (establishing that if states or regions do not implement the Exchanges by their implementation deadline, the federal government will operate the Exchange).

151. Patient Protection and Affordable Care Act of 2010 § 9001, *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1401, 124 Stat. 1029 (showing taxes on high-cost “Cadillac” plans as a mechanism to keep insurance premiums low). Another mechanism to keep insurance premiums low is to tax medical loss ratios. *Id.* §§ 9010, 10050.

152. *See* Pear & Calmes, *supra* note 56, at A18.

153. *See* Patient Protection and Affordable Care Act of 2010 § 3022 (establishing the Medicare Shared Savings Program for the formation of accountable care organizations); Patient Protection and Affordable Care Act of 2010 § 3023 (establishing a pilot program on payment bundling); Patient Protection and Affordable Care Act of 2010 § 3001 (establishing value-based purchasing for hospitals); Patient Protection and Affordable Care Act of 2010 § 3025 (discussing provisions to cut Medicare payments by eliminating payments for excess hospital readmissions); Patient Protection and Affordable Care Act of 2010 § 2702 (stopping payments for hospital-acquired conditions); Patient Protection and Affordable Care Act § 3401, *amended by* Health Care

The authors of the ACA believed a right to health care for the uninsured could be made accessible and affordable through market forces and competition. The reliance on the private market may have been politically necessary, but this strategy depends on a myriad of potentially reluctant actors coming together to create a viable insurance market where one has not previously succeeded.

C. QUASI-SUPERSTATUTES

The literature on subconstitutionalism presents the concept of superstatutes as a binary question: a piece of legislation either is or is not a superstatute.¹⁵⁴ The discussion of subconstitutionalism would benefit from further refinement to include a third category of “quasi-superstatutes.” These quasi-superstatutes are statutes that have the ambition of addressing an important social problem and undergo serious public deliberation (two qualities of superstatutes), but fail to achieve the entrenchment necessary to deliver their promised solution.¹⁵⁵ These statutes are quasi-superstatutes because the rights or new legal norms they create are not fully accepted by the public, either because the public support is lacking or because not enough of the public experiences the benefits of the new right or legal norm to create functional entrenchment before it is rolled back by courts or future Congresses. The apparent fragility of the ACA’s central aim, to create a right to health care for the uninsured, makes it more likely that the ACA will be a quasi-superstatute than a superstatute.

One example of a quasi-superstatute is the Americans with Disabilities Act (ADA).¹⁵⁶ When it passed, the ADA was heralded as an “emancipation proclamation” for the disabled.¹⁵⁷

and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1105, 124 Stat. 1029 (discussing reduction in the Part A “market basket” annual increases); Health Care and Education Reconciliation Act of 2010 § 1102 (discussing reduction in payments under Medicare Advantage).

154. See A REPUBLIC OF STATUTES, *supra* note 8, at 26–28 (describing attributes of superstatutes, but not mentioning the result or ability of only partial satisfying superstatute criteria).

155. See *id.* at 26 (providing additional information on the three overarching attributes of superstatutes).

156. See Americans with Disabilities Act of 1990, Pub. L. No. 101-336, 104 Stat. 327.

157. See Edmund Newton, *Disabled: The Battle Goes On*, L.A. TIMES, Aug. 16, 1990, at E1 (describing the statute as “an ‘emancipation proclamation’ for

The employment discrimination and accommodation provisions were designed to dramatically increase access to and maintenance of jobs for the disabled.¹⁵⁸ To be sure, the ADA has created significant benefits for the disabled, such as the changes to the built environment requiring handicap-accessibility to public buildings, sidewalks, and transportation.¹⁵⁹ But many agree the ADA fell short on its initial promise of increasing employment among disabled persons.¹⁶⁰ The prevailing theory for why the ADA failed to live up to its promise is the judiciary's hostility to the ADA's employment protections.¹⁶¹ This reflects a general public backlash against what were perceived as onerous accommodation requirements for employers and a lack of public support for the disabled. As of 2007, an estimated 97% of cases brought to enforce the ADA's employment provisions had been decided in favor of employers,¹⁶² and employment rates among the disabled declined or stayed flat in the first decade following the ADA's passage.¹⁶³ With the ADA, the Supreme Court's

43 million disabled Americans"); *see also* 136 Cong. Rec. 17,369 (1990) (statement of Sen. Harkin) (displaying the language as attributed to Senator Harkin); 135 Cong. Rec. 19,888 (1989) (statement of Sen. Kennedy) (displaying the language as attributed to Senator Kennedy).

158. Michael Selmi, *Interpreting the Americans with Disabilities Act: Why the Supreme Court Rewrote the Statute, and Why Congress Did Not Care*, 76 GEO. WASH. L. REV. 522, 522 (2008).

159. *See, e.g., id.* at 553, 574.

160. *See Chevron U.S.A. Inc. v. Echazabal*, 536 U.S. 73, 78 (2002) (discussing whether or not an employee can be screened from employment because of their disability and its relation to the employee's safety); *Sutton v. United Air Lines, Inc.*, 527 U.S. 471, 475 (1999) (discussing the word "disability"); *see also* Robert L. Burgdorf Jr., "Substantially Limited" Protection from Disability Discrimination: The Special Treatment Model and Misconstructions of the Definition of Disability, 42 VILL. L. REV. 409, 539-46 (1997); Matthew Diller, *Judicial Backlash, the ADA, and the Civil Rights Model*, 21 BERKELEY J. EMP. & LAB. L. 19, 22 (2000); Chai R. Feldblum, *Definition of Disability Under Federal Anti-Discrimination Law: What Happened? Why? And What Can We Do About It?*, 21 BERKELEY J. EMP. & LAB. L. 91, 139-60 (2000); Aviam Soifer, *The Disability Term: Dignity, Default, and Negative Capability*, 47 UCLA L. REV. 1279, 1303-08 (2000); Michael Ashley Stein, *Same Struggle, Different Difference: ADA Accommodations as Antidiscrimination*, 153 U. PENN. L. REV. 579, 631-36 (2004); Rebecca Hanner White, *Deference and Disability Discrimination*, 99 MICH. L. REV. 532, 537-39 (2000).

161. *See Selmi, supra* note 158, at 526-27.

162. Amy L. Allbright, 2006 Employment Decisions Under the ADA Title I - Survey Update, 31 MENTAL & PHYSICAL DISABILITY L. REP. 328, 328 (2007).

163. *See* INST. OF MED. COMM. ON DISABILITY IN AM., THE FUTURE OF DISABILITY IN AMERICA 454-56 (Marilyn J. Field & Alan M. Jette eds., 2007),

narrow interpretations were a type of retrenchment. The retrenchment was furthered when the political process failed to correct the Court's narrowing of the ADA's protections. Indeed, some have theorized the Court's decisions were based on perceptions of the public's lack of support for broad mandates for disability accommodations or Congressional ambivalence when drafting the ADA.¹⁶⁴

A statute becomes entrenched through the recursive interpretation, implementation, expansion, and refinement by courts, agencies, and future legislatures.¹⁶⁵ Conversely, a statute may become retrenched through narrowing judicial interpretation, failures of enforcement or implementation by agencies, and Congressional antipathy or apathy toward statutory fixes, refinement, or expansion.¹⁶⁶ The lack of public support required to achieve the functional entrenchment necessary to become a superstatute differentiates superstatutes from their quasi-super counterparts. The narrow judicial interpretations of the ADA's provisions could be corrected by a public push for Congressional action to restore and clarify the ADA. Congress's long silence on the issue may have signaled that such public support was lacking.¹⁶⁷ The ACA's embattled individual mandate is not susceptible to a simple legislative fix.¹⁶⁸ As discussed above, the ACA faced not only judicial

available at <http://www.ncbi.nlm.nih.gov/books/NBK11434/pdf/TOC.pdf>.

164. See Selmi, *supra* note 158 at 526–27.

165. See Eskridge & Ferejohn, *supra* note 9, at 1229–30.

166. *Cf. id.* at 1228.

167. See ADA Amendments Act of 2008, Pub. L. No. 110-325, § 4(a), 122 Stat. 3553 (showing in 2008 Congressional passage of the ADA Amendments Act was eighteen years after the ADA's initial passage); Jeannette Cox, *Crossroads and Signposts: The ADA Amendments Act of 2008*, 85 IND. L.J. 187, 188 (2010) (discussing reversal of the courts' narrow interpretation of the term "disability," which thus broadened the class of persons covered by the ADA); see also, e.g., Stacy A. Hickox, *The Underwhelming Impact of the Americans with Disabilities Act Amendments Act*, 40 U. BALT. L. REV. 419, 421–22 (2011) (discussing that despite Congress' effort to counter the judiciary's narrowing of the ADA, scholars are skeptical of the Americans with Disabilities Act Amendments Act's impact on the employment prospects for disabled individuals because Congress left unchanged the difficult standard that a person must prove he or she is "substantially limited" in a major life activity to be considered disabled under the Act.).

168. Options for the individual mandate include restructuring the mandate as a voluntary incentive (such as a tax credit) to purchase health insurance without a penalty, which may as a policy matter reduce the number of those who become insured and increase the costs of coverage.

challenges to its key individual mandate provision, but also faces political and market challenges that could undermine the public support for its guarantee of health care access to the uninsured.¹⁶⁹

Falling into the category of quasi-superstatutes does not mean that a statute may never emerge as a superstatute. For example, the 2008 amendments to the ADA overrode many of the courts' previous interpretations that narrowed the definition of a "disability."¹⁷⁰ Although some believe the ADA amendments did not go far enough, such Congressional action could be the type of incremental legislative elaboration and strengthening that eventually rescues the ADA from the quasi-superstatute category.¹⁷¹ Statutes and public opinion are not fixed entities, and especially for statutes that have failed to become functionally entrenched through broad public support, legal and social norms can evolve with public opinion.

That a would-be superstatute could end up as a quasi-superstatute underscores the point that the way a new right or legal norm is structured and implemented matters as much as mustering the political will to get it passed in the first place.¹⁷² Congress, for example, has been accused of intentionally leaving vague critical terms in the ADA, such that courts' narrow interpretations of these terms were consistent with Congress's own ambivalence.¹⁷³ Although Congress can amend, expand, or refine a statute that fails to achieve its initial promise, it is not always easy to garner the political will and interest group coordination necessary for statutory fixes as

169. See *supra* Part II.B.

170. Compare Americans with Disabilities Act of 1990, Pub.L. No. 101-336, 104 Stat. 327 with Americans with Disabilities Act Amendments Act of 2008, the ADA Amendments Act, Pub. L. No. 110-325, 122 Stat. 3555 (2009).

171. See Hickox, *supra* note 167, at 421–22.

172. See Daryl J. Levinson, *Parchment and Politics: The Positive Puzzle of Constitutional Commitment*, 124 HARV. L. REV. 657, 704 (2011) (“[N]othing about the process or pedigree of enactment guarantees the sustainability of general-interest reforms. What matters, instead, is that the downstream political process is structured in a way that gives residual as well as newly created supporters of these reforms sufficient political power to fend off attacks from opponents.”).

173. See Selmi, *supra* note 158, at 526–27 (arguing that despite the ADA's broad bipartisan support in Congress when passed, the ADA's textual vagueness on key provisions such as what constitutes a “disability” is evidence that Congress itself was ambivalent about to whom and what extent its protections should apply).

coalitions may quickly dissipate following passage.¹⁷⁴ Moreover, it may be easier to gather public support for legislative enhancement to a popular superstatute than for a quasi-superstatute that is marked by the stigma of disappointment and ineffectiveness. A statute that fails to deliver benefits quickly to a sufficient group may lack the sustained interest-group advocacy necessary for a would-be superstatute to become entrenched in the public's mind. The cautionary tale of quasi-superstatutedom can shed light on how a statute like the ACA may move from its fragile start to become a superstatute that guarantees a durable right to health care.

III. DEVELOPING A DURABLE RIGHT TO HEALTH CARE

The apparent fragility of the ACA's right to health care contains lessons regarding strategic considerations for developing a durable right to health care. Much of the vulnerability of the right to health care is concentrated early in the ACA's lifespan, during the long time frame between its passage and the delivery of its benefits. If it survives this critical period, the right to health care could become increasingly entrenched as interest groups emerge to defend the right and political feedback strengthens the existing arrangement relative to those who seek its repeal. This Part first outlines a path for the ACA's right to health care to become a durable right and then discusses the lessons to be gleaned from the ACA's early vulnerabilities for the development of a durable right to health care.

A. THE AFFORDABLE CARE ACT'S PATH TO DURABILITY

The ACA's fragile right to health care is most vulnerable in its infancy. Its prospects of becoming a durable right depend on its survival until the point that its benefits begin. Most of the benefits of the ACA's right to health care for the uninsured will not begin to take effect until 2014, and they could require several additional years to reach full implementation.¹⁷⁵ Some

174. See Clayton P. Gillette, *Lock-In Effects in Law and Norms*, 78 B.U. L. REV. 813, 828 (1998); Levinson, *supra* note 172, at 704.

175. See CONG. BUDGET OFFICE, *supra* note 55, at tbl.2 (showing that initial CBO estimates of coverage for newly uninsured use a five-year timeline (2014–2019) to estimate the total coverage effects of the ACA's insurance reforms and Medicaid expansion).

benefits took effect soon after passage, including: provisions allowing young adults under the age of twenty-six to remain on their parents' health insurance policies, prohibitions on denials of coverage for children with preexisting conditions, and the creation of temporary high-risk pools for adults with preexisting conditions.¹⁷⁶ But these benefits appear to have had a negligible effect on broader public support of the Act, perhaps because the benefits of these smaller programs do not outweigh the larger political opposition to the individual mandate.¹⁷⁷ Principles of behavioral economics explain how statutes and regulations gain entrenchment through positive political feedback: the reform can sow the seeds of its own political support by endowing emerging interest groups with valuable benefits.¹⁷⁸

The endowment effect predicts that once established, statutory or regulatory schemes have a stronger tendency toward maintenance of the status quo over advocates for change or retrenchment.¹⁷⁹ The endowment effect describes the phenomenon where individuals' aversion to changes perceived as a loss of existing benefits exceeds their motivation to obtain the benefit in the first place.¹⁸⁰ For example, a person who bought a bottle of wine for \$5 thirty years ago may refuse to sell the wine to a wine merchant for \$100 today, though he is unwilling to spend \$100 to purchase the same bottle of wine.¹⁸¹ In a statutory context, the advantage of the endowment effect's inertia against change only applies once the statute has been

176. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-48, § 1001, 124 Stat. 119, 130–131, *amended by* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, §§ 1004, 2301, 124 Stat. 1029, 1034–1036, 1081–1082 (expanding coverage for dependents up to age twenty-six); Patient Protection and Affordable Care Act, § 1201, *amended by* Health Care and Education Reconciliation Act § 2301 (prohibiting health plans from excluding children under nineteen on the basis of preexisting condition); Patient Protection and Affordable Care Act § 1101 (creating temporary highrisk pools for adults with preexisting conditions).

177. See KAISER FAM. FOUND., *supra* note 112, at 8 (table showing lack of increase in public support of the ACA).

178. See Levinson, *supra* note 172, at 687.

179. See Russell Korobkin, *The Endowment Effect and Legal Analysis*, 97 NW. U. L. REV. 1227, 1266–67 (2003).

180. See Cherie Metcalf, *Introduction: Emerging Paradigms of Rationality—Theory and Applications*, 35 QUEEN'S L.J. 1, 12–14 (2009) (providing additional information on the endowment effect). See generally Richard H. Thaler, *Toward a Positive Theory of Consumer Choice*, 1 J. ECON. BEHAV. & ORG. 39 (1980) (explaining endowment effect).

181. Thaler, *supra* note 180, at 43.

established—when all its institutions, benefits, and procedures have been fully implemented.¹⁸² If the ACA's right to health care can survive the long and uncertain implementation phase, the tens of millions of individuals, plus the health insurance plans, employers, and providers who stand to benefit, could create a strong constituency of support that may lead to its entrenchment.

Whether or not they coalesce into a politically active interest group, a diverse group of individuals and entities will gain valuable benefits under the ACA's reforms.¹⁸³ For example, groups of people who typically lack employer-sponsored health care, such as those who lose their jobs, work for a small business, work part time, or retire early, would all potentially benefit from the availability of affordable, non-excludable health plans on the Exchanges and tax credit subsidies to purchase health insurance.¹⁸⁴ The problem with these groups is that although they might account for millions of individuals at any given time, people may move fluidly through these different statuses of employment. Long-term membership in this group of beneficiaries could be limited. More stable groups of defenders may emerge, such as individuals with preexisting medical conditions who lack large group or government-provided coverage for long periods of time due to inability to work. In addition, employers may increasingly embrace the Exchanges as a cost-effective option to provide health insurance to their employees.¹⁸⁵ Though subject to significant additional regulation, health insurance companies could join the defenders of the ACA to keep the millions of new customers who had previously remained outside the health insurance market.¹⁸⁶ Health care providers may also welcome the influx of additional insured patients and concomitant

182. Korobkin, *supra* note 179, at 1266–67.

183. See *Who Benefits from Health Care Ruling?*, MSN MONEY (Jun. 28, 2012, 3:29 PM), <http://money.msn.com/health-and-life-insurance/article.aspx?post=8c68398b-f0cf-48e5-8216-d29b2b4547cf>.

184. See KAISER COMM'N ON MEDICAID AND THE UNINSURED, *THE UNINSURED: A PRIMER—KEY FACTS ABOUT AMERICANS WITHOUT HEALTH INSURANCE* 2–7, 11–13 (2006).

185. Christine Eibner, Peter Hussey, and Federico Girosi, *The Effects of the Affordable Care Act on Workers' Health Insurance Coverage*, 363 *NEW ENG. J. MED.* 1393, 1393–65 (2010).

186. Robert I. Field, *Regulation, Reform and the Creation of Free Market Health Care*, 32 *HAMLIN J. PUB.L. & POL'Y* 301, 324, 329 (2011).

reductions in uninsured and unreimbursed care.¹⁸⁷ Drug manufacturers and others who will supply the medical needs of the newly covered also stand to benefit.¹⁸⁸ With the benefits of health insurance coverage, new customers, or new patients, the endowment effect predicts that the beneficiaries of the ACA's right to health care will have greater motivation (and thus exert greater political pressure) to maintain these benefits than opponents will have to repeal the law.¹⁸⁹

The phenomenon of political entrenchment can be compared to the economic notion of increasing returns, which stems from the amplification of initial choices through path dependence.¹⁹⁰ A classic example of the phenomenon has been observed in the persistence of the QWERTY keyboard layout due to historical, seemingly insignificant accidents that gave this layout an advantage in the market over other more efficient layouts.¹⁹¹ In a more salient example, the complex structure of health care coverage in the U.S. (split between private, employment-based coverage for workers, government-based coverage for seniors, the poor, and the disabled, and large coverage gaps of uninsured) has been attributed to historical decisions by government and private firms to subsidize employment-based health insurance and to remove costly, difficult-to-insure populations from the private health insurance market into government programs.¹⁹²

The factors that explain the entrenchment of political arrangements have been analogized to factors that lead to increasing economic returns: (1) political arrangements that have large setup costs increase incentives to maintain the initial arrangement; (2) political institutions that are tailored to the political arrangement increase the cost of change; and (3)

187. *Id.* at 324.

188. Reed Abelson, *In Health Care Overhaul, Boons for Hospitals and Drug Makers*, N.Y. TIMES, Mar. 22, 2010, at B1.

189. See Gillette, *supra* note 174, at 827; see also Louise Radnofsky, *Repeal Health Law? It Won't Be Easy*, WALL ST. J. (Oct. 29, 2011), <http://online.wsj.com/article/SB10001424052970203687504576655130486204862.html> (arguing that repealing "ObamaCare" will not be as easy as many presidential candidates propose).

190. See Levinson, *supra* note 172, at 690.

191. See, e.g., Ron Martin & Peter Sunley, *Path Dependence and Regional Economic Evolution*, 6 J. OF ECON. GEOG. 395, 399–400 (2006).

192. See Jacob S. Hacker, *The Historical Logic of National Health Insurance: Structure and Sequence in the Development of British, Canadian, and U.S. Medical Policy*, 12 STUD. AM. POL. DEV. 57, 107 (1998).

political coordination by interest groups increase inertia and stability in the status quo as more people rely upon and expect to utilize the arrangement moving forward.¹⁹³ As applied to the ACA, the costs of passage in terms of political will and coordination were large.¹⁹⁴ In addition, the relative benefits of the institutional arrangement settled upon by the ACA may be magnified by comparison to the costs of returning to the pre-ACA status where problems of uninsured and rising health care costs were largely unaddressed.¹⁹⁵ Once states, health insurance providers, and other market players have sunk costs into developing institutions like Exchanges under the ACA, there will be a disincentive to dismantle these institutions in favor of other models.¹⁹⁶ The coordination effect of the coalition of interest groups that could emerge to defend the ACA's right to health care may increase the political value of the ACA's benefits as more people come to count on them. Moreover, the longer the ACA's individual mandate and other reforms persist, the less they may be perceived by opponents as infringements on liberty or economic interests. People become accustomed to existing legal and economic arrangements so that constraints, such as the payment of payroll taxes to fund Medicare or the obligation of all drivers to obtain auto insurance, are no longer viewed as objectionable.¹⁹⁷

Most of the public outrage at the ACA has focused on the individual mandate, which appears to have driven the majority of the opposition to the ACA generally.¹⁹⁸ Once implemented, opposition to the mandate may decline if the 83% of Americans who already have coverage through their employer or a

193. Levinson, *supra* note 172, at 690.

194. David E. Sanger, *For Historic Stakes, a Big Obama Gamble on a Partisan Victory*, N.Y. TIMES, Mar. 22, 2010, at A1.

195. See Levinson, *supra* note 172, at 684 (“[T]he greater the costs of re-coordinating on a different settlement, the more resilient we should expect current institutional arrangements to be. Institutional arrangements that are costly to set up and costly to do without will be protected by substantial coordination buffers.”).

196. See *id.*

197. *Id.* at 691.

198. See Radnofsky, *supra* note 189 (citing a Kaiser Health Tracking Poll finding 67% of those polled would repeal the individual mandate, but significant majorities would keep other ACA provisions including tax credits for small businesses to offer health coverage to employees (82%), prohibitions on denials of coverage for preexisting conditions (73%), and tax-credit subsidies for low income Americans to purchase coverage (72%)).

government program realize their own health care coverage will remain relatively unaffected by the ACA.¹⁹⁹ For many of those previously uninsured who will have to purchase insurance under the mandate, the sting of being forced to buy health insurance may be lessened if their policy is subsidized by tax credits, they are eligible for Medicaid under its expanded eligibility criteria, or, as young adults, they may purchase low-cost, catastrophic policies to meet the requirement.²⁰⁰ Many others, such as those with preexisting health conditions, will purchase their health insurance gladly, happy to have access to health coverage at all.

These models from behavioral economics tell us that the opponents of the ACA, while formidable, are in a race against the implementation of its benefits. If the ACA's key provisions survive to implementation, the endowment effect and increasing political returns will begin to ossify and entrench the ACA's institutional structures and increase the durability of its right to health care.

B. IMPLICATIONS FOR EFFORTS TO ESTABLISH A DURABLE RIGHT TO HEALTH CARE

The structure of the ACA's right to health care for the uninsured through private insurance reforms was driven by political necessity.²⁰¹ To gain enough votes to pass, the legislation had to cover the uninsured through expansions in the private health insurance market rather than solely through government benefit programs.²⁰² The ACA's coverage structure reflects the existing health care system's coverage based on private, employer-based health insurance and piecemeal government coverage for subgroups, rather than an effort to design the optimal system for universal coverage and

199. *U.S. Health Insurance (Quarterly)*, GALLUP-HEALTHWAYS WELL-BEING INDEX, <http://www.gallup.com/poll/151190/health-insurance-quarterly.aspx> (last visited Nov. 16, 2012) (poll showing eighty-three percent of Americans report having insurance coverage).

200. Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-48, § 1401, 124 Stat. 119, 213–20 (premium subsidies); Patient Protection and Affordable Care Act of 2010 § 2001 (Medicaid expansion); Patient Protection and Affordable Care Act of 2010 § 1302 (catastrophic plans for young adults under thirty).

201. See Arnold J. Rosoff, *Of Stars and Proper Alignment: Scanning the Heavens for the Future of Health Reform*, 159 U. PA. L. REV. 2083, 2100, 2116–17 (2011).

202. See *id.*

administration of health care services.²⁰³ Absent a significant turn of political will to upend the path-dependent system that emerged from the early choices to link health care coverage to employment, any effort to create a durable right to health care will face similar political and practical challenges as the ACA.²⁰⁴ There are, however, a few lessons to be drawn from the challenges faced by the ACA for designers of health care coverage strategies, including lessons about implementation timeframes, complexity, uncertainty, and structure.

The largest lesson is that the timeframe for implementation of the ACA's right to health care is too long. The four-year lag between the Act's passage and most of its reforms spans two elections and gives opponents time to mobilize political challenges before the beneficiaries of the Act begin to realize most of its benefits. Unlike the seniors who gained Medicare benefits within a year of its passage, the interest groups that coalesced around the ACA's passage may fracture and cool before public support emerges from the delivery of popular benefits. The campaign to educate the public about the ACA's benefits is more difficult because the benefits remain years away. Over time, the public, even those who previously supported the Act, may start to doubt that they will benefit under the provisions of the ACA.²⁰⁵

The long time frame for implementation of the health insurance reforms may have been driven by the nature of the private insurance market, whose financial models and underwriting practices span years rather than months.²⁰⁶ In addition, the time frame allows states time to organize the new marketplaces for health insurance plans. States must undertake initiatives to implement the Exchanges and create new administrative bodies to oversee implementation, often

203. See *id.* at 2097–99 (discussing the historical origins and subsequent entrenchment of the U.S. employer-based health insurance system).

204. See *id.* at 2100 (“We can imagine and argue for all types of health care system models and configurations—single-payer governmental systems, mixed public-private systems, employment-based private systems, managed competition, and so on—but any debate must begin with what we presently have.”).

205. See KAISER FAM. FOUND., *supra* note 112, at 11 (suggesting that supporters of the health reform law are beginning to lose confidence they will ever actually benefit from the law).

206. See INST. OF MED., *supra* note 20, at 84 (tables demonstrating the fact that financial modeling occurs over years).

through separate state legislation.²⁰⁷ It is unclear whether the four-year time frame for implementation was the shortest period in which the coverage reforms could be implemented realistically or whether it was agreed upon as a concession to the health insurance industry and states to ease the burden of implementation. When compared to Medicare's single-payer administration and one-year implementation, the decision to distribute the responsibility for health care coverage reforms among myriad private health insurers and the fifty states might explain why the implementation is so lengthy under the ACA. In this manner, the long time frame for realization of the right to health care under the ACA points to another lesson for designers of a right to health care: the role of complexity.

The complexity of the ACA generally, and the mechanics of its right to health care specifically, may stand in the way of its public support.²⁰⁸ Most of the public still does not understand the main features of the right to health care under the ACA, not to mention the interlocking nature of the nondiscrimination provisions, health insurance Exchanges, tax credits and subsidies, and the individual mandate.²⁰⁹ The case for opposing the individual mandate (i.e., that government is forcing you to purchase an expensive product you do not wish to buy) seems easier for the public to understand intuitively than the idea that the individual mandate is economically necessary to have health insurance policies that do not discriminate on the basis of preexisting conditions or health status.²¹⁰ As pointed out earlier, months or years after passage, the uninsured that stand to benefit most directly still do not understand or believe the ACA will help them.²¹¹ Complexity is a barrier to durability when it makes implementation and selling the new law to the public difficult.²¹²

207. See *State Actions to Implement Health Insurance Exchanges*, *supra* note 137.

208. See Forrest Maltzman & Charles R. Shipan, *Change, Continuity, and the Evolution of the Law*, 52 AM. J. POL. SCI. 252, 257 (2008) ("Major laws that are more complex are more likely to be amended.").

209. See KAISER FAM. FOUND., *supra* note 112, at 7 (showing public confusion over the elements of the ACA).

210. See *supra* Part II.B.2.

211. See Altman, *supra* note 118.

212. Atul Gawande, *Something Wicked This Way Comes*, NEW YORKER (June 28, 2012), <http://www.newyorker.com/online/blogs/comment/2012/06/something-wicked-this-way-comes.html> (arguing that the ACA's attempt to cover the uninsured addresses a "wicked problem" that is messy, ill-defined,

A third lesson is that, to the extent possible, the right to health care should not be built upon an uncertain legal foundation.²¹³ Although the individual mandate was upheld by the Supreme Court in June 2012, the intervening twenty-seven months while the legal challenges were pending spelled a period of suspended animation for the implementation of many of the law's key provisions.²¹⁴ The legal challenges to the individual mandate undermined the right to health care by introducing uncertainty to the implementation process.²¹⁵ States have been wary of spending resources to assemble the Exchanges.²¹⁶ The insurance industry's amicus brief to the Supreme Court was an unvarnished plea for resolution of the uncertainty as health plans prepared to come into compliance with the ACA's myriad health insurance reforms.²¹⁷ Even those individuals who understand the health insurance protections scheduled to take effect in 2014 may not feel confident that those benefits will survive legal or political challenge. The result of this uncertainty is that stakeholders throughout the system engaged in a kind of stutter-step, which prevented them from sinking resources toward implementation.²¹⁸ Without sunk costs, the barriers to dismantling or abandoning the ACA's right to health care are reduced.²¹⁹

and complex, and for such wicked problems, "[Generally,] reforms pursued straight forward goals but required inherently complicated, difficult-to-explain means of implementation").

213. See Maltzman & Shipan, *supra* note 208, at 256–57.

214. See *supra* Part II.B.2.

215. See Brief for America's Health Ins. Plans as Amicus Curiae in Partial Support of Certiorari Review at 5–10, Nat'l Fed'n of Indep. Bus. v. Sebelius, No. 11-393, slip op. (U.S. June 28, 2012).

216. See *State Actions to Implement Health Insurance Exchanges*, *supra* note 137 (showing a large number of states have not implemented Exchanges).

217. Brief for America's Health Ins. Plans as Amicus Curiae in Partial Support of Certiorari Review, *supra* note 215, at 3 (“[Our] comprehensive compliance efforts, however, are being conducted in a cloud of uncertainty about the durability of the monumental changes being made and the legal regime that will govern insurance plans going forward. Only a prompt and definitive ruling by this Court on the individual mandate’s constitutionality can restore needed certainty to the health care market.”).

218. See *id.* at 3, 5–10; Gillette, *supra* note 174, at 819 (“[N]o single party will incur the costs of deviation from the existing standard without assurances that offsetting benefits can be realized as a result of mass movement to the new equilibrium.”).

219. See Martin & Sunley, *supra* note 191, at 412 (discussing inertia of sunk costs).

A final lesson is that the federal government's options to strengthen the federal right to health care have been significantly hemmed in by the Roberts Court. One option is that the federal government could follow explicitly the roadmap set forth by the Court's ruling on the ACA. If a right to health care is going to be delivered in significant portion through a private health insurance market, it will require something like an individual mandate to avoid the adverse selection death spiral. Such a mandate is beyond the power of a federal government *unless* it is functionally structured as a tax.²²⁰ This is a difficult political needle to thread—preserving the centrality of a private health insurance system without appearing to impermissibly compel individuals to purchase health insurance on the one hand, or raise taxes to fund such purchase on the other. Nor may Congress look to its spending power to impose conditions to expand, alter, or strengthen the right for those covered by large federal-state programs.²²¹ Medicaid, like the health care industry of which it is a part, is so large and consumes so much of the state budget that it was declared coercive for the federal government to require states to expand the program as a condition of keeping existing Medicaid dollars.²²² The larger the spending program and the more dependent the state is on federal funding, the less power the federal government has to require states to agree to expand such programs before running afoul of federalism concerns, even if the expansion is almost entirely funded by federal dollars.²²³

Another option remains: the federal government could undertake to finance and administer the health care program itself through a singlepayer system like Medicare. Although singlepayer health reform is often derided as politically infeasible, the ACA has taught us that health reform through private insurance expansion, with its individual mandate albatross, is fraught with its own political challenges: a right to

220. Nat'l Fed'n of Indep. Bus. v. Sebelius, No. 11-393, slip op. at 35–36 (U.S. June 28, 2012) (listing three factors that made the individual mandate, in the Court's opinion, functionally operate as a tax as opposed to a penalty: (1) the amount of tax relative to the infraction is minimally burdensome compared to the cost of purchasing insurance; (2) there is no scienter requirement; and (3) the exaction is collected by the IRS through normal means of tax collection).

221. *Id.* at 50–54.

222. *Id.* at 50–52.

223. *Id.*

health care through private coverage must be crafted from a cabined spectrum of Congressional powers, but easily can be weighed down with so much complexity that it risks being incomprehensible to its own beneficiaries.²²⁴ A singlepayer system, funded with taxes and administered by the federal government, avoids the legal and market challenges of a right to health care that depends on coordination of private industry, individuals, and states. Although more politically difficult to pass through Congress, a single payer right to health care would have the advantage of quicker delivery of benefits, stronger interest group support, and a simpler concept for the public to understand (i.e., Medicare for all). The difference between the path taken by the ACA and the approach taken by Medicare might mean the difference between a fragile quasi-superstatute and a durable superstatutory right to health care.

IV. CONCLUSION

The ACA creates a new right to health care for the uninsured through private insurance market reforms.²²⁵ This expanded right, though momentous in its scope, was constructed in a way that was politically expedient and structurally fragile.²²⁶ Passed amidst bitter partisan division and an ambivalent public, the expanded benefits to the uninsured are poorly understood and slow to be implemented, while political opposition and opportunity for retrenchment grows.²²⁷ In addition, the right depends on private actors, private health insurance companies, and willing states to administer and participate in a newly transparent, competitive, and streamlined private health insurance market, while these same actors hesitate to invest in the infrastructure of this market due to uncertainty from legal and political challenges to the ACA.²²⁸

All of these challenges make it more likely, in the short term, that the ACA's right to health care will be ephemeral or hollow—a quasi-superstatute rather than a durable superstatute. The ACA's weaknesses are time-limited and will

224. See KAISER FAM. FOUND., *supra* note 112.

225. See *supra* Part I.C.

226. See *supra* Part II.B.1.

227. See *id.*

228. See *supra* Part I.C.

rapidly diminish if the right to health care survives until implementation.²²⁹ Once implemented, interest groups and institutional defenders could coalesce around its substantial benefits and begin to ossify its structure against political attack.²³⁰ The ACA's fragility highlights the importance of how such social reforms are structured (or not) to achieve entrenchment and durability after the ink is dry on the new legislation. Failed reforms and quasi-superstatutes carry harms beyond the loss of the promised social good; they squander political and economic resources and create increased public distrust in the ability of legislative reform to deliver durable rights.²³¹

229. *See supra* Part III.A.

230. *See id.*

231. *See supra* Part III.B.