**Western New England Law Review**

Volume 23 *23 (2001-2002)*
Issue 2

Article 3

1-1-2002

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> Without health there is no happiness. And attention to health, then, should take the place of every other object. . . . The most uninformed mind, with a healthy body, is happier than the wisest valetudinarian.
>
> Thomas Jefferson[1]

> Doctors and hospitals have become such massively important features of contemporary life that to be cut off from the help they provide is not only dangerous but also degrading.
>
> Michael Walzer[2]

## INTRODUCTION

After President Clinton's failed attempt in 1993 to reform the United States health care system, some observers predicted that the system would reform itself through free-market competition.[3] Competition among insurance companies and health plans, some believed, would expand access, reduce prices, and improve quality.[4] Yet the free market has failed to do any of these things. The number of uninsured Americans has steadily increased.[5] Prices, al-

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1. I JEFFERSONIAN CYCLOPEDIA: A COMPREHENSIVE COLLECTION OF THE VIEWS OF THOMAS JEFFERSON 402 (J. P. Foley ed., 1967).

2. MICHAEL WALZER, SPHERES OF JUSTICE: A DEFENSE OF PLURALISM AND EQUALITY 89 (1983).

3. *See* Erik Eckholm, *While Congress Remains Silent, Health Care Transforms Itself*, N.Y. TIMES, Dec. 18, 1994, at A1.

4. *See id.*

5. According to the most recent data, in 1999, 15.5% of Americans lacked health insurance coverage; although this number was down from the previous year, it was an increase from 13.6% at the start of the 1990s. *See* Mary Leonard, *Questions of Care: The Shattering Cost of Disease*, BOSTON GLOBE, Oct. 3, 2000, at A22 (citing the U.S. Census Bureau). For data on the trend of increasing uninsured throughout the 1990s,

though stable for a few years,[6] have surged recently,[7] and the quality of care has eroded.[8] In fact, most of the incremental federal and state legislation, passed since the failed Clinton Health Plan, remedies the inadequacies of the free-market model of distributing health care.[9]

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see HEALTH INSURANCE ASSOCIATION OF AMERICA, SOURCE BOOK OF HEALTH INSURANCE DATA 22 (1998).

6. *See* Katharine Levit et al., *Health Spending in 1998: Signals of Change*, HEALTH AFF., Jan.-Feb. 2000, at 124, 125 (documenting that health care's share of gross domestic product remained stable for six consecutive years, from 1993 to 1998).

7. *See* Julie Appleby, *Medical Costs Are Rising and Insurance Premiums Could Jump 20% - Signs That Managed Care Isn't Working*, USA TODAY, Dec. 8-10, 2000, at A1 (reporting biggest premium hikes in a decade, and challenging effectiveness of HMOs to control health care inflation); Jon Gabel et al., *Job-Based Health Insurance in 2000: Premiums Rise Sharply While Coverage Grows*, HEALTH AFF., Sept.-Oct. 2000, at 144, 145 (finding that premiums across the country among all plan types rose 8.3% in 2000, the largest increase since 1993); *see also* Kip Sullivan, *On the 'Efficiency' of Managed Care Plans*, HEALTH AFF., July-Aug. 2000, at 139 (arguing that there is inconclusive evidence to support claim that managed care health plans save money).

8. *See* David V. Himmelstein et al., *Quality of Care in Investor-Owned vs. Not-for-Profit HMOs*, 282 J. AM. MED. ASS'N 159, 162 (1999) (concluding that investor-owned HMOs, which now dominate the managed care marketplace, deliver lower quality of care than not-for-profit plans when researchers analyzed data from the National Committee for Quality Assurance and other applicable industry data); *see also* John V. Jacobi, *Patients at a Loss: Protecting Health Care Consumers Through Data Driven Quality Assurance*, 45 U. KAN. L. REV. 705, 708 (1997) (arguing that managed care's undermining of the fiduciary relationship has eroded quality of care). For a thorough discussion of how to define, measure, and improve the quality of care, see Beth C. Weitzman, *Improving Quality of Care*, *in* HEALTH CARE DELIVERY IN THE UNITED STATES 370 (Anthony R. Kovner & Steven Jonas eds., 1999).

9. *See, e.g.*, Newborns' and Mothers' Health Protection Act of 1996, 29 U.S.C. § 1185 (1999), 42 U.S.C. §§ 300gg-4, 300gg-51 (2000) (prohibiting, *inter alia*, a health plan from denying mothers and newborns at least 48 hours in a hospital after a vaginal delivery and 96 hours after a cesarean); Mental Health Parity Act of 1996, 29 U.S.C. § 1185a (1999) (proscribing group health plans offering mental health benefits from setting annual or lifetime dollar limits on mental health benefits that are lower than those for medical and surgical benefits); Women's Health and Cancer Rights Act of 1998, 29 U.S.C. § 1185b (2000) (requiring health coverage for all stages of reconstructive surgery after mastectomies, including surgery necessary for symmetrical appearance); Health Insurance Portability and Accountability Act of 1996, 42 U.S.C. § 300gg (2000) (remedying problems related to employees with pre-existing medical conditions losing health insurance when changing jobs).

The states have also passed incremental legislation addressing the failures of the free-market model. *See* Fred J. Hellinger, *The Expanding Scope of State Legislation*, 276 J. AM. MED. ASS'N 1065 (1996) (detailing states' efforts to legislate in the health care arena); Note, *Recent Legislation–Health Care Law–"Drive Through Delivery" Regulation*, 109 HARV. L. REV. 2116 (1996) (describing the content and context of a Massachusetts statute directed at regulating the treatment of women at childbirth); *see generally* NATIONAL HEALTH LAW PROGRAM, 1997 MANUAL ON STATE AND LOCAL RESPONSIBILITY FOR INDIGENT HEALTH CARE (1997), *available at* www.healthlaw.org (regularly updated); Families USA, THE BEST FROM THE STATES, PARTS I AND II, TEXT

For some health care advocates, the surest way to motivate Congress to pass universal health insurance legislation is to argue that access to health care is a fundamental right guaranteed by the United States Constitution.[10] Unfortunately, like education, the United States Supreme Court has held that the Constitution does not guarantee such a right.[11] Nevertheless, legal advocates have successfully turned to state constitutional law to expand access to education.[12] Could a health care advocate do the same in the context of expanding access to health care? The purpose of this Article is to explore this question.[13]

Part I of this Article briefly reviews the emergence of state

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OF KEY STATE HMO CONSUMER PROTECTION PROVISIONS (1998), *available at* www.familiesusa.org/best1.htm, and /best2.htm.

10. *See* Wendy K. Mariner, *Access to Health Care and Equal Protection of the Law: The Need for a New Heightened Scrutiny*, 12 AM. J.L. & MED. 345 (1986) (arguing for a heightened scrutiny for health care interests under the equal protection clause); Tom Stacy, *The Courts, the Constitution, and a Just Distribution of Health Care*, KAN. J.L. & PUB. POL'Y, Winter 1993-94, at 77 (exploring the link between principles of distributive justice, the Constitution, and the proper role of the courts, and arguing that courts should play a larger role in redressing the current unjust distribution of health care); Wendy E. Parmet, *Health Care and the Constitution: Public Health and the Role of the State in the Framing Era*, 20 HASTINGS CONST. L.Q. 267, 312-19 (1993) (using social contract theory and early public health laws to argue that the framers of federal constitution intended not only to empower but also to obligate the government to provide for the public health).

11. *See* San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1, 55 (1973)(holding that education is not a fundamental federal constitutional right, and precluding the possibility of federal relief for inequitable funding of school systems). *But cf.* Susan H. Bitensky, *Theoretical Foundations for a Right to Education Under the U.S. Constitution: A Beginning to the End of the National Education Crisis*, 86 NW. U. L. REV. 550, 553 (1992) (arguing that "[d]octrines interpreting the Constitution are rich with possible theoretical bases for asserting an unenumerated affirmative right to education"); Timothy D. Lynch, Note, *Education as a Fundamental Right: Challenging the Supreme Court's Jurisprudence*, 26 HOFSTRA L. REV. 953 (1998) (criticizing the Supreme Court's holding in *Rodriguez*).

*See* Maher v. Roe, 432 U.S. 464, 479 (1977); Harris v. McRae, 448 U.S. 297 (1980)(holding that Medicaid is not required to fund abortion services for indigent woman seeking to exercise reproductive choice); *see also* Wideman v. Shallowford Cmty Hosp., 826 F.2d 1030, 1036-37 (11th Cir. 1987) (rejecting federal constitutional right to medical services). *But cf.* Mariner, *supra* note 10, at 37 (criticizing the Supreme Court for not acknowledging health care as constitutionally protected); Stacy, *supra* note 10, at 82-85 (same).

Under some circumstances, however, there is a federal statutory right to emergency medical care. *See* Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (1997) (obligating hospitals that participate in Medicare and maintain emergency departments to screen and stabilize patients who suffer from an emergency medical condition regardless of the patient's ability to pay).

12. See *infra* Part I, for a discussion of such litigation.

13. Since having adequate health insurance has become, in part, a prerequisite for having access to doctors and hospitals in the United States, "access to health care," for

constitutionalism and discusses how legal advocates have used state constitutional law to expand the right to public education. Part II identifies and analyzes both explicit and implicit health care provisions contained in state constitutions. It concludes that given the paucity of these provisions, they would not be effective for expanding access to health care. A better strategy is to explore whether a state's constitution contains a constitutional interest in fair equality of opportunity.[14] Part III provides a preliminary sketch of a health care equal protection theory—that is a framework within which one could challenge a state's health care financing laws under the state's equal protection clause. Finally, Part IV tests this framework by applying it to Massachusetts' health care financing laws. It concludes that these laws may violate the state's equal protection guarantees because they unequally distribute access to health care, thereby burdening some residents' fair equality of opportunity interests.

## I. STATE CONSTITUTIONAL LAW AND PUBLIC EDUCATION

The current use of state constitutional law as a source for expanding individual rights is a relatively recent phenomenon. Most scholars trace its origins to 1977 when Justice William Brennan challenged state supreme courts to use their own constitutions to expand individual rights in light of the United States Supreme Court's conservative turn in the 1970s.[15] Since his challenge, state supreme courts have responded resoundingly. In the 1980s and 1990s, state courts issued over 350 rights-expanding decisions[16] in

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purposes of this article, refers to "access to affordable health insurance." *See infra* Part III.C.

14. Below "fair" equality of opportunity is distinguished from "formal" or "negative" equality of opportunity. The latter protects opportunity by proscribing discrimination based on race, ethnicity, religion, gender and so forth, while the former protects opportunity by guaranteeing essential background conditions, such as access to educational institutions, necessary for having a competitive chance at opportunities formally open to all. *See infra* Part III.B.

15. *See* William J. Brennan, Jr., *The Bill of Rights and the States: The Revival of State Constitutions as Guardians of Individual Rights*, 61 N.Y.U. L. REV. 535, 548 (1986); William J. Brennan, Jr., *State Constitutions and the Protection of Individual Rights*, 90 HARV. L. REV. 489, 503 (1977). For an excellent overview of state constitutionalism, see James A. Gardner, *Introduction* to 1 STATE EXPANSION OF FEDERAL CONSTITUTIONAL LIBERTIES: INDIVIDUAL RIGHTS IN A DUAL CONSTITUTIONAL SYSTEM, at ix, xi-xvii (James A. Gardner ed., 1999) and G. ALAN TARR, UNDERSTANDING STATE CONSTITUTIONS (1998).

16. *See* Gardner, *supra* note 15 at xxvii (citing Sol Wachtler, *Our Constitutions—Alive and Well*, 61 ST. JOHN'S L. REV. 381, 397 (1987)).

areas such as criminal procedure,[17] individual privacy,[18] protection for the mentally ill,[19] abortion rights,[20] and same-sex marriage rights.[21]

One of the most significant uses of state constitutional law has been in the area of public school financing.[22] There, legal advocates have used either a state constitution's equal protection clause[23] or its education clause[24] to overcome large disparities in funding and

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17. *See* Gardner, *supra* note 15, at xxv (noting that "state courts have been most willing to chart . . . independent course[s]" in the area of criminal procedure).

18. *See* Commonwealth v. Wasson, 842 S.W.2d 487, 501-02 (Ky. 1992) (providing heightened protection for gay and lesbian intimate associations). *See generally* Ken Gormley & Rhonda G. Hartman, *Privacy and the States*, 65 TEMP. L. REV. 1279 (1992)(discussing a complete treatment of state constitutionality privacy guarantees).

19. *See generally* Antony B. Klapper, Comment, *Finding a Right in State Constitutions for Community Treatment of the Mentally Ill*, 142 U. PA. L. REV. 739, 833-35 (1993) (urging the use of state constitutionalism to expand the rights of the mentally ill in civil commitment procedures).

20. *See* Moe v. Sec'y of Admin. & Fin., 417 N.E.2d 387, 404 (Mass. 1981) (using state's due process and equal protection clauses to hold that its restrictions on abortion funding under Massachusetts' Medicaid program were unconstitutional). *See generally* Kevin Francis O'Neill, *The Road Not Taken: State Constitutions as an Alternative Source of Protection for Reproductive Rights*, 11 N.Y.L. SCH. J. HUM. RTS. 1 (1993) (exploring the use of state constitutions as an alternative or supplemental source for protecting reproductive rights).

21. *See* Baker v. State, 744 A.2d 864, 867 (Vt. 1999) (holding that Vermont "is constitutionally required to extend to same-sex couples the common benefits and protections that flow from marriage under Vermont law").

22. *See, e.g.*, Kimberly J. Gost, Recent Case, Sheff v. O'Neill, *678 A.2d 1267 (Conn. 1996)*, 28 RUTGERS L.J. 909, 917 (1997) (discussing a state court decision that found an obligation by the Connecticut legislature, under the State's Equal Protection Clause, to remedy racial imbalances in the school system). *See generally* Allen W. Hubsch, *Education and Self-Government: The Right to Education Under State Constitutional Law*, 18 J.L. & EDUC. 93, 121-27 (1989) (discussing state equal protection); Allen W. Hubsch, *The Emerging Right to Education Under State Constitutional Law*, 65 TEMP. L. REV. 1325 (1992); William E. Thro, Note, *To Render Them Safe: The Analysis of State Constitutional Provisions in Public School Finance Reform Litigation*, 75 VA. L. REV. 1639, 1670-78 (1989) (discussing equality guaranty provisions in state constitutions).

23. *See* DuPree v. Alma Sch. Dist. Number Thirty, 651 S.W.2d 90, 95 (Ark. 1983)(using a state equal protection clause successfully in the area of public education financing); Serrano v. Priest, 557 P.2d 929, 957-58 (Cal. 1976)(same); Horton v. Meskill, 376 A.2d 359, 374-75 (Conn. 1977)(same); Bismarck Pub. Sch. Dist. 1 v. State, 511 N.W.2d 247, 262-63 (N.D. 1994)(same); Washakie County Sch. Dist. Number One v. Herschler, 606 P.2d 310, 335-36 (Wyo. 1980)(same); Pauley v. Kelly, 255 S.E.2d 859, 878 (W. Va. 1979)(same).

24. An education clause exists in every state constitution except Mississippi. *See* William E. Thro, *Judicial Analysis During the Third Wave of School Finance Litigation: The Massachusetts Decision As a Model*, 35 B.C. L. REV. 597, 602 n.29 (1994) (citing educational clauses from forty-nine states). These clauses require the state to maintain a system of free public education. *Id.* States have used the education clause to strike down disparate public school financing systems. *See* Opinion of the Justices, 624 So.2d

educational quality between rich and poor school districts.[25]

In 1993, for example, the Massachusetts Supreme Judicial Court ("SJC") used the state's education clause to analyze public school financing. In *McDuffy v. Secretary of the Executive Office of Education*,[26] the SJC held that the Commonwealth of Massachusetts has a constitutional obligation to provide all public school students with an education.[27] Although the plaintiffs used an equal protection analysis, the court, for the first time, focused on whether the education clause itself required this action. By analyzing the intentions of the framers, the language and structure of the constitution, and other sources, the SJC concluded that the education clause was intended to mandate adequate education for all public school students.[28]

Likewise, in one of the earliest public school finance cases litigated under state constitutional law, the New Jersey Supreme Court, in *Robinson v. Cahill*,[29] declined to use the state's equal protection language because it was uncomfortable in defining education as a fundamental right.[30] Instead the court used the education clause of the state's constitution, which required the legislature to

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107, 110-11 (Ala. 1993); Rose v. Council for Better Educ., Inc., 790 S.W.2d 186, 213-15 (Ky. 1989); McDuffy v. Sec'y of the Executive Office of Educ., 615 N.E.2d 516, 555 (Mass. 1993); Helena Elementary Sch. Dist. No. 1 v. State, 769 P.2d 684, 690 (Mont. 1989); Abbott v. Burke, 575 A.2d 359, 408 (N.J. 1990); Edgewood Indep. Sch. Dist. v. Kirby, 777 S.W.2d 391, 397 (Tex. 1989).

25. These two strategies have been described as separate waves of school finance litigation, where the use of the equal protection clause, the second wave, has been less successful than the use of the education clause, the third wave. The unsuccessful use of the federal equal protection clause was the first wave. *See* Thro, *supra* note 24, at 600-04 (discussing the three waves in the context of comparing the methodology of *McDuffy v. Sec'y of the Executive Office of Educ.*, 615 N.E.2d 516 (Mass. 1993) with other third wave decisions).

26. 615 N.E.2d 516 (Mass. 1993).

27. *Id.* at 548. *But see* Doe v. Superintendent of Sch., 653 N.E.2d 1088, 1095 (Mass. 1995) (holding that each individual student does not have a fundamental right to an education while acknowledging the importance of education and that the Commonwealth has a general obligation to educate its children pursuant to *McDuffy*).

28. The education clause reads, in relevant part, "it shall be the duty of legislatures and magistrates, in all future periods of this commonwealth, to cherish the interests of literature and the sciences. . . ." MASS. CONST. pt. 2 ch. 5, § 2. The defendants argued that the phrase "shall be the duty. . .to cherish" was permissive language and not obligatory. *McDuffy*, 615 N.E.2d at 524.

29. 303 A.2d 273 (N.J. 1973).

30. The court was hesitant to find a fundamental right violation under its equal protection clause in the context of education observing that "the equal protection clause may be unmanageable if it is called upon to supply categorical answers in the vast area of human needs, choosing those which must be met and a single basis upon which the State must act." *Id.* at 283.

maintain a "thorough and efficient" educational system.[31]

Other state courts, however, have held that education is a fundamental right and have used their state's equal protection clause to strike down unequal public financing arrangements as unconstitutional.[32] For example, in *Serrano v. Priest*,[33] the California Supreme Court held that education is a fundamental right and that inadequate funding in poor schools was denying this right to some children in violation of the state's equal protection clause.[34] The *Serrano* court's decision was predicated on its belief that education was a fundamental right because "[u]nequal education . . . leads to unequal job opportunities, disparate income, and handicapped ability to participate in the social, cultural, and political activity of our society."[35] In other words, the court reasoned that meeting educational needs plays a significant role in preserving a child's future opportunities; it gives each child a fair chance at competing for jobs and participating effectively in contemporary social life. Since this important connection between educational needs and opportunity exists, the court justified treating education as a fundamental right.[36]

## II. HEALTH CARE PROVISIONS IN STATE CONSTITUTIONS

### A. *Explicit "health" or "health care" provisions*

While almost every state constitution has explicit language regarding the provision of adequate education,[37] there is a paucity of similar language regarding the provision of adequate health care

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31. *Id.* at 295-97.

32. *See* Randal S. Jeffrey, *Equal Protection in State Courts: The New Economic Equality Rights*, 17 LAW & INEQ. 239, 271-78 (1999) (citing state courts holding education as fundamental right).

33. 487 P.2d 1241 (Cal. 1971).

34. *Id.* at 1257-58. The court initially used the federal equal protection clause to make its argument, but it later modified its decision to use the California Constitution alone. *See* Serrano v. Priest, 557 P.2d 929, 951-52 (Cal. 1977) (en banc) (modifiying its decision due to San Antonio Indep. Sch. Dist. v. Rodriguez, 411 U.S. 1 (1973)).

Some states have used their educational clause and their equal protection clause. *See* DuPree v. Alma Sch. Dist. No. 30, 651 S.W.2d 90, 93 (Ark. 1983); Horton v. Meskill, 376 A.2d 359, 370-74 (Conn. 1977); Tenn. Small Sch. Sys. v. McWherter, 851 S.W.2d 139, 152-56 (Tenn. 1993); Pauley v. Kelly, 255 S.E.2d 859, 863-66 (W. Va. 1979).

35. 487 P.2d at 1257 (quoting San Francisco United Sch. Dist. v. Johnson, 478 P.2d 669, (Cal. 1971)).

36. *See id.* at 1258-59; *see also DuPree*, 651 S.W.2d at 93 (noting that "[e]ducation becomes the essential prerequisite that allows our citizens to be able to appreciate, claim, and effectively realize their established rights").

37. *See supra* note 24.

services. Only eight state constitutions—Alaska, Hawaii, Michigan, Mississippi, North Carolina, New York, South Carolina, and Wyoming—directly allocate to the state responsibility for promoting or protecting health, or assisting the indigent sick.[38] Of these, six states—Alaska, Hawaii, Michigan, North Carolina, New York, and Wyoming—have constitutional provisions requiring the legislature to promote and protect the public health.[39] None of these states, however, has interpreted such provision to mean that the state must expand access to health care for the uninsured or underinsured.[40] These health promotion/protection provisions, presumably, authorize state legislatures to protect the public health generally by mandating vaccines, and regulating the environment, food, and safety, etc. Nevertheless, since a population with inadequate health insurance may pose a public health problem, an advocate could use these statutes to argue for increasing funding for state health insurance programs. Unfortunately, even if successful, this strategy would have limited application since only these six states have adopted such provisions.

Other explicit state constitutional provisions require a legisla-

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38. *See* ALASKA CONST. art. VII, § 4 ("[t]he legislature shall provide for the promotion and protection of public health"); HAW. CONST. art. IX, § 3 ("The State shall have the power to provide financial assistance, medical assistance and social services for persons who are found to be in need of and are eligible for such assistance and services as provided by law."), § 1 ("The State shall provide for the protection and promotion of the public health."); MICH. CONST. art. 4, § 51 ("The legislature shall pass suitable laws for the protection and promotion of the public health . . . ."); MISS. CONST. art. IV, § 86 ("It shall be the duty of the legislature to provide by law for the treatment and care of the insane; and the legislature may provide for the care of the indigent sick in the hospitals in the state . . . ."); N.C. CONST. art. XI § 4 ("Beneficient provisions for the poor, the unfortunate and the orphan is one of the first duties of a civilized and Christian state."); N.Y. CONST. art. 17, § 3 ("The protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefor shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine."); S.C. CONST. art. XII, § 1 ("The health, welfare, and safety of the lives and property of the people of this State and the conservation of its natural resources are matters of public concern. The General Assembly shall provide appropriate agencies to function in these areas of public concern and determine the activities, powers, and duties of such agencies."); WYO. CONST. art. 7, § 20 ("As the health and morality of the people are essential to their well-being, . . . it shall be the duty of the legislature to protect and promote these vital interests . . . .").

39. *See* sources cited *supra* note 38; *see also* LA. CONST. art. 12, § 8 ("The legislature may establish a system of economic and social welfare, unemployment compensation, and public health.").

40. A Michigan court, however, held that this language implicitly mandated the provision of mental health services by the county health clinic. Coen v. Oakland County, 400 N.W.2d 614, 615 (Mich. 1986) (per curiam).

ture to fund health-related activities or target a specific population for health care benefits. For example, Mississippi, Hawaii, and Arkansas require the legislature to pass laws for the treatment and care of the insane.[41] However, both Mississippi's and Hawaii's provisions merely permit, but do not mandate, laws for the care of the indigent sick in state hospitals.[42]

Thus, an advocate has little explicit state constitutional language to rely on in attempting to expand individual rights to health care. An alternative strategy, however, would be to look for implicit constitutional language such as welfare or similar assistance provisions aimed at benefiting the poor generally. Since many states have not expanded Medicaid to cover citizens who fall below the federal poverty level,[43] constitutional provisions to assist them could require increasing access to health care services.

### B. *Implicit Health Care Provisions*

There are many other state constitutional provisions that could be used indirectly to support increased access to health care. These provisions do not mention promoting or protecting health, or providing health care services *per se*, but they do contain beneficent or welfare language that may be used to support increasing access to health care for those who cannot afford it.[44] For example, a North

41. *See* ARK. CONST. art. 19, § 19 ("It shall be the duty of the General Assembly to provide by law for the support of institutions for the education of the deaf and dumb and the blind, and also for the treatment of the insane."); HAW. CONST. art. IX, § 2 ("The State shall have the power to provide for the treatment and rehabilitation of handicapped persons."); MISS. CONST. art. IV, § 86.

42. *See* HAW. CONST. art. IX, § 3; MISS. CONST. art. IV, § 86; *cf.* GA. CONST. art. 3, § 9, ¶ VI(i) (authorizing the General Assembly to provide an Indigent Care Trust Fund, where moneys in the fund are to be used exclusively for primary health care programs for the state's medically indigent citizens and children, for expanding Medicaid eligibility and services, or for programs to support those efforts that disproportionately serve the medically indigent).

43. Only seven states—Delaware, Hawaii, Massachusetts, Minnesota, Oregon, Rhode Island, and Vermont (and the District of Columbia)—have Medicaid earnings thresholds that are at least equal to the federal poverty level ($13,650 a year for a family of three in 1998). *See* Jocelyn Guyer & Cindy Mann, *Employed But Not Insured: A State-by-State Analysis of the Number of Low-Income Working Parents Who Lack Health Insurance* 2 (Feb. 9, 1999), *available at* http://www.cbpp.org/2-9-99mcaid.htm.

44. *See* ALA. CONST. art. IV, § 88 ("It shall be the duty of the legislature to require the several counties of this state to make adequate provisions for the maintenance of the poor."); Atkins v. Curtis, 66 So. 2d 455, 458 (Ala. 1953) (per curiam) (holding that the Alabama legislature has the power to determine who constitutes the "poor"); *see also* ALASKA CONST. art. VII, § 5 ("The legislature shall provide for public welfare"); ARIZ. CONST. art. 22, § 15 ("Reformatory and penal institutions, and institutions for the benefit of the insane, blind, deaf, and mute, and such other institutions as the

Carolina court interpreted the state's constitutional provision requiring "beneficent provisions for the poor" to include medical treatment, without cost, to the indigent sick.[45] Moreover, Alabama's constitutional provision requiring counties of the state "to make adequate provisions for the maintenance of the poor" has been interpreted to support the constitutionality of the Alabama Health Care Responsibility Act, which, *inter alia*, imposed financial responsibility for the medical care of county indigents upon the county itself.[46]

Given that there are twenty-three states that have some form of constitutional provision for assisting the poor,[47] this strategy offers more potential than relying on explicit health-related state constitutional provisions. Unfortunately, only four of the twenty-three state provisions contain mandatory language.[48] Moreover, many state courts limit the effectiveness of these poverty provisions be-

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public good may require, shall be established and supported by the State in such manner as may be prescribed by law . . . . "); IDAHO CONST. art. X, § 1 (same); KAN. CONST. art. VII, § 1 ("Institutions for the benefit of mentally or physically incapacitated or handicapped persons, and such other benevolent institutions as the public good may require, shall be fostered and supported by the state."); *id.* § 4 ("The respective counties of the state shall provide . . . for those inhabitants who, by reason of age, infirmity or other misfortune, may have claims upon the aid of society."); MONT. CONST. art XII, § 3(3) ("The legislature may provide such economic assistance and social and rehabilitative services for those who, by reason of the age, infirmities, or misfortune are determined by the legislature to be in need."); N.Y. CONST. art. 17, § 1 ("The aid, care and support of the needy are public concerns and shall be provided by the state. . . ."), *discussed in* Tucker v. Toia, 371 N.E.2d 449, 451 (N.Y. 1977)(interpreting the New York constitutional provision as mandatory); N.C. CONST. art. XI, § 4 ("Beneficent provisions for the poor, the unfortunate, and the orphan is one of the first duties of a civilized and Christian state."); TEX. CONT. art. 16, § 8 ("Each county in the State may provide, in such manner as may be prescribed by law . . . for taking care of, managing, employing and supplying the wants of its indigent and poor inhabitants . . . .").

45. Graham v. Reserve Life Ins. Co., 161 S.E.2d 485, 491 (N.C. 1968); *cf.* Bayne v. Sec'y of State, 392 A.2d 67, 72-73 (Md. 1978) (finding that provision of medical services for indigent persons is a primary function of government and an appropriation to carry out that function is not an appropriation for "maintaining the State Government," so as to invoke the referendum limitation of MD. CONST. art. 16, § 2).

46. *See* Bd. of Comm'rs v. Bd. of Trs. of the Univ. of Ala., 483 So. 2d 1365, 1366 (Ala. Civ. App. 1985); Marengo County v. Univ. of S. Ala., 479 So. 2d 48, 51 (Ala. Civ. App. 1985); *see also* Childree v. Health Care Auth., 548 So. 2d 419, 421 (Ala. 1989)(per curiam) (holding county financially responsible for indigents who were subject to involuntarily commitment proceedings).

47. *See* William C. Rava, *State Constitutional Protections for the Poor*, 71 TEMP. L. REV. 543, 554 & n.99, 555 & n.114, 557 & n.127, 558 & n.138 (1998) (analyzing state constitutional welfare protections for the poor and finding that there are twenty-three states with welfare provisions for the poor, where four provide a mandatory duty, four a permissive grant, four a broad grant of power, and eleven an implied grant of power).

48. *Id.* at 554 & n.99.

cause they apply a very deferential rational basis review when adjudicating claims of welfare assistance under these provisions.[49] Thus, state legislatures are given a great deal of latitude in designing the nature and scope of their assistance programs.

## III. A THEORY OF HEALTH CARE EQUAL PROTECTION FOR STATE CONSTITUTIONS

Unlike education, then, there is little explicit or implicit textual basis in state constitutions for expanding access to health care services. Yet, in education financing litigation, legal advocates were successful in some states using state equal protection language.[50] Part III, therefore, develops a theory of equal protection for health care—a legal framework within which one can challenge a state's health care financing laws using a state's equal protection guarantees.

Part III.A provides an overview of state equal protection law and explains why it may be a powerful tool for expanding access to health care. Part III.B argues that, assuming one can interpret a state constitution to protect fair equality of opportunity, having one's health care needs met is an interest that deserves heightened state constitutional scrutiny. This is demonstrated by relying, in part, on Norman Daniels' analysis of how meeting health care needs protects a person's normal opportunity range, i.e., the range of life plans otherwise open to a person but for his unmet health care needs.[51] Protecting one's normal opportunity range is, in turn, essential for protecting fair equality of opportunity.

Part III.C analyzes the relationship between health insurance, access to hospitals and doctors, and a person's well-being. This analysis explains the connection between having health insurance and preventing, restoring, and maintaining one's normal opportunity range. Finally, Part III.D examines how a state government's role in financing health insurance and/or health care may violate the state's equal protection clause. This section argues that once the state undertakes to finance health insurance, it must do so in a constitutionally neutral manner so as not to exclude any constitu-

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49. *See* Helen Hershkoff, *Positive Rights and State Constitutions: The Limits of Federal Rationality Review*, 112 HARV. L. REV. 1132, 1170-71 (1999) (questioning the reasons—democratic legitimacy, federalism, and separation of powers—for using federal rationality review in state court adjudication of claims to welfare assistance under state constitution poverty clauses).

50. *See supra* note 23 and accompanying text.

51. *See infra* pp. 20-23.

tionally protected options. If a state constitution protects fair equality of opportunity, then it should protect, to some degree, a resident's normal opportunity range. A state's decision to help some, but not all, of its residents gain access to health care will exclude or shrink part of one's normal opportunity range otherwise available, thereby violating the state's equal protection clause.

### A. *State Equal Protection Law*

Currently, the Supreme Court applies the federal equal protection clause of the Fourteenth Amendment[52] to cases where state law infringes upon one's fundamental right,[53] or when it discriminates against a suspect classification.[54] In either case, the court will subject the law to strict scrutiny review, requiring the government to show that the law is necessary to promote a compelling state interest.[55] Under this review, state laws are presumptively unconstitutional.

Typically, if the court finds that the state law does not discriminate based on a suspect classification or impinge upon a fundamental right, it subjects the law to a rational basis standard of review. The government is required merely to show that the law is rationally related to a legitimate state interest.[56] Under this review, the state law is presumptively constitutional. Thus, when one challenges a state law for interfering with an individual's rights, the Court will use one of two standards only, either strict scrutiny or rational basis review, depending on whether the Court finds a fundamental right at stake.[57]

Except for Delaware and Mississippi, every state's highest court has held that its respective state constitution guarantees equal

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52. U.S. CONST. amend. XIV, § 1 (stating that "[n]o state shall . . . deprive any person of life, liberty or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws").

53. *See* Shapiro v. Thompson, 394 U.S. 618, 630 (1969) (fundamental right to travel); Loving v. Virginia, 388 U.S. 1, 12 (1967) (right to marry whomever one wants); Griswold v. Connecticut, 381 U.S. 479, 485 (1965) (right to privacy).

54. *See* United States v. Carolene Prods. Co., 304 U.S. 144, 152-53 n.4 (1938); Loving v. Virginia, 388 U.S. 1, 12 (1967) (suspect classification of race); Hernandez v. Texas, 347 U.S. 475, 479 (1954) (national origin).

55. *See Shapiro*, 394 U.S. at 634 (holding that the challenged state action must be "necessary to promote a *compelling* governmental interest").

56. *See* New York City Transit Auth. v. Beazer, 440 U.S. 568, 592-94 (1979).

57. The Court will review a state law that discriminates based on a quasi-suspect classification like gender under a slightly lower, but still heightened, standard. Under this standard, the law is constitutional if it is substantially related to an important state interest. *See* Craig v. Boren, 429 U.S. 190, 197-98 (1976).

protection under the law.[58] In many instances, state courts have chosen to interpret their respective equal protection guarantees identically, or similarly, to how the Supreme Court interprets the federal equal protection clause.[59] Under this so-called "lock-step" approach, state equal protection law provides a state resident with the same protection as the Constitution. It does so because the state courts conform to federal precedent when interpreting the same language, including the equal protection clause.[60]

However, states are free to go beyond the Fourteenth Amendment and provide their residents more protection by interpreting their equal protection guarantees more expansively than the Supreme Court interprets the Fourteenth Amendment.[61] By one estimate, twenty-one states have "explicitly held that their states' equal protection affords greater protections" than the Constitution.[62] Among these states, some afford greater protections because their respective state equal protection clause contains explicit language expanding the categories of classes of persons protected.[63] For example, the Massachusetts Constitution specifies, unlike the Consti-

58. *See* Jeffrey, *supra* note 32, at 251-52 (documenting that state courts have derived equal protection from a variety of different state constitutional provisions such as "provisions guaranteeing equal protection, equality, due process, or variations on due process; provisions prohibiting the state from granting special privileges or immunities, denying privileges or immunities, or enacting local or special laws; or a combination of provisions") (footnotes omitted); *see also* Jason W. Hayes, *Amendment One: The Nebraska Equal Protection Clause*, 32 CREIGHTON L. REV. 611, 618-26 (1998) (surveying state equal protection clauses from across the country and categorizing them with respect to differences in language and legal effect).

59. *See* Jeffrey, *supra* note 32, at 254-57 (finding that "twenty-seven states have explicitly held that their states' equal protection guarantees are identical, or essentially identical, to that of federal equal protection (seven states), or that the tests, standards or approaches are the same (nine states), or that the protections are similar (seven states), or simply have consistently applied federal standards in adjudicating state equal protection claims (four states)") (footnotes omitted).

60. *See* 1 JENNIFER FRIESEN, STATE CONSTITUTIONAL LAW: LITIGATING INDIVIDUAL RIGHTS, CLAIMS AND DEFENSES § 1-6(b) (3rd ed. 2000) (explaining that "[l]ock-step is a term used to describe an interpretive approach that conforms the meaning of state clauses to the prevailing federal rule for counterpart federal clauses"); *see also* Robert F. Williams, *Foreword: The Importance of an Independent State Constitutional Equality Doctrine in School Finance Cases and Beyond*, 24 CONN. L. REV. 675, 678 (1992) (criticizing the lock-step approach since it "inevitably treats the state constitution as having no legal effect" and citing a wide range of judicial and academic commentators critical of the lock-step approach).

61. *See* FRIESEN, *supra* note 60, § 1-6 (discussing independent state constitutionalism).

62. Jeffrey, *supra* note 32, at 254 & n.67.

63. *See* Hayes, *supra* note 58, at 622-23 & n.53 (citing thirteen states that define suspect classes in their equal protection clauses under which courts apply heightened scrutiny).

tution, that "[e]quality under the law shall not be denied or abridged because of sex, race, color, creed or national origin."[64] Because of this language, Massachusetts' equal protection clause provides more protection against gender discrimination than the Federal Equal Protection Clause.[65]

Other states, however, interpret their equal protection clause more expansively by deciding not to follow the Supreme Court's interpretation of similar constitutional language and by not being constrained by federal precedent. For example, some states use an "interstitial" or "supplemental" interpretive approach when applying their state constitution.[66] Under this approach, the state court treats current federal law as "the presumptively current standard for state law as well, except when the state court finds persuasive reasons to 'depart' or 'diverge' from the Supreme Court, or fill the 'gaps' left by its opinions."[67]

An even more expansive approach is the "primacy" approach to state constitutional interpretation.[68] Under this approach, a state court treats "federal doctrine regarding parallel constitutional interests as relevant, but not binding. Supreme Court decisions have no more weight than opinions from sister states construing a similar clause."[69] Importantly, under this approach "state constitutional questions should be addressed first, and. . .in approaching these questions state courts should treat state constitutions as free-standing, wholly independent sources of positive, constitutional law."[70]

Understanding these interpretive approaches can help a legal advocate predict when and if a state court might go beyond federal precedent to thus expand individual rights to health care. When urging a state court to expand its equal protection guarantee, a legal advocate might employ one of the following strategies.

First, he or she might identify whether the state's equal protec-

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64. MASS. CONST. art. CVI; *see* Murphy v. Comm'r of Dep't of Indus. Accidents, 612 N.E.2d 1149, 1154 (Mass. 1993). The Fourteenth Amendment merely says ". . . nor shall any State . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. CONST. amend. XIV, § 1.

65. *See* Commonwealth v. King, 372 N.E.2d 196, 206 (Mass. 1977).

66. *See* FRIESEN, *supra* note 60, § 1-6(c); Gardner, *supra* note 15, at xxx.

67. *Id.*; *see also* Gardner, *supra* note 15, at xxx (stating that the supplemental approach holds that the "state courts should turn to the state constitution only after it becomes apparent that the United States Constitution provides inadequate protection").

68. *See* FRIESEN, *supra* note 60, § 1-6(a); Gardner, *supra* note 15, at xxx.

69. FRIESEN, *supra* note 60, § 1-6(a) (footnotes omitted).

70. Gardner, *supra* note 15, at xxx.

tion clause either explicitly (with text) or implicitly (through interpretation) has gone beyond the federal list of suspect classifications to include gender and disability. The advocate would then argue that poverty or uninsurance[71] deserves to be added to this list—if not as a suspect class, rather as a quasi-suspect class deserving heightened scrutiny.[72] Although no state has done this so far, states which have already expanded their equal protection language may be more amenable to this strategy than others.

Another strategy would be to argue that access to health care institutions, or health itself, is a fundamental right, and the state must protect that right by enacting universal health care legislation.[73] One New Jersey court, for example, held that health is a fundamental right under the New Jersey Constitution because of the state's long history of providing for its residents' health.[74] In fact, in 1988, the Massachusetts legislature made a finding that access to basic health care services is a natural, essential, and inalienable right under the Massachusetts Constitution, which provides generally for inalienable rights to enjoying and defending one's life and liberty.[75] However, it has since repealed that finding.[76] Nevertheless, since a number of states include similar inalienable rights language,[77] an advocate could argue that access to health care is a

71. Instead of arguing that wealth is a suspect class, one might argue that the uninsured are constructively disabled since lacking access to health care institutions is functionally equivalent to being disadvantaged at no fault of one's own, assuming one has not genuinely chosen to not have insurance.

72. *See, e.g.*, Frank I. Michelman, *Foreword: On Protecting the Poor Through the Fourteenth Amendment*, 83 HARV. L. REV. 7, 33-39 (1969) (arguing for a governmental duty of minimal protection under the Fourteenth Amendment). One might use Michelman's arguments but apply them to more flexible state equal protection clauses.

73. *See* Stacy, *supra* note 10, at 83 (stating that other fundamental rights cases support the idea of equal access to public institutions that affect "life opportunities").

74. *See* Right to Choose v. Byrne, 405 A.2d 427, 432 (N.J. Super. Ct. Ch. Div. 1979) (holding that restrictions on abortion funding under Medicaid violated a fundamental right to health under the state constitution). *But see* Right to Choose v. Byrne, 450 A.2d 925, 934 (N.J. 1982) (declining "to proceed as far as the Chancery Division in declaring" health to be a fundamental right).

75. *See* MASS. CONST. pt. I, art. I (proclaiming that "[a]ll people are born free and equal and have certain natural, essential and unalienable rights; among which may be reckoned the right of enjoying and defending their lives and liberties . . . in fine, that of seeking and obtaining their safety and happiness"); MASS. GEN. LAWS ch. 118F, § 1 (repealed 1996) (stating that "the access of residents of the commonwealth to basic health care services is a natural, essential, and unalienable right which is protected by Article I of Part the First of the Constitution").

76. In 1996, the Massachusetts legislature repealed the 1988 Mass. Medical Security Act, which contained this finding. *See* MASS. GEN. LAWS ch. 118F, § 2 (repealed 1996).

77. *See, e.g.*, ALA. CONST. of 1875 art. I, § 1; ALASKA CONST. art. I, § 1; CAL.

prerequisite for securing such generally protected rights.

Third, even if access to health care is not a fundamental right, an advocate could argue that access to health care is an important interest because it is a vital prerequisite for exercising other constitutionally protected interests.[78] Like education, access to health care is essential for providing individuals with a fair chance at competing for jobs, careers, and public offices legally open to all. If a state constitution goes beyond protecting against discrimination based on race, gender, religion, and national origin, and protects opportunity against unfair competition for jobs and offices, one could argue that once a state undertakes to provide access to health care, providing it unequally violates equal protection. The government would not be acting neutrally when distributing resources necessary for exercising opportunity interests. Given health care's role in protecting opportunity, one could try to convince a state court to go beyond the federal two-level analysis of fundamental rights violations and apply a middle-level review to laws interfering with opportunity interests.[79] It is this third strategy that this Article will explore below.[80]

### B. *The "Special" Importance of Meeting Health Care Needs*

To employ this strategy, it is necessary to explain why access to health care is important. Health care's importance derives, in part, from its role in preventing, maintaining, and restoring one's normal opportunity range. Unmet health care needs, in other words, shrink the range of opportunities otherwise available to an individual and therefore undermine one's share of opportunities formally open to all.

Having one's health care needs met today is different than at any other time in our history. As the political philosopher Michael

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CONST. art. I, § 1; COLO. CONST. art. 2, § 3; FLA. CONST. art. I, § 2; IDAHO CONST. art. 1, § I; IND. CONST. art. 1, § I; IOWA CONST. art. I, § 1; KAN. CONST. Bill of Rights § 1; KY. CONST. § 1; ME. CONST. art. I, § I; MO. CONST. art. I, § 2; N.H. CONST. pt. I, art. 2 ("inherent rights"); N.J. CONST. art. I, ¶ 1; N.D. CONST. art. 1, § 1; OHIO CONST. art. 1, § 1; OKLA. CONST. art. 2, § 2 ("inherent rights"); OR. CONST. art. I, § 1 ("inherent rights"); PA. CONST. art. I, § 1 ("inherent rights"); S.D. CONST. art. VI § 1 ("inherent rights"); VT. CONST. ch. I, art. 1; WIS. CONST. art. I, § 1 ("inherent rights").

78. *See* Mariner, *supra* note 10, at 349 (defending a new heightened scrutiny for analyzing claims of unequal access to health care which "may be especially suitable to the review of equal protection claims under state constitutional provisions").

79. *See* Jeffrey, *supra* note 32, at 257-59 (offering various methods of adjudicating state equal protection challenges).

80. By pursuing this third strategy, I do not mean to suggest that the other two are less viable or incorrect; in fact, I hope others pursue them as well.

Walzer has aptly noted, "[d]octors and hospitals have become such massively important features of contemporary life that to be cut off from the help they provide is not only dangerous but also degrading."[81] Currently, doctors and hospitals can do tremendous things towards preventing, maintaining, and restoring health. For example, medical personnel can prevent fatal cancer through early detection and treatment; they can cure infections with antibiotics; they can prevent a myriad of otherwise debilitating or fatal diseases through vaccination and early detection; and they can manage chronic diseases such as diabetes, hypertension, and arthritis, among others.

Philosopher Norman Daniels has defended health care needs as "special" by analyzing the relationship between unmet health care needs and their impact on opportunity.[82] By "special," he means that society should treat preferences for health care differently from other kinds of preferences, because unmet health care needs adversely impact opportunity.[83] The following explains Daniels' theory of health care needs and shows its relevance for the argument that follows.

Norman Daniels, in *Just Health Care*, extends moral and political philosopher John Rawls' theory of justice to develop an independent theory of justice for health care distribution.[84] His theory has two parts. The first part is descriptive; it explains the central function of health care, which reveals its special importance compared to other needs or wants we may have. The second part is normative; it connects the central function of health care to Rawls' fair equality of opportunity principle and argues that society should meet health care needs to the extent it has an obligation to guarantee fair equality of opportunity. This Article focuses on Daniel's theory of health care needs, that is, the first part of his theory.

"[W]e must talk about health-care *needs*," Daniels argues, "if we are to explain what is special about health care . . . ."[85] Moreover, a theory of health care needs will explain why we believe some kinds of health care are more special than others and why health

81. WALZER, *supra* note 2, at 89.

82. *See* NORMAN DANIELS, JUST HEALTH CARE 19-35 (1985).

83. *See id.* at 23-26.

84. *See id.* at 42-48. *See generally* JOHN RAWLS, A THEORY OF JUSTICE §§ 3, 11, 46 (rev. ed. 1999) (arguing that principles of justice are fair when chosen under conditions of equality and that this would include a principle of fair equality of opportunity, which imposes an obligation on society to provide resources necessary for individuals to compete fairly for jobs and offices).

85. DANIELS, *supra* note 82, at 23.

care is more special than other social goods. He argues that an analysis of the relationship between ill health and opportunity will explain the special importance of health care needs.

Daniels claims that preferences for certain categories of needs should be given special weight. In particular, we should give special weight to needs that are "necessary for maintaining normal functioning for individuals, viewed as members of a natural species."[86] Health care fits into this category of important needs because it is needed "to prevent or cure diseases, which are deviations from normal functional organization."[87] In other words, meeting health care needs helps prevent, maintain, or restore deviations from normal species functioning. Maintaining normal species functioning, in turn, is crucial for preventing, maintaining, or restoring what Daniels calls one's "normal opportunity range."[88] One's "normal opportunity range," according to Daniels, is "the array of life plans reasonable persons in [their society] are likely to construct for themselves."[89] Although one's normal opportunity range is relative to key features of a society—for example, its material wealth and technological development "and even important cultural facts about it" (attitudes toward family and careers)—normal species-functioning, Daniels contends, "provides us with one clear parameter affecting the share of the normal range open to a given individual."[90] Importantly, "[i]t is this parameter which the distribution of health care affects."[91] As Daniels aptly summarizes:

> [N]ormal species-typical functioning provides us with one clear parameter relevant to determining what share of the normal range is open to a given individual *holding constant, for the moment, the individual's skills and talents.* Impairments of normal functioning through disease and disability constitute a fundamental restriction on individual opportunity *relative to that portion of the normal range which the individual's particular skills and talents would ordinarily have made available to him.*[92]

My approach abstracts a central *function* of health care, the maintenance of species-typical functional organization and func-

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86. *Id.* at 33.
87. *Id.*
88. *Id.*
89. *Id.*
90. *Id.*
91. *Id.*
92. Norman Daniels, *Fair Equality of Opportunity and Decent Minimums: A Reply to Buchanan*, 14 PHIL. & PUB. AFF. 106, 107-08 (1985) (emphasis added).

tion, and notes its central *effect* on opportunity. Specifically, diseases, in different ways and to different degrees, impair the opportunity available to an individual, relative to the *normal opportunity range* for his society. It is this effect on quality of life that makes health care more "special" than many other things which enhance life quality.[93]

The special importance of health care needs, then, arises from the connection between ill health and achieving or maintaining one's normal opportunity range. Meeting health care needs is one very important way of mitigating the adverse affects that disease and disability have on our normal opportunity range. Since people have a strong interest in protecting their normal opportunity range, they ascribe special importance to meeting health care needs.[94]

Daniels' account of the "specialness" of health care needs is not perfect. For example, illness and diseases produce other major misfortunes besides loss of opportunities such as death, acute and chronic pain, and suffering generally, which can account for the specialness of health and health care irrespective of any lost opportunities.[95] Moreover, "[i]mpairment of species-typical activity does not always coincide with constriction of a person's opportunity compared to the normal opportunity range of his society."[96] A certain degree of impairment may be normal for a society, or we may want to alleviate what is species-typical. For example, some cancer and diseases resulting from an aging immune system are species-

93. *Id.* at 107.

94. This strong interest in protecting or restoring opportunity is evidenced by our society's strong and widespread laws proscribing discrimination based on disability and requiring reasonable accommodations to allow disabled individuals to participate in activities and employment they would have otherwise been unable to do. *See, e.g.,* Architectural Barriers Act of 1968, 42 U.S.C. §§ 4151-4157 (1994) (requiring buildings constructed with federal funds or leased by the federal government to be accessible to people with disabilities); Rehabilitation Act of 1973, 29 U.S.C. §§ 791-796 (1994 & Supp. 1999) (mandating nondiscrimination and affirmative action by federal employers and for federal contractors and mandating nondiscrimination and reasonable accommodations by recipients of federal assistance, including education programs, public facilities, transportation, and health and welfare services); Education for All Handicapped Children Act of 1975, 20 U.S.C. §§ 1401-1456 (1994 & Supp. 1999), now known as the Individuals with Disabilities Education Act (IDEA); The Americans with Disabilities Act of 1990, 42 U.S.C. §§ 12101-12213 (1994), 47 U.S.C. §§ 225, 611 (1994) (proscribing discrimination and mandating reasonable accommodations in private employment (Title I), state and local services (Title II), public accommodations privately operated (Title III), and in telecommunications (Title IV)).

95. *See* Lawrence Stern, *Opportunity and Health Care: Criticisms and Suggestions*, 8 J. MED. & PHIL. 339, 346-49 (1983).

96. *Id.* at 345.

typical; these would fall outside the scope of special health care needs.[97] And finally, making normal species-function the central goal of health care could produce overly demanding policies if fulfilling this goal requires us "to bring individuals closer to the ideal of normal species functioning—which is nothing less than a life free of disease and disability, since the latter are defined as departures from normal species functioning."[98]

Nevertheless, this account captures the shared intuitive idea that unmet health care needs, in part, adversely impact one's range of opportunities for one's society. In addition, it captures the shared assumption that, for our society at least, people have a strong interest in protecting opportunities that would have been open to them had they had access to health care services.[99] The fact that premature death and acute and chronic pain are also linked to unmet health care needs provides more, not less, evidence of its special importance.

Assuming, then, that health care's "specialness" is tied, in part, to its role in protecting one's normal opportunity range, it is then necessary to determine whether a state's constitution protects its citizens' normal opportunity range and to what extent. Before this question is explored in the context of the Massachusetts Constitution, this Article examines the relationships among health insurance, access to medical services, and individual well-being to explain the role of health insurance in protecting one's normal opportunity range.

### C. *The Importance of Providing Affordable Health Insurance*

A fundamental criterion for accessing the United States' health care "system" is one's ability to pay (excluding active duty military personnel and veterans). Some individuals pay for health care services directly (i.e., out of pocket). Most people, however, pay for health care services indirectly by using some form of health insurance. Currently, the United States, and each state, offer a public-private mix of health insurance plans in which one obtains health insurance in one of four ways: (1) through employer-subsidized private insurance, which accounts for about 58% of the population; (2)

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97. *See id.* at 351.

98. Allen Buchanan, *Health-Care Delivery and Resource Allocation*, *in* MEDICAL ETHICS 291, 315 (Robert M. Veatch ed. 1989); *see also*, Allen E. Buchanan, *The Right to a Decent Minimum of Health Care*, 13 PHIL. & PUB. AFF. 55, 62-66 (1984) (criticizing Daniels' approach in the context of defending a right to health care).

99. *See* sources cited *supra* note 94.

through self-purchased private insurance, which accounts for about 4% of the population; (3) through Medicare, the government insurance program for the elderly and disabled, which accounts for about 12% of the population; or (4) through Medicaid, the cooperative state and federal program that provides medical assistance for the poor, which accounts for about 9% of the population.[100] Accounting for the changing unemployment rates, and the changing eligibility status of persons using public insurance, about 15% of the population remains uninsured,[101] and about 10% under-uninsured throughout the United States.[102]

Thus, the key to one's ability to pay for health care is having some form of adequate health insurance coverage.[103] Today, health insurance status "is probably the most important factor determining the allocation of health care . . . ."[104] Insurance status determines not only one's ability to access doctors and hospitals, but also the amount and quality of medical care these institutions will provide.[105]

Consider the following actual cases. Pat McFarland severely injured three fingers in a machine he used for customizing automobile parts. He was rushed to a nearby private hospital and forced to wait three hours "while emergency room doctors tried to make arrangements to get him transferred to . . . the county hospital."[106]

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100. *See* THOMAS S. BODENHEIMER & KEVIN GRUMBACH, UNDERSTANDING HEALTH POLICY 22 (2d ed. 1998). Approximately 2% of the population receives insurance through active military service or the Department of Veterans Affairs. *See id.*

101. *Id.*

102. Pamela Farley Short, PhD & Jessica S. Banthin, PhD, *New Estimates of the Underinsured Younger Than 65 Years*, 274 J. AM. MED. ASS'N 1302, 1305-06 (1995) (estimating that twenty-nine million people are underinsured).

103. There are, of course, significant non-economic barriers to accessing health care, e.g., cultural and language barriers, among others. *See* John Billings, *Access to Health Care Services*, *in* HEALTH CARE DELIVERY IN THE UNITED STATES, *supra* note 8, at 401, 414. By far the most significant barrier is economic and therefore the focus of this section. *See id.* at 404.

104. Stacy, *supra* note 10, at 78.

105. *See* John Z. Ayanian, MD, MPP et al., *Unmet Health Needs of Uninsured Adults in the United States*, 284 J. AM. MED. ASS'N 2061, 2061 (2000) (concluding that "long-term-uninsured [more than one year] adults reported much greater unmet health needs than insured adults" and that providing them access "could have substantial clinical benefits"); *see also* OFFICE OF TECH. ASSESSMENT, CONG. OF THE U.S., DOES HEALTH INSURANCE MAKE A DIFFERENCE?–BACKGROUND PAPER 2 (1992) (concluding that there is a relationship between health insurance status and access to–and types and amounts–of services one receives); Billings, *supra* note 103, at 409.

106. *Equal Access to Health Care: Patient Dumping: Hearing Before the Subcomm. on Human Res. and Intergovernmental Relations of the House Comm. on Gov't Operations*, 100th Cong. 271 (1987) [hereinafter *Equal Access*].

Pat McFarland did not have health insurance. He finally received treatment eleven hours later at the county hospital, but it was too late. Doctors had to amputate two fingers and two-thirds of another.[107]

Like Pat McFarland, William Jenness did not have health insurance when he needed it most. After being involved in a car accident, he was immediately taken by ambulance to the nearest hospital where he was diagnosed with a tear in his aorta. "However, once it was determined that he had no medical insurance and could not make the required $1,000 deposit, the hospital made arrangements for him to be transferred to the county hospital."[108] This was done despite the family's attempt to convince the hospital to accept partial payment or a credit card. "Four hours elapsed between the time of the accident and Mr. Jenness' arrival at the county hospital. A surgical team . . . struggled to patch five tears in Mr. Jenness' heart. Two and a half hours later, Mr. Jenness died in surgery. An autopsy report said that almost a quart of blood was found in his chest."[109]

These cases were among numerous others documented in California in 1985-87 and reported in a hearing before the United States House of Representatives in 1987. These hearings were held in response to "the continuing problem of patient dumping."[110] Although illegal by 1987,[111] hospitals continued to refuse "to treat an

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107. *Id.*

108. *Id.* at 273.

109. *Id.* Consider also the story of Sharon Ford. About to deliver, Sharon Ford sought treatment at a private hospital. However, when the hospital learned that she was enrolled in an insurance program that the hospital did not have a contract with, they refused to admit her. She then went to another private hospital that accepted her insurance and preliminary tests showed that the fetus was in trouble. However, because of a computer mistake, the hospital could not find evidence of her insurance coverage. Although the fetus was in danger, she was told that "unless she had her insurance card, she would have to make her way to . . . the county hospital." *Id.* at 271. When the father finally found her insurance card, he was told that the county hospital was already called and that they should proceed there. "Barely half an hour after she arrived at [the county hospital] the baby was born dead. The [hospital's] obstetrician said it appeared that the baby was dying slowly during Ms. Ford's 3-hour search for care." *Id.*

110. *Id.* at 7. Patient dumping is "the refusal of hospitals, usually private hospitals, to treat patients in need of emergency care . . . because of their inability to pay." Andrew Jay McClurg, *Your Money or Your Life: Interpreting the Federal Act Against Patient Dumping*, 24 WAKE FOREST L. REV. 173, 174 (1989).

111. In 1986, Congress passed the Emergency Medical Treatment and Active Labor Act, which requires any hospital with an emergency department receiving Medicare funds to treat any person who comes into their emergency room with an emergency medical condition regardless of their ability to pay. *See* 42 U.S.C. §§ 1395dd(b)-(c) (1994).

emergency patient, even though the hospital [was] physically capable of doing so, simply because the patient [was] unable to pay."[112]

Congress enacted an "anti-dumping" law in 1986 in the face of "the increasing number of reports that hospital emergency rooms are refusing to accept or treat patients with emergency conditions *if the patient does not have medical insurance.*"[113] Some estimated that about "300,000 Americans are refused care each year at hospital Emergency Departments because they are uninsured or inadequately insured."[114] An analysis of the 1987 National Medical Expenditures Survey, which collected demographic, health status, and medical care use and expenditure data on about 30,000 people, suggested that nearly one million people "failed to get emergency care, of whom half actively sought it."[115]

In 1992, in the context of a growing "crisis" in the United States' health insurance system, the United States Congress, Office of Technology Assessment, studied the connection between having adequate health insurance and receiving necessary medical care.[116] Entitled "Does Health Insurance Make a Difference?," the study evaluated "all the available literature" on this question and concluded that "[r]esearch conducted in the last decade supports *the common-sense notion* that having or lacking health insurance coverage is related to gaining access to services, to the types, quality and intensity of the care that is delivered, and, *logically, to patient health.*"[117]

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112. *See* Deberry v. Sherman Hosp. Ass'n, 741 F. Supp. 1302, 1304 (N.D. Ill. 1990).

113. H.R. Rep. No. 99-241(I), at 27 (1986), *reprinted in* 1986 U.S.C.C.A.N. 42, 605 (emphasis added); *see also* Elliott B. Oppenheim, *A Review of the Emergency Medical Treatment and Active Labor Act*, 85 ILL. B.J. 212, 213-14 (1997) (noting that the law was intended to prevent economic discrimination, that is, to prevent hospitals from shunting off unprofitable patients).

114. David Himmelstein & Steffie Woolhandler, *Care Denied: US Residents Who Are Unable to Obtain Needed Medical Services*, 85 AM. J. PUB. HEALTH 341, 343 (1995).

115. *Id.* at 343; *see also* David A. Ansell, MD & Robert L. Schiff, MD, *Patient Dumping: Status, Implications, and Policy Recommendations*, 257 J. AM. MED. ASS'N 1500, 1500 (1987).

116. OFFICE OF TECH. ASSESSMENT, *supra* note 105.

117. OFFICE OF TECH. ASSESSMENT, *supra* note 105, at 2 (emphasis added). Overall the Office of Technical Assessments' ("OTA") "key findings" suggested (1) that an uninsured person was 3 times more likely than a privately insured person to use less medical care, to receive inadequate medical care, and to have negative health outcomes; (2) that the uninsured were 1.3 times more likely than publicly insured individuals [e.g., Medicaid] to access health care services and 1.5 times more likely to receive inadequate care; and (3) that the publicly insured person was up to 2.5 times more likely than a privately insured person to receive inadequate care and 4 times more likely to have negative health outcomes. *Id.*

In 1996 the Harvard School of Public Health conducted a national survey of almost four thousand Americans, one of the largest studies to date, that confirmed this vital connection between health insurance and well-being.[118] Overall, the study found that forty-eight million Americans have problems getting or paying for needed care, as twenty million are uninsured and twenty-eight million have inadequate coverage.[119] Specifically, the study determined that the uninsured "were 4 times more likely than the insured to report an episode of needing and not getting medical care and 3 times more likely to report a problem in paying for medical bills."[120] Moreover, 79% of those individuals reporting difficulty in obtaining medical treatment "point to serious consequences."[121]

Insurance status, then, is the key to accessing health care institutions; it determines the quantity and quality of services one will receive. Since access to health care institutions is intricately connected to one's health insurance status, it follows that having adequate health insurance plays a significant role in protecting one's well-being, and in protecting, maintaining, and restoring one's normal opportunity range. With over forty million people uninsured, and about twenty-nine million underinsured throughout the nation, millions of Americans are at risk of not receiving the medical care

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Some specific studies that the OTA reviewed found that (1) the uninsured are "less likely than privately insured individuals to have a usual source of care . . . , use preventive services . . . , visit a physician . . . , and be hospitalized . . . ," and they are "more likely to report that they have not received needed care . . . ;" (2) that the uninsured are up to 4 times as likely as the privately insured "to require both avoidable hospitalizations and emergency hospital care," which was consistent with their self-reports about putting off going to the doctor when they needed care; (3) that uninsured patients may be up to twice as likely to be at risk of dying when they reach the hospital door; and (4) even when care is not initially delayed, uninsured patients admitted to the hospital "have been found to be half as likely as insured patients to receive certain high-cost (but not necessarily more appropriate and effective) procedures." *Id.* at 2-3.

118. Karen Donelan et al., *Whatever Happened to the Health Insurance Crisis in the United States?: Voices from a National Survey*, 276 J. AM. MED. ASS'N 1346 (1996). For example, in one randomly chosen verbatim account, an uninsured individual described his difficulties getting care: "I need a specific medicine [for my multiple sclerosis] that lessens the exacerbations of the disease and I can't afford to get it. It's very frustrating and makes me angry because I'm progressing in my disease without the medicine that could possibly slow it up." *Id.* at 1349. The authors note the real significance of their study: "The voices of the people that we surveyed give life to the statistics and tell us a story of millions of individual crises in getting and paying for health care each year." *Id.*

119. *Id.* at 1350.

120. *Id.* at 1347.

121. *Id.* at 1349.

they need.[122]

### D. *How State Health Care Financing Laws "Interfere" with One's Normal Opportunity Range*

State governments play a major role in financing health care and health insurance for their respective residents.[123] Every state has chosen to participate in the Medicaid program[124] and some, like Massachusetts, have gone beyond the minimum federal standards and expanded the program to reach residents whose income is 200% of the federal poverty level.[125]

No state, however, guarantees universal access to health care. Each state contains various patchwork quilts of Medicaid coverage, community health centers, uncompensated care pools, and a myriad of targeted programs.[126] At best, some states like Hawaii, Minnesota, and Wisconsin have uninsured rates averaging less than 10% of the population; at worst, some states like Texas, New Mexico, Arizona, Arkansas, and California have uninsured rates between 20 - 25%.[127] Even within the best states, however, variations in the uninsured are still significant. For example, in Wisconsin, where 7.9% of the population was uninsured in 1995-96, county level rates varied from 4.0% to 17.0% in 1994.[128]

Given that each state has chosen to undertake a significant responsibility in helping its residents access medical care, and given the connection between access, well-being, and opportunity, does leaving hundreds of thousands of residents without health insurance

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122. *See* BODENHEIMER & GRUMBACH, *supra* note 100, at 21; Short & Banthin, *supra* note 102, at 1302.

123. *See* National Health Law Program, State and Local Responsibility for Indigent Health Care, *at* http://nhelp.org/publications.shtml#state (Nov. 8, 1997) (detailing public insurance and assistance programs for all fifty states); Guyer & Mann, *supra* note 43, at 3.

124. A state is not required to participate in the Medicaid program, but if it does then it must comply with the Federal Medical Act and its implementing regulations. *See* 42 U.S.C.A. §§ 1396-1397f (1992 & Supp. 2000); 42 C.F.R. §§ 430-430.104 (2000).

125. See *infra* Part IV.A for a description of the Massachusetts Medicaid program. *See generally*, National Health Law Program, *supra* note 123.

126. *See* National Health Law Program, *supra* note 123. Uncompensated care pools reimburse hospitals and community health centers for providing free care to residents that have no source of health insurance. See *infra* notes 186-191 and accompanying text for a discussion of the uncompensated care pool in Massachusetts.

127. *See* Leonard, *supra* note 5, at A22 (citing Census Bureau data to calculate three year averages of uninsured rates). Recently, Massachusetts has brought its uninsured population below 10%. *See supra* note 5 and accompanying text.

128. *See* Jill A. Marsteller et al., *Variations in the Uninsured: State and County Level Analyses* 2 (June 11, 1998), *available at* www.urban.org/health/variatfull.pdf.

violate a state's equal protection guarantee? To answer this question, a legal advocate must overcome at least the following two hurdles. First, whether a state's health care financing system "interferes" with or "denies" a resident's constitutionally protected interest, assuming one can identify a protected interest in the state constitution such as an interest in normal opportunity range; and second, whether the courts must review this interference under a heightened level of review or merely a deferential one.

1. Indirect State Action

A strategy for overcoming the first hurdle is to argue that a state law can indirectly "interfere" with a citizen's constitutionally protected interest by unequally distributing a resource necessary for exercising that interest. In other words, a state can deny equal protection indirectly by not acting neutrally—by acting in a manner that prevents some people from exercising their constitutionally protected interest, even if the state had no obligation to provide the underlying benefit in the first place.[129] Applying this argument to the subject at hand, it can be asserted that the state's health care financing laws unequally distribute access to health care, which is necessary to exercise one's interest in his normal opportunity range (assuming the state's constitution protects that interest).[130] Even if a state has no affirmative constitutional duty to provide health care, a state may unconstitutionally interfere with a citizen's opportunity interest if the state's financial assistance protects some citizens' opportunities but not others'.

In certain contexts the United States Supreme Court has rec-

129. *See* Memorial Hosp. v. Maricopa County, 415 U.S. 250, 269 (1974) (holding that although the state has no obligation to provide medical care, once it does, it may not restrict it by imposing unconstitutional residency requirement); Harper v. Va. State Bd. of Elections, 383 U.S. 663, 666 (1966) (holding that if state chooses its legislature with elections, it cannot deny participation by charging poll tax); Griffin v. Illinois, 351 U.S. 12, 19 (1956) (holding that if a state provides for appellate process, it must provide indigents with free trial transcripts); Women's Health Ctr. of W. Va. v. Panepinto, 446 S.E.2d 658, 667 (W. Va. 1993) (holding that when the state government provides medical care for the poor, "it has an obligation to do so in a neutral manner so as not to infringe on the constitutional rights of our citizens"); *see also*, Symposium, *Is There a Constitutional Right to Vote and Be Represented?: The Case of the District of Columbia*, 48 AM. U. L. REV. 589, 615 (1999) (interpreting *Griffin* and *Harper* as articulating the principle that "the government may not provide benefits to people on a basis that discriminates against the poor – even if the government had no obligation to provide the underlying benefit in the first place").

130. Below, I argue that the Massachusetts Constitution protects this interest in fair equality of opportunity; however, one would have to do this analysis on a state-by-state basis.

ognized that even if a state has no obligation to provide a benefit to its citizens, once it does, it must do so in a constitutionally permissible manner. For example, in *Griffin v. Illinois*,[131] the Court held that even though Illinois had no constitutional obligation to provide any appellate review of criminal convictions, once this system was in place, the state was required to provide the poor with free trial transcripts to make their appellate rights meaningful.[132]

However, the United States Supreme Court, in a series of abortion funding cases, was not persuaded that withholding Medicaid funding for abortions "interfered" with a woman's fundamental right of reproductive choice, even if the state had funded other medical care.[133] For example, in *Maher v. Roe*,[134] the Court noted that the "Constitution imposes no obligation on the States to pay the pregnancy-related medical expenses of indigent women, or indeed to pay any of the medical expenses of indigents."[135] However, the Court also noted that "when a State decides to alleviate some of the hardships of poverty by providing medical care, the manner in which it dispenses benefits is subject to constitutional limitations."[136]

In *Maher*, the Court found that the manner in which Connecticut dispensed medical benefits did not run afoul of the Constitution. It found that the Equal Protection Clause does not require a state, which chooses to participate in the Medicaid program, to fund medical services incident to non-therapeutic abortions for indigent woman even if it funds services incident to childbirth.[137] The Court reached this result by reasoning that poverty is not a suspect class, and the restriction *does not impinge* upon the woman's fundamental right of reproductive choice.[138]

Likewise, in *Harris v. McRae*,[139] the Court upheld federal regulations restricting Medicaid abortion funding because the Court

131. 351 U.S. 12 (1956).

132. *Id.* at 19.

133. *Cf.* DeShaney v. Winnebago County Dep't of Soc. Servs., 489 U.S. 189, 195 (1989) (finding that the state had no positive duty to protect citizens from private behavior). For an overview and critical commentary on the Supreme Court's adherence to the notion of a negative conception of the Constitution, see Susan Bandes, *The Negative Constitution: A Critique*, 88 MICH. L. REV. 2271 (1990).

134. 432 U.S. 464 (1977).

135. *Id.* at 469.

136. *Id.* at 469-70.

137. *Id.* at 470.

138. *See id.* at 470-74 (finding "the Connecticut regulation places no obstacles . . . in the pregnant woman's path to an abortion").

139. 448 U.S. 297 (1980).

found that the regulations *did not place any obstacle* in a woman's path.[140] In fact, the *Harris* Court found that the restrictions placed on an indigent woman were not even the product of government action, but of private action, namely, the woman's indigence.[141]

However, some state courts, including Massachusetts, have gone beyond the Supreme Court's narrow interpretation of what constitutes government "interference" of constitutionally protected interests. These courts have held that similar abortion funding restrictions do interfere with, or place obstacles in front of, a woman's fundamental right of reproductive choice.[142] For example, the Supreme Court of West Virginia, interpreting its own constitution as providing enhanced guarantees over the federal constitution, held that "when state government seeks to act 'for the common benefit, protection and security of the people' in providing medical care for the poor, it has an obligation to do so in a *neutral manner* so as not to infringe upon the constitutional rights of our citizens."[143] Given the reality of being poor, the court found that the denial of funding for medically necessary abortions affects the health and safety of

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140. *Id.* at 316-18.

141. *Id.* at 316.

142. *See* Comm. to Defend Reprod. Rights v. Myers, 625 P.2d 779, 781 (Cal. 1981) (having enacted a general program for providing medical services to the poor, the state statute that withholds benefits from otherwise qualified people solely because they seek to exercise their constitutional right to reproductive choice is "plainly unconstitutional" under the state constitution); Doe v. Maher, 515 A.2d 134, 162 (Conn. Super. Ct. 1986) (finding that regulations under the Connecticut's Medicaid Program restricting funding of abortion violates the equal protection clause of the state constitution); Moe v. Sec'y of Admin. & Fin., 417 N.E.2d 387, 398, 402 (Mass. 1981) (recognizing the Supreme Court's "negative constitutional principle" underlying Roe v. Wade, 410 U.S. 113 (1973), but going beyond its application in Harris v. McRae, 448 U.S. 297 (1980), and finding that the state's choice not to fund abortions is "achiev[ing] with carrots what [it] is forbidden to achieve with sticks" and is, therefore, unconstitutional pursuant to the state's equal protection guarantees); Women of Minn. v. Gomez, 542 N.W.2d 17, 19 (Minn. 1995) (interpreting the Minnesota Constitution to afford broader protection than the federal Constitution, and finding that the state statute funding childbirth-related services but forbidding funding for therapeutic abortions violates a woman's fundamental right of privacy); Right to Choose v. Byrne, 450 A.2d 925, 928 (N.J. 1982) (finding that the state statute prohibiting Medicaid funding for abortions except to save the life of the mother violates the equal protection guarantee under state constitution); Planned Parenthood Ass'n v. Dep't of Human Res., 663 P.2d 1247, 1261 (Or. App. 1983) (holding that the state's prohibition on funding medically necessary abortions is invalid under Oregon Constitution Privileges and Immunity Clause); Women's Health Ctr. of W. Va., Inc. v. Panepinto, 446 S.E.2d 658, 667 (W.Va. 1993) (finding abortion restriction under the Medicaid program violates state's duty to provide medical care for the poor in a neutral manner so as not to infringe upon the constitutional rights of citizens).

143. *Panepinto*, 446 S.E.2d at 667 (emphasis added).

indigent women.[144]

The question, the court noted, becomes whether this "impingement on safety" resulting from the state statute "rises to the level of impermissible state action."[145] The court held that it did, because the state's "equal protection clause" serves the goal of "fundamental fairness."[146] Specifically, the state constitution "imposes an 'obligation upon state government . . . to preserve its neutrality when it provides a vehicle' for the exercise of constitutional rights."[147] "Given [the state's] enhanced constitutional protections," the court concluded that "the provisions of [the challenged statute] constitute undue government interference with the exercise of the federally-protected right to terminate a pregnancy."[148] Therefore, because the state undertook to fund medical care for the poor, and because the funding was not neutral, the state violated its constitution's equal protection guarantee.[149]

The Supreme Court of New Jersey also held that its state's Medicaid statute restricting funding for non-therapeutic abortions "violates the right of pregnant women to equal protection of the law."[150] Recognizing that "[n]either poverty nor pregnancy gives rise to membership in a suspect class," and that there is no fundamental right to funding for an abortion, the court reasoned that the equal protection violation occurred because the state funding "discriminates between those [women] for whom medical care is necessary for childbirth and those for whom an abortion is medically necessary . . . . By granting funds when life is at risk, but withholding them when health is endangered,"[151] the court observed that "the statute denies equal protection to those women entitled to necessary medical services under Medicaid."[152] Therefore, the court concluded, the statute "*impinges* upon the fundamental right of a woman to control her body and destiny . . . [because] the State admittedly seeks to influence the decision between abortion and childbirth."[153]

Thus, some states have provided more protection for a wo-

144. *Id.* at 665.
145. *Id.*
146. *See id.* at 666.
147. *Id.* (citing United Mine Workers v. Parsons, 305 S.E.2d 343, 354 (1983)).
148. *Id.* at 667.
149. *See id.*
150. Right to Choose v. Byrne, 450 A.2d 925, 927-28 (N.J. 1982).
151. *Id.* at 934.
152. *Id.*
153. *Id.* (emphasis added).

man's right to reproductive choice by expanding the manner in which the government can "interfere" with protected constitutional interests. The state courts agree with the Supreme Court that there is a fundamental right to privacy, which includes reproductive choice. They also agree that there is no fundamental right to resources that one might need to exercise that right. Moreover, they agree that when a government undertakes to provide the resources, it must do so in a constitutionally permissible manner.

However, some states part company with the Supreme Court over whether unequally distributing the resources necessary to exercise a protected interest actually "interferes" with that interest. Unlike the Supreme Court, which requires the government action to "directly interfere" with, or "place obstacles" in the path of, the interest, some state courts only require that the government action "indirectly interfere" with that interest.[154] In other words, some state courts have found that laws unequally distributing resources necessary for exercising a protected interest constitute state action even though they "indirectly interfere" with that interest.

This expanded approach of government "interference" is what the legal advocate can argue to state courts when applying a state's equal protection guarantee to challenge its health care finance laws. If a state constitution protects an interest in normal opportunity range, and a state has undertaken to provide access to health care services, then financing laws that unequally distribute this access will "indirectly interfere" with that interest.

### 2. Judicial Review

In attempting to argue that by providing unequal assistance in obtaining health care a state violates its equal protection guarantees, a legal advocate must overcome a second hurdle—the level of judicial review. The legal advocate must persuade a state court that it should use a heightened standard of review or scrutiny and that the financing laws at issue fail this review. In other words, he must convince the state court to go beyond the rigid federal levels of review—strict scrutiny or rational basis—and use some degree of mid-level review, given the importance of health care and its role in protecting opportunity.

A number of states, which have gone beyond the Supreme

154. *See, e.g.*, Moe v. Sec'y of Admin. & Fin., 417 N.E.2d 387, 401 (1982) (noting that "it is unimportant whether the burden imposed [by the law] is direct or indirect"), discussed *infra* in Part IV.C.

Court in expanding equal protection guarantees in other contexts, have adopted their own methods of judicial review to analyze equal protection claims.[155] Importantly, these methods do not fit squarely within the rational basis or strict scrutiny regime. One study estimates that of those states which provide more expansive equal protection guarantees, twelve have developed their own, more flexible, methods of judicial review.[156] For example, some states apply a balancing test whereby the court "place[s] a greater or lesser burden on the state to justify a classification depending on the importance of the individual right involved."[157] In some cases, these balancing tests allow a court to analyze interests that are less than fundamental.[158] Other states apply an intermediate scrutiny test. Under this test, classifications must bear "a reasonable and substantial relationship to the object sought to be accomplished by the legislation."[159] Still others use "heightened rational basis" scrutiny.[160]

What is important to note about these various methods is the

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155. *See* Jeffrey, *supra* note 32, at 257-58, nn.72-76.

156. *Id.* at 257.

157. Herrick's Aero-Auto-Aqua Repair Serv. v. Alaska Dep't of Transp. & Pub. Facilities, 754 P.2d 1111, 1114 (Alaska 1988) (citations omitted); *see also* DuPree v. Alma Sch. Dist. No. 30, 651 S.W.2d 90, 93 (Ark. 1983) (balancing students' right to receive education against the government's financing plan); Robinson v. Cahill, 303 A.2d 273, 282 (N.J. 1973) (finding education not to be a fundamental right but analyzing equal protection challenges by weighing the detriment to children's education against the justification for school financing); Olsen v. State, 554 P.2d 139, 145 (Or. 1976) (adopting the New Jersey balancing approach in *Robinson*).

158. *See DuPree*, 651 S.W.2d at 93; Butte Cmty. Union v. Lewis, 712 P.2d 1309, 1311, 1314 (Mont. 1986) (holding that when an important interest such as welfare benefits is implicated, the classification must be reasonable and must outweigh the individual interest in obtaining benefits to be constitutional), superseded by constitutional amendment as stated in *Zempel v. Uninsured Employers' Fund*, 938 P.2d 658, 662 (Mont. 1997); David J. Shannon, Note, *"No Pass, No Play": Equal Protection Analysis Under the Federal and State Constitutions*, 63 IND. L.J. 161, 174-75 (1987) (discussing Montana's middle tier analysis in *Bartmess v. Bd. of Trs.*, 726 P.2d 801 (Mont. 1986), for interests that are less than fundamental).

159. Benderson Dev. Co. v. Sciortino, 372 S.E.2d 751, 757 (Va. 1988) (citations omitted); *see also* Idaho Sch. for Equal Educ. Opportunity v. Evans, 850 P.2d 724, 733 (Idaho 1993) (determining "whether the legislation substantially furthers some specifically identifiable legislative end"); Harman v. Marsh, 467 N.W.2d 836, 847 (Neb. 1991) (holding that, to be constitutional, a classification must bear a "reasonable and substantial relationship to the object sought to be accomplished by the legislation") (citations omitted); Carson v. Maurer, 424 A.2d 825, 831 (N.H. 1980) (per curiam) (holding that the appropriate standard of review for classifications involving sufficiently important rights is "whether the challenged classifications are reasonable and have a fair and substantial relation to the object of the legislation").

160. *See* Johnson v. State Hearing Exam'rs Office, 838 P.2d 158, 164-66 (Wyo. 1992) (holding that state law provides greater protections against discrimination than federal law, including a "heightened" rational basis scrutiny).

flexibility they provide the legal advocate for going beyond the rigid, analytic, two-tiered regime into which the Supreme Court has boxed itself. Not only might a state court provide more heightened review for an expanded number of classifications but also for an expanded number of non-fundamental rights. The latter expansion is particularly relevant for purposes of this Article because the Article has assumed that although the individual has no fundamental state constitutional right to health care, a state court should nevertheless treat the normal opportunity range interest under some type of heightened review. The flexibility of state constitutional review provides the necessary tools for dealing with this important but non-fundamental interest.[161] Part IV of this Article applies this legal framework to determine whether the Massachusetts health care financing laws run afoul of Massachusetts equal protection guarantees.

## IV. APPLICATION: UNIVERSAL HEALTH INSURANCE PURSUANT TO THE MASSACHUSETTS EQUAL PROTECTION CLAUSE

Although some commentators have criticized the Massachusetts Supreme Judicial Court for ignoring its own rich constitutional history, and for frequently ruling in lockstep with the Constitution,[162] analysis of the SJC is still appropriate for two reasons. First, there is sufficient evidence that the SJC does engage in independent state constitutional adjudication that protects individual liberties beyond the federal minimum.[163] Second, SJC decisions have influ-

161. Importantly, for purposes here, the Massachusetts SJC has indicated a willingness to take a flexible approach to equal protection analysis. *See infra* note 248 and accompanying text.

162. *See* James A. Gardner, *The Failed Discourse of State Constitutionalism*, 90 MICH. L. REV. 761, 785-89, 793-94 (1992) (arguing that Massachusetts is an example of a state that fails to use its constitutional history to provide a proper distinction between federal and state constitutional analysis and more often than not takes a lockstep jurisprudential approach).

163. *See* Robert A. Marangola, *High Court Study: Independent State Constitutional Adjudication in Massachusetts: 1988-1998*, 61 ALB. L. REV. 1625, 1629, 1631-34 (1998) (noting that the SJC uses the primacy approach half the time, and uses a combination of the supplemental and dual approach for the other half, but overall the SJC utilizes the Massachusetts Constitution "to protect individual liberties beyond what the Supreme Court has determined to be the minimum").

In particular, the SJC has on numerous occasions exercised its prerogative to interpret its constitution more broadly. *See* Moe v. Sec'y of Admin. & Fin., 417 N.E.2d 387, 400 (Mass. 1981) (discussing how the Massachusetts Constitution affords a greater degree of protection to woman's right to choose abortion than does the Federal Constitution); Dist. Attorney for Suffolk Dist. v. Watson, 411 N.E.2d 1274, 1279, 1293 (Mass. 1980) (finding that the death penalty contravenes Massachusetts' Declaration of Rights

enced other state high courts' decision making, which is important for legal advocates outside Massachusetts.[164]

Thus, Part IV uses the Massachusetts Equal Protection Clause to challenge the constitutionality of its health care financing laws. First, it briefly summarizes Massachusetts' public health insurance programs, explains how they unequally distribute access to health care, and identifies their impact on Massachusetts residents. Part IV next argues for an interpretation of the Massachusetts Constitution which would include a protected interest in fair equality of opportunity, and hence one's normal opportunity range. After demonstrating that the SJC has gone beyond the Supreme Court in what it determines is state interference, and that the state's unequal distribution of health care interferes with a resident's normal opportunity range interest, Part IV defends the application of a heightened standard of review and argues that the financing laws fail this review.

### A. *Massachusetts Health Insurance System*

With the failure of the Clinton health insurance reform, Massachusetts, like many states, turned away from universal health insurance legislation in favor of an incremental approach. In 1996, the legislature abandoned the 1988 Massachusetts Medical Security Act,[165] which called for universal coverage within eight years, and

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even if permissible under the Federal Constitution); Commonwealth v. Soares, 387 N.E.2d 499, 515-16 (Mass. 1979) (using peremptory challenges to eliminate black jurors deprived defendants of their State constitutional right to a fair trial by an impartial jury; more strict than requirement of Federal Constitution); *cf.* Dist. Attorney for Plymouth Dist. v. N. Eng. Tel. & Tel. Co., 399 N.E.2d 866, 872 (Mass. 1980) (Liacos, J., dissenting) (arguing that article 14 of the Declaration of Rights may provide protections beyond those of the Federal Constitution in the area of unreasonable searches and seizures); Commonwealth v. Ortiz, 380 N.E.2d 669, 675 (Mass. 1978) (holding that the State Constitution may afford greater protections than Federal Constitution, but not in circumstances of this case).

164. *See* David Blumberg, *Influence of the Massachusetts Supreme Judicial Court on State High Court Decisionmaking 1982-1997: A Study in Horizontal Federalism*, 61 ALB. L. REV. 1583 (1998). For example, although Massachusetts was not the first state to hold that the state constitution required the provision of an "adequate education" and that the state's system of school financing was unconstitutional, since *McDuffy* "ten state high courts have cited [it] in opinions that decided the constitutionality of their own state education funding system." *Id.* at 1606 n.137 (citing the ten cases). Moreover, these states are spread throughout the country, including Alabama, Arizona, and Florida. *Id.* at app. 1.

165. MASS. GEN. LAWS ANN. ch. 118F, § 1 (West 1993) (repealed 1996) (noting that "the access of residents of the commonwealth to basic health care services is a natural, essential, and unalienable right"). Massachusetts also abandoned a "pay or play" statute, which required employers to provide their employees with health insur-

replaced it with expanded coverage for children and a pharmaceutical benefit program for low income seniors.[166] The following provides an overview and a recent evaluation of Massachusetts' current health care assistance programs.

Most Massachusetts non-elderly adult residents, almost 70% in 1998, have employer-based health insurance.[167] For residents without employer-provided insurance, Massachusetts offers about seventy-five different health care programs. These programs primarily benefit low-income uninsured and underinsured Massachusetts residents, and range from comprehensive insurance programs such as MassHealth, to local, targeted programs, such as the Family Planning Program.[168]

At the center of these programs is MassHealth, Massachusetts' version of Medicaid, which offers comprehensive benefits to persons whose family income is below 200% of the federal poverty level.[169] The remaining programs attempt to reach these individuals who do not qualify for MassHealth, but who do not have access to insurance by any other means. For example, if a child is not eligible for MassHealth, he may be eligible for the Children's Medical Security Plan,[170] which provides limited primary care, and for the Uncompensated Care Pool,[171] which offsets payments for hospital

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ance coverage or to contribute to a state fund for financing coverage, *see* MASS. GEN. LAWS ch. 151A, § 14G(b) (1998) (amended 1996), in light of federal court decisions putting its legality in doubt. *See, e.g.*, Standard Oil Co. v. Agsalud, 442 F.Supp. 695, 709 (N.D. Cal. 1977), *aff'd* 633 F.2d 760 (9th Cir. 1980) (invalidating Hawaii's Prepaid Health Act under Employees Retirement Income Security Act (ERISA)).

166. MASS. GEN. LAWS ch. 118G, § 18 (1998) (originally enacted as An Act Assisting in Making Health Care Available to Low Income Uninsured and Underinsured Residents of the Commonwealth, Acts of 1997, ch. 47). More recently, the legislature passed laws protecting patients' rights. *See* An Act Protecting the Health and Safety of Massachusetts Consumers from Certain Managed Care Practices in the Insurance Industry, MASS. GEN. LAWS ANN. ch. 6A, § 16D (Supp. 2000). *See infra* note 168 for a description of these and other Massachusetts' programs.

167. MASS. DIV. OF HEALTH CARE FIN. & POLICY, MASSACHUSETTS HEALTH CARE TRENDS: 1990-1999 25 (Oct. 2000) [hereinafter TRENDS] *available at* http://www.state.ma.us/dhcfp/pages/pdf/trends.pdt; *see also* MASS. DIV. OF HEALTH CARE FIN. & POLICY, HEALTH INSURANCE STATUS OF MASSACHUSETTS RESIDENTS 9 (Oct. 1998) (reporting 82% for 2000) [hereinafter HEALTH STATUS] *available at* http://www.state.ma.us/dhcfp/pages/pdf/hism1200.pdf.

168. *See* MASS. DIV. OF HEALTH CARE FIN. & POLICY, ACCESS TO HEALTH CARE IN MASSACHUSETTS (2000) (containing information on seventy-five health care programs available to Massachusetts residents who are uninsured or underinsured) [hereinafter ACCESS] *available at* http://www.state.ma.us/dhcfp (to order catalog).

169. *See* MASS. GEN. LAWS ch. 118E, §§ 9A, 9B (1998).

170. *See* MASS. GEN. LAWS ch. 111, § 24G (1998).

171. *See* MASS. GEN. LAWS ch. 118G § 18 (1998).

care, if needed. Other gap-filling programs such as the Senior Pharmacy Assistance Program[172] help the elderly and disabled who are not covered under MassHealth or who are underinsured. Below is a brief description and evaluation of these four programs.[173]

MassHealth, formally known as Massachusetts' Medicaid program, offers "comprehensive health care coverage to more than 500,000 eligible Massachusetts residents, including low-income families, children up to age eighteen, pregnant women, individuals with disabilities, and individuals out of work for an extended period of time."[174] MassHealth has expanded eligibility to children and families to 200% of the federal poverty level and has carved out different programs for individuals not eligible for traditional MassHealth.[175] Those eligible are typically enrolled in a managed care plan and provided with a comprehensive set of benefits, including hospital and physician services, dental, optical, laboratory, mental health services, and others.[176] The program is administered by the Division of Medical Assistance.[177]

The Children's Medical Security Plan is a health insurance program that provides only limited primary and preventive care for children under nineteen. A child under nineteen is eligible only if he is not eligible for MassHealth and has no other source of insurance.[178] Children of families whose income is at or below 200% of the federal poverty level participate for free. Families with incomes between 201% and 400% contribute $10.10 per child per month,

172. *See* MASS. GEN. LAWS ch. 118E, § 16B (1998) (repealed as of Oct. 1, 2001).

173. I have chosen these four programs because the Division of Health Care Finance and Policy has specifically evaluated each. *See infra* note 174.

174. MASS. DIV. OF HEALTH CARE FIN. & POLICY, AN EVALUATION OF HEALTH CARE PROGRAMS FOR LOW INCOME UNINSURED AND UNDERINSURED MASSACHUSETTS RESIDENTS 4 (Mar. 1998) [hereinafter EVALUATION].

175. *Id.* MassHealth offers numerous benefit packages depending on income and personal circumstances: MassHealth Standard (traditional Medicaid); MassHealth CommonHealth (for disabled adults and children not eligible for MassHealth Standard); MassHealth Family Assistance (for children who do not qualify for MassHealth Standard or CommonHealth); MassHealth Family Assistance for Adults without Children (for adults working for small employers who cannot afford premiums); MassHealth Prenatal (for pregnant women); MassHealth Basic (for individuals unemployed for a long period of time); MassHealth Buy-In (for selected individuals with private insurance premiums); and MassHealth Limited (for emergency services). *See* ACCESS, *supra* note 168, at 9-31.

176. *See* ACCESS, *supra* note 168, at 11.

177. *Id.* at 1.

178. MASS. DIV. OF HEALTH CARE FIN. & POLICY, AN EVALUATION OF HEALTH CARE PROGRAMS FOR LOW INCOME UNINSURED AND UNDERINSURED MASSACHUSETTS RESIDENTS, CHAPTER 1: THE CHILDREN'S MEDICAL SECURITY PLAN 2 (June 2000).

but not more than $31.50 per month. Families with incomes over 400% of the federal poverty level contribute the full premium of $52.50 per child per month.[179] Benefits include, in part, routine well-baby check-ups, immunizations, doctor's office visits, limited mental health visits, emergency care up to $1000, certain diagnostic tests, up to $200 per year of durable medical equipment, up to $200 per year for prescription drugs, and primary and preventive dental benefits.[180] The Department of Public Health administers the program by contracting with a private entity, Unicare, to process claims and to provide customer service, premium collection, and utilization management.[181] As of March 2000, about 21,000 children were enrolled in this program; children under twelve in families between 201-400% of federal poverty level constitute the majority of the enrollment.[182]

The Senior Pharmacy Assistance Program, administered by the Massachusetts Division of Medical Assistance, helps persons sixty-five and older who are not eligible for MassHealth and have no other health insurance that provides prescription drug coverage.[183] To be eligible, individuals must also be Massachusetts residents, have lived in the state for the past six months, and have a gross annual income below 150% of the federal poverty level.[184] Eligible participants receive a $750 benefit for prescription drugs, and must make co-payments of $3 for generic drugs and $10 for brand name drugs. As of February, 1998, 20,000 seniors were enrolled, the majority of which were white women with an average age of seventy-seven.[185]

Finally, Massachusetts has an uncompensated care pool ("pool"), administered by the Division of Health Care Finance and Policy.[186] The pool reimburses hospitals and community health centers that provide free heath care services to Massachusetts residents who are uninsured or underinsured.[187] To be eligible, a per-

179. *Id.*
180. *Id.*
181. *Id.*
182. *Id.* at 3-5.
183. EVALUATION, *supra* note 174, at 25.
184. *Id.*
185. *Id.*
186. *See* MASS. GEN. LAWS ch. 118G, § 18 (1998).
187. MASS. DIV. OF HEALTH CARE FIN. & POLICY, AN EVALUATION OF HEALTH CARE PROGRAMS FOR LOW INCOME UNINSURED AND UNDERINSURED MASSACHUSETTS RESIDENTS, CHAPTER 3: THE UNCOMPENSATED CARE POOL 14 (Nov. 2000) [hereinafter POOL].

son must be a Massachusetts resident and have no other source of coverage for a medically necessary service.[188] The pool acts as a "payer of last resort," and all applicants, therefore, are first screened for eligibility in other programs.[189] Once a patient applies, he may be eligible for one of three types of free care: full free care, for people with family income up to 200% of the federal poverty level; partial free care, for those with family income between 201-400% of the federal poverty level; and medical hardship assistance, for people of any income whose medical expenses exceeds their ability to pay.[190] The pool is funded by three sources: a hospital assessment ($215 million), a surcharge on payers (HMOs and insurers) ($100 million), and the state's general fund ($30 million).[191]

Although these programs are praiseworthy, they represent a patchwork quilt that is incomplete, complicated to administer and use, and ultimately unstable. In spite of these programs, surveys of the health insurance status of Massachusetts residents show that about 350,000 - 400,000 residents were uninsured in 2000.[192] Moreover, a 1998 survey reported that another 300,000 were uninsured for various times during the previous year.[193] And of the insured, 25 - 30% reported being underinsured.[194] Those individuals most likely to be uninsured were between ages nineteen and thirty-nine; about 4.4% of children up to the age of five did not have health insurance and neither did 7.1% of children six through eighteen. Most uninsured adults, about 300,000, were employed.[195] Significantly, over 80% of the uninsured adults were willing to pay for low

188. *Id.* at 15.

189. *Id.*

190. *Id.* at 14. For a thorough discussion of types of free care and eligibility guidelines, see BETH LAFORTUNE GIES, MASS. DIV. OF HEALTH CARE FIN. & POLICY, THE FREE CARE APPLICATION: A GUIDE FOR ACUTE HOSPITALS AND COMMUNITY HEALTH CENTERS (1999); MASS. REGS. CODE tit. 114.6, § 10.00 (1999) (outlining criteria for determining eligibility for free care at acute care hospitals and freestanding community health centers); MASS. REGS. CODE tit. 114.6, § 11.00 (2000) (discussing the administration of uncompensated care pool).

191. POOL, *supra* note 187, at 17.

192. *See* TRENDS, *supra* note 167, at 21 (indicating 6.5% of Massachusetts' nonelderly population uninsured); POOL, *supra* note 187, at 6 (reporting 5.9% or 364,622 uninsured).

193. HEALTH STATUS, *supra* note 167, at 1.

194. *Id.* at 2. Underinsured included individuals who reported problems accessing care due to lack of enough coverage or encountering financial barriers. *Id.*

195. *Id.* at 1. Sixty percent of uninsured residents were willing to pay up to $100 per month, and 35% up to $300 per month. *Id.* at 18.

cost insurance, if available.[196]

Due to this lack of affordable health insurance, many residents either do not access care, delay the care, or receive the care in emergencies only.[197] The majority of adults who were uninsured were aware of the programs available but were not eligible.[198] For many who are eligible, complicated enrollment procedures and the stigma associated with the programs are barriers to their use.[199] Moreover, even among those individuals who were insured, 30% reported needing medical services not covered, or indicated that financial barriers prevented them from getting needed care.[200]

More importantly, the stability of the programs rests, in part, on a robust economy.[201] Given the strong relationship between health insurance and employment, if the economy were to slow down or go into a recession, the number of uninsured would rise quickly due to increased unemployment and employers cutting benefits. If the number of uninsured were to rise, that would put pressure on existing programs and require the state to choose between cutting benefits or lowering eligibility.

Are the state's health care assistance programs constitutional under the state's equal protection clause? In other words, do the health care financing laws impermissibly interfere with a protected constitutional interest? To answer this question, one must first explore whether the Massachusetts Constitution contains a protected interest in fair equality of opportunity. Fair equality of opportunity is understood here as an interest in having the state take positive steps to produce fairness in the competition for jobs, careers, offices, and other social rewards, by providing background institutions that help level the "playing field" for these goals.[202] Universal

196. *Id.* at 2. Sixty percent of the working uninsured adults were offered insurance by their employer but could not afford it, or others (26%) were not currently covered due to a waiting period. *Id.*

197. *Id.* at 18, 22, 25 (noting that the uninsured were more likely to receive care in emergency rooms than in office settings, reported lower inpatient care use, and were twice as likely not to receive needed care). For a discussion of the consequences of having no health insurance, see *supra* Part III.C.

198. HEALTH STATUS, *supra* note 167, at 30.

199. EVALUATION, *supra* note 174, at 33, 40.

200. HEALTH STATUS, *supra* note 167, at 25.

201. *Id.* at 30 (noting that a contributing factor to the lower uninsured rates in 1998 was "a strong state economy").

202. *See* RAWLS, *supra* note 84, § 14, at 73 (stating that fair equality of opportunity requires more than making positions and offices in society open in the formal sense of proscribing discrimination; it prescribes that all persons be given a "fair chance to attain" social positions and offices formally open to all); *see also* DANIELS, *supra* note

primary and secondary public education are examples of background institutions necessary for guaranteeing fair equality of opportunity, given their role in protecting one's normal opportunity range. Likewise health care institutions, like hospitals and doctors, also help guarantee fair equality of opportunity because inadequate access to these institutions adversely impacts one's normal opportunity range.

Once it is determined that the state constitution protects fair equality of opportunity, one must consider whether the financing laws interfere with this interest in a manner that runs afoul of the state's equal protection clause. And finally, one must determine under what standard a court should review the interference of this protected interest. Would it use a heightened or merely a rational basis standard of review, and would the laws survive one or both types of review?

These are the questions that the remaining sections of this Article will consider. Part IV.B locates the constitutional interest of fair equality of opportunity in the state constitution's equality provision. It argues for an interpretation of the provision that goes beyond an interest in proscribing discrimination; instead, it suggests that the provision includes an interest in having access to essential background institutions, like education or health care, which protect a person's normal opportunity range. Finally, Part IV.C shows how the financing laws indirectly interfere with this interest, why a court should review this interference under a heightened standard, and why the laws would not survive this review.[203]

### B. *Protecting Opportunity Under Massachusetts Equal Protection Clause*

The equal protection language of the Massachusetts Constitution is set out in Part I, Article 1, as amended in 1976 by Art. CVI. Massachusetts' equal protection clause goes beyond the Fourteenth Amendment because it specifies that "equality under the law shall not be denied or abridged because of sex, race, color, creed or national origin."[204] Like the Fourteenth Amendment, Massachusetts' analysis of its equal protection clause includes two methods: analyz-

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82, at 39-42, 50 (noting that "the notion of fair equality of opportunity . . . is focused on producing fairness in the competition for jobs and careers").

203. *See infra* Part IV.C.

204. MASS. CONST. art. CVI. The Massachusetts Constitution was also amended to prohibit discrimination against handicapped persons. *See* MASS. CONST. art. CXIV.

ing whether the law discriminates against a suspect classification, or whether the law denies a fundamental right to some individuals but not to others.[205] Under both methods, Massachusetts has expanded its equal protection analysis beyond the Fourteenth Amendment. First, it held that gender is a suspect classification deserving of strict scrutiny review.[206] Second, Massachusetts has indicated a willingness to go beyond the two-tiered fundamental/non-fundamental rights doctrine and apply a balancing approach when interests affected are very important.[207]

The approach here would require the SJC to consider whether meeting health care needs is important enough to require equal access to affordable health insurance. In other words, instead of asking whether health care is a fundamental right, this section asks whether health care, like education, is an important constitutional interest. This section locates that interest in the meaning of equality itself and argues that a court could interpret the Massachusetts Constitution equality language as going beyond protecting formal (or negative) equality opportunity, which forbids discrimination based on suspect classifications. Instead, a court could interpret it as protecting fair equality of opportunity, which prescribes taking affirmative steps to guarantee background institutions that help citizens compete for jobs and careers open to all. Since having no health insurance undermines fair equality of opportunity by shrinking one's normal opportunity range, having access to health insurance becomes an important state constitutional interest.

To begin the analysis, one must first establish a method of constitutional interpretation. In *McDuffy v. Secretary of Executive Office of Education*,[208] the SJC set out its method of constitutional

205. *See* Murphy v. Dep't of Corr., 711 N.E.2d 149, 152 n.3 (Mass. 1999) (noting that the standard of review for equal protection is identical for federal and state constitutions). But see *infra* notes 238-41 and accompanying text for an argument for a flexible approach to judicial review.

206. Commonwealth v. King, 372 N.E.2d 196, 206 (Mass. 1977) (raising the scrutiny applied to sex discrimination to a level "at least as strict as the scrutiny required by the Fourteenth Amendment for racial classifications").

207. *See* Marcoux v. Attorney Gen., 375 N.E.2d 688, 689 n.4 (Mass. 1978) (describing strict scrutiny and rational basis tests as "shorthand for referring to the opposite ends of a continuum of constitutional vulnerability determined at every point by the competing values involved"); *see also* Attorney Gen. v. Mass. Interscholastic Athletic Ass'n, 393 N.E.2d 284, 291 n.28 (Mass. 1979) (citing *Marcoux*). *But see* English v. N. Eng. Medical Ctr., Inc., 541 N.E.2d 329, 333 (Mass. 1989) (explaining its constitutional "continuum" in a way that seemed to minimize any difference between its analysis and the federal analysis).

208. 615 N.E.2d 516 (Mass. 1993).

interpretation. There it decided the question of whether the state's education clause required the legislature to provide adequate education for all residents. When interpreting the state constitution, the court held, one must look to (1) the language and structure of the provision so that it is construed "to achieve its dominating purpose,"[209] and (2) "the conditions under which [the provision] and its several parts were framed, the ends which it was designed to accomplish, the benefits it was expected to confer, and the evils it was hoped to remedy."[210]

1. Language and Structure of the Equal Protection Clause

The Massachusetts equal protection clause reads, in relevant part, that "all men are born free and equal." This language was amended in 1976 to say "all people are born free and equal."[211] The amended article goes on to say that "equality under the law shall not be denied or abridged because of sex, race, color, creed or national origin."[212] What is of interest here is the meaning of the word "equal" in the phrase "free and equal." Does it mean merely identical treatment under the law, i.e., the law shall not discriminate based on these enumerated classifications? Or, did "equal" originally mean something more?

An historical study of the Massachusetts Constitution discovered that a Lockean social compact theory formed the basis for its justification, influencing its language and effect.[213] "The people of Massachusetts," explains Robert Peters, "shared with Locke this view [that] . . . the state of nature was a state of freedom and a state of equality."[214] Locke's concept of natural freedom was understood as "a power,"[215] or as a positive concept of liberty, meaning freedom of self-determination. "This positive concept of liberty as a power of self-direction," explains Peters, "was commonly accepted in Massachusetts during the Revolution."[216]

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209. *Id.* at 523 (citations omitted).
210. *Id.* (citations omitted).
211. MASS. CONST. art. CVI.
212. *Id.*
213. *See* RONALD M. PETERS, JR., THE MASSACHUSETTS CONSTITUTION OF 1780: A SOCIAL COMPACT 65-114 (1978). For a discussion of Locke's influence on the federal constitution, see James A. Gardner, *Consent, Legitimacy and Elections: Implementing Popular Sovereignty Under the Lockean Constitution*, 52 U. PITT. L. REV. 189, 205-13 (1990).
214. PETERS, *supra* note 213, at 70.
215. *Id.* at 71.
216. *Id.*

This view of natural liberty "as a power of self-determination had as its direct corollary the concept of natural equality, which was defined as an *equality of liberty*."[217] This equality of liberty was "in essence, political equality of the most basic sort": that no person had political dominion over any other as a matter of birth right.[218] Importantly, Peters points out, the meaning of equality in this social compact theory had two facets: on the one hand there was equality of participation, i.e., equality of consent; and on the other, there was equality before the law.[219] Thus, "equality" meant more than having the state's laws apply identically to its residents; it also meant each resident must be given an equal chance at participating in government.[220]

2. Conditions Under Which the Clause Was Framed

Examining the meaning of "equality" thus supports the conclusion that the Massachusetts Constitution intends to protect residents not only from an unequal application of the laws, but also from unequal participation in making them. This conclusion could be read narrowly to support the right to vote or the right to more effective representation in government. It could also be read broadly to support a government obligation to guarantee important background conditions that help secure meaningful participation in the Commonwealth generally. It should be read broadly for the following reasons.

The importance of political equality in both theory and practice was well understood in Massachusetts in 1780. The theoretical importance of political equality finds expression in the constitution's preamble, which states:

> The body politic is formed by a voluntary association of individuals: it is a social compact, by which . . . all shall be governed by certain laws for the common good. It is the duty of the people, therefore, in framing a constitution of government, to provide for an *equitable mode of making laws*, as well as for *an impartial interpretation*, and a faithful execution of them; that every man may, at all times, find his security in them.[221]

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217. *Id.* at 72 (emphasis added).

218. *Id.* at 73.

219. *Id.* at 190.

220. This is the meaning often referred to as "popular sovereignty." *See* PETERS, *supra* note 213, at 2; *see also* Gardner, *supra* note 213, at 200.

221. MASS. CONST. pmbl. (emphasis added).

The preamble expresses a Lockean social contract where individuals consent to government primarily for security, and they find this security in the government's duties not only to apply and execute the laws impartially, but also to guarantee equitable participation in their "mode of making."[222]

The guarantee of participation in government is an expression of the broader concept of the right to self-determination. This is supported by observing that in the context of adopting the equality language in Part I, Article I, the delegates also adopted Part II, Chapter 5, section 2—the education clause. The importance of including an education clause signifies an understanding that the government plays a role in equalizing background conditions necessary for fairness in the competition for social positions.

A central reason for including the education clause was its strong relationship to equal political participation and the equal exercise of one's rights and liberties generally. "Knowledge is among the most essential foundations of liberty," wrote John Adams, the principal architect of the Massachusetts Constitution and drafter of the original education clause which was ratified verbatim.[223] "There is substantial evidence that John Adams believed that widespread public education was integral to the very existence of a republican government."[224] Moreover, Adams wrote, "liberty cannot be preserved without a general knowledge among the people,. . .[and for this reason] the preservation of the means of knowledge among the lowest ranks, is of more importance to the public than all the property of all the rich men in the country."[225] Others also observed that without universal education "learning and virtue will but rarely be found among the mass of the citizens, all offices of course must fall into the hands of men of fortune, figure and education."[226] The very possibility, in other words, for equal participation in government, depended on the provision of adequate education for all.

Beyond being a prerequisite for political participation, adequate access to educational institutions, as viewed by the framers,

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222. *Id.*

223. PETERS, *supra* note 213, at 120.

224. McDuffy v. Sec'y of the Executive Office of Educ., 615 N.E.2d 516, 535 (Mass. 1993).

225. *Dissertation on the Canon and the Feudal Law*, *in* 3 THE WORKS OF JOHN ADAMS 456-57 (Boston, Charles C. Little & James Brown 1851).

226. PETERS, *supra* note 213, at 119 (quoting the MASSACHUSETTS SPY, May 4, 1780).

was a prerequisite for life's basic opportunities generally, i.e., for self-determination. It was and is necessary for the enjoyment of the other rights and liberties secured by the constitution. For example, the education clause itself recognizes education's role as "*being necessary* for the preservation of [the people's] rights and liberties."[227] And this is consistent with the preamble's claim that the central end of government is not only to protect the body politic, but "to *furnish* the individuals who compose it with *the power* of enjoying in safety and tranquility their natural rights, and the blessings of life."[228] Thus, the education clause is evidence that the framers of the Massachusetts Constitution envisioned the goals of government going beyond protection of its inhabitants merely in the sense of preventing others from discriminating against them. Its goals also included, in part, guaranteeing access to institutions, which are important for enjoying the very rights the people consented to protect.

Given the inclusion of the education clause in the original constitution of 1780, then, the framers understood that equal application of the law was not enough to satisfy the meaning of being "free and equal." The education clause suggests that the framers understood the need for a state to provide the resources to meet the educational needs that are a prerequisite to satisfying fair equality of opportunity. Thus, by utilizing the education clause to guarantee adequate education for all children, the framers possibly recognized that a difference exists between formal equality and fair equality of opportunity.

Meeting educational needs was one very important means for satisfying fair equality of opportunity in 1780. However, the extent to which access to health care institutions affected one's basic opportunities was probably not on the framers' minds, given the limited role medicine had at that time. Today, however, access to health care institutions arguably affects one's basic life opportunities in the same way educational institutions did in 1780; thus, there is no reason to believe that the moral logic of the equality provision should not extend to health care institutions. If the Massachusetts

227. *See* MASS. CONST. Pt. II, ch. 5, § 2 ("Wisdom, and knowledge, . . . diffused generally among the body of the people *being necessary* for the preservation of their rights and liberties . . .") (emphasis added); *cf.* JOHN LOCKE, THE SECOND TREATISE OF GOVERNMENT 6 (Thomas P. Peardon ed., Liberal Arts Press, 1952) (1690) ("Every one . . . ought . . . to preserve the rest of mankind, and may not . . . take away or impair the life, or what *tends to the preservation of the life*, the liberty, *health*, limb, or goods of another.") (emphasis added).

228. MASS. CONST. pmbl. (emphasis added).

Constitution places a strong interest in education because of its role in helping achieve fair equality of opportunity, then it presumably places a similar interest in other institutions that also help achieve fair equality of opportunity.

Nevertheless, to the extent that anything could have been done to meet health care needs in the framing era, it was commonplace for the government to play an active role in helping all residents. For example, early in Massachusetts history the legislature took its residents' health seriously. "Public responsibility for the prevention of disease and the care of the ill was rooted most firmly in the New England colonies and especially in the Massachusetts Bay Colony."[229] Moreover, "[a]s far back as 1629, the General Court of Massachusetts Bay Colony acted to protect the public health by limiting the number of passengers on each ship carrying migrants to the new colony."[230] "By 1764," observed one historian, "the city of Boston was actively involved in providing free inoculations and follow-up care for the poor."[231] And significantly, "[a]s the public health historian John Blake has noted, Boston's regulation of smallpox inoculation implicitly expressed the principle that government has a role to play in protecting the health of the public."[232] Therefore, government did all it could to meet health care needs by helping all its residents.

In no way could the framers have understood the role that health care institutions would eventually have in protecting fair equality of opportunity. Nonetheless, since these institutions do play a significant role in protecting one's normal opportunity range similar to that of educational needs in the framing era, one can reasonably speculate that had access to heath care been of primary importance when the Massachusetts Constitution was formed, the framers would have explicitly provided for it.

### C. *Massachusetts Equal Protection Analysis of Health Care Financing Law*

Once it is clear that the Massachusetts Constitution protects

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229. Wendy E. Parmet, *Health Care and the Constitution: Public Health and the Role of the State in the Framing Era*, 20 HASTINGS CONST. L.Q. 267, 286 (1993).

230. *Id.* at 287 (citing Bernard Bailyn, *The New England Merchants in the Seventeenth Century*, *in* PURITANISM IN SEVENTEENTH CENTURY MASSACHUSETTS 86 (David Hall ed., 1968)).

231. *Id.* at 289 (citing JOHN B. BLAKE, PUBLIC HEALTH IN THE TOWN OF BOSTON 1630-1822, 94, 116 (1959)).

232. *Id.* at 290 (citing BLAKE, *supra* note 231, at 115).

fair equality of opportunity, the inquiry becomes whether the health care financing laws at issue "interfere" with this protected interest. As noted above, Massachusetts, along with a number of other states, has gone beyond the Federal Constitution when determining whether a state law "interferes" with a state resident's constitutionally protected interests.[233] In *Moe v. Secretary of Administration and Finance*,[234] the Supreme Judicial Court held unconstitutional a state statute restricting Medicaid funding for any non-life-threatening abortion.[235] In finding the statute unconstitutional, the SJC explicitly rejected the Supreme Court's reasoning in *Harris v. McRae*.[236] There, the Supreme Court upheld a substantially similar statute because it did not directly "interfere" with a woman's right to reproductive freedom; the statute itself did not place any obstacles in the woman's path, and the government was under no obligation to remove obstacles not of its own creation.[237]

In *Moe*, the SJC moved beyond the Supreme Court's adherence to the premise that a government can only burden a constitutional interest by "indirect" interference.[238] "[I]t is unimportant," the SJC stated, "whether the [state] burden is direct or indirect."[239] What is important, the SJC found, is that the government act neutrally, that is, with "genuine indifference," when it chooses to enter constitutionally protected areas to establish a medical assistance program and selectively limit its funding.[240] Noting that "[w]e are not free to disregard the practical realities,"[241] the court found that the statute "'injected coercive financial incentives favoring childbirth into a decision that is constitutionally guaranteed to be free from governmental intrusion.'"[242]

In essence, then, the court found that the state cannot indirectly interfere with constitutionally protected interests when it chooses how to allocate public funds. The choice not to fund abortions has the practical effect of taking reproductive choice away

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233. See *supra* note 142 and accompanying text for a discussion of state law interference.

234. 417 N.E.2d 387 (Mass. 1981).

235. *Id.* at 404.

236. *Id.* at 400; *see* Harris v. McRae, 448 U.S. 297, 316 (1980).

237. See *supra* note 140 and accompanying text for a discussion of *Harris*.

238. 417 N.E.2d at 401.

239. *Id.* (citing Supreme Court First Amendment jurisprudence for this same proposition).

240. *Id.* at 402.

241. *Id.* at 401 (discussing Healy v. James, 408 U.S. 169, 183 (1972)).

242. *Id.* (quoting *Harris*, 448 U.S. at 333 (Brennan, J., dissenting)).

from women who rely on publicly funded health care, essentially forcing them to choose childbirth. Thus, the plaintiff in *Moe* was asserting a right to have abortion non-discriminatorily funded, since unequal funding indirectly interfered with her constitutionally protected reproductive rights.[243]

Similarly, the state's choice to allocate funds so that only some residents can obtain health insurance, and not all, indirectly interferes with a resident's constitutional interest in his normal opportunity range. The practical effect of selectively funding health insurance for some and not others is to force some to choose not to meet their health care needs, and likely forgo opportunities they might otherwise have had.[244] It is this shrinking opportunity range for health care needs that shows how the state indirectly interferes with its residents' constitutional interest in fair equality of opportunity.[245] In other words, a plaintiff challenging the laws in Massachusetts would assert a right to have his normal opportunity range non-discriminatorily funded, since unequal funding interferes with his fair equality of opportunity interest.

If the health care financing laws at issue interfere with a resident's constitutional interest in fair equality of opportunity, the next question is whether this law can withstand judicial scrutiny or review. As a preliminary matter, however, one must determine what standard of review is appropriate where the interest is important but not fundamental. Under the federal two-tiered approach, the Supreme Court would review the law under a rational basis test.[246] Under this approach, then, the state's financing laws would be constitutional if they are rationally related to a legitimate state interest.

Unlike the federal approach, however, Massachusetts does not appear to be locked into this rigid dichotomy; it has adopted a more flexible stance with respect to judicial review of the constitutionality of its laws. For example, the SJC has conceived of the dichotomy between rational basis and strict scrutiny review as "[s]horthand for referring to the *opposite ends of a continuum* of constitutional vulnerability *determined at every point by the compet-*

243. *See* Jeffrey, *supra* note 32, at 329-30 (referring to this right as a "substantive equal protection right").

244. See *supra* notes 100-117 and accompanying text for a discussion on the effects of inadequate health insurance.

245. See *supra* at Part III.B for a discussion of equal access to health care.

246. See *supra* notes 56-57 and accompanying text for an explanation of when the Court will apply the rational basis test.

*ing values involved.*"[247] In *Moe*, the court noted that "[w]e have at times expressed . . . [strict scrutiny] in similar language [as the Supreme Court]," but "[a]t the same time, we have recognized to some extent the limitations inherent in such a rigid formulation [of judicial review]."[248] The SJC has found that its cases exemplify "a more flexible approach to the weighing of interests that must take place."[249] Therefore, instead of mechanically applying either a rational basis or strict scrutiny test, the SJC has, in some cases, chosen to balance the interests involved—the plaintiff's right versus the state's interest in regulating the exercise of that right.[250]

Whether the SJC will apply this flexible balancing approach to create a third, heightened level of review is unclear. Its use of this flexible approach suggests that the court is open to a weighing process not wedded to either rational basis or strict scrutiny review. However, when asked on a couple of occasions to create a third level of review the court has refused. For example, in *Murphy v. Department of Correction*, the plaintiff, a prisoner, challenged a state statute requiring him to submit a DNA sample for inclusion into the state database.[251] He conceded that he had no fundamental privacy interest given his prisoner status and asked the court to

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247. Marcoux v. Attorney Gen., 375 N.E.2d 688, 689 n.4 (Mass. 1978) (emphasis added); *see also* Attorney Gen. v. Mass. Interscholastic Athletic Ass'n, 393 N.E.2d 284, 291 n.28 (Mass. 1979) (citing *Marcoux* for this proposition).

248. *Moe v. Sec'y of Admin. & Fin.*, 417 N.E.2d 387, 403 (Mass. 1981) (noting that its "recent cases in this area [of judicial review] exemplify a more flexible approach to the weighing of interests that must take place"); *see* Planned Parenthood League v. Attorney Gen., 677 N.E.2d 101, 104-06 (Mass. 1997) (engaging in same balancing of interest approach used in *Moe* when finding unconstitutional a state statute requiring pregnant minors to obtain parental consent before having an abortion); *see also In re* Spring, 405 N.E.2d 115, 119 (Mass. 1980) (balancing an individual's strong interest in bodily integrity against state's interests); Comm. of Corr. v. Myers, 399 N.E.2d 452, 456-58 (Mass. 1979) (balancing applicable state and individual interests to determine when it is appropriate to enforce lower court's order compelling prisoner to undergo life sustaining hemodialysis); Superintendent of Belchertown State Sch. v. Saikewicz, 370 N.E.2d 417, 427-29 (Mass. 1977) (balancing applicable state and individual interests to determine when guardian may refuse medical treatment for third person). *But see* Murphy v. Dep't of Corr., 711 N.E.2d 149, 152 n.3 (Mass. 1999) (noting that the standard of review for equal protection claims is identical under state and federal constitutions); Doe v. Superintendent of Schs., 653 N.E.2d 1088, 1097 (Mass. 1995) (applying rational basis test to non-fundamental interest and implying that only a two-tiered approach to judicial review exists).

249. *Moe*, 417 N.E.2d at 403.

250. *See id.* at 404 (explaining that state's interest in preserving life is to be balanced against the woman's interest in choosing a medically necessary abortion); *Planned Parenthood*, 677 N.E.2d at 104 (explaining the balancing of interests approach).

251. *Murphy*, 711 N.E.2d at 153 n.4.

use its flexible approach and apply a third level of review in considering whether the statute impermissibly interfered with his privacy interests.[252] The court refused the request, noting that the "flexible approach" does not require a third level of review, and that the intrusion into his privacy was minimal, "especially in light of the lowered privacy expectation of convicted persons."[253]

The SJC also refused the request for a third level of review in *English v. New England Medical Center, Inc.*.[254] There the plaintiff challenged the state's charitable immunity statute, which limited recovery in his malpractice claim, arguing that it infringed his right to a jury trial guaranteed by the Massachusetts Constitution.[255] The SJC held that the statute did not infringe on the plaintiff's right to a jury trial.[256] The court, while acknowledging its use of a flexible balancing approach to determine the constitutionality of legislation, declined plaintiff's invitation to adopt a third level of review in the context of a non-fundamental interest in tort recovery.[257]

In both *Murphy* and *English*, however, the SJC merely declined the invitation to adopt a third level of review under the facts of each case.[258] For example, in *Murphy*, the court found that the interest involved—the privacy of a prisoner—to be of diminished importance.[259] In contrast, access to affordable health insurance is of tremendous importance in light of its role in protecting one's interest in fair equality of opportunity.[260] The advocate, then, must make the case for the heightened importance of the constitutional interests of accessing health care.

Although the SJC has declined to use the flexible approach to create a heightened standard of review, it has not abrogated or overruled its position that rational review and strict scrutiny are opposite ends of a continuum of constitutional analysis where competing values determine the outcome. It has merely indicated that this

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252. *Id.*

253. *Id.*

254. 541 N.E.2d 329 (Mass. 1989).

255. *Id.* at 330-31.

256. *Id.* at 331.

257. *Id.* at 333 (rejecting request to create standard stricter than rational basis for interest in tort recovery).

258. *Murphy*, 711 N.E.2d at 153 n.4; *see also English*, 541 N.E.2d at 333 (noting that "our acceptance of that method of analysis does not require us to adopt a third level of review").

259. *Murphy*, 711 N.E.2d at 153.

260. *See supra* Part III.C (discussing the importance of health care insurance in helping to protect equality).

language does not require adopting additional levels of review. The possibility remains open that the right case might justify creating such a standard.[261]

If an advocate can convince the SJC to adopt a balancing of interests approach in the context of an interest in access to health insurance, then he must next convince the court that the financing laws would fail under this review. Below, I apply the balancing of interests approach and argue that the health care financing laws would not withstand this type of review.

In applying an interest balancing test, one must weigh the plaintiff's constitutional interest involved—protecting, maintaining, or restoring one's normal opportunity range versus the state's interest in regulating its social programs.[262] The state has primarily a financial interest in unequally distributing health care resources because it has limited resources in which to help the uninsured. The putative goal of its medical assistance laws is to help the uninsured and underinsured, but the state "has a valid interest in preserving the fiscal integrity of its programs and . . . it may legitimately attempt to limit expenditures for public assistance programs."[263] The state will argue that its medical assistance programs are not universal because it has made a legitimate choice to help as many people as best it can, given the fact that it is not possible to provide health insurance for every resident.[264] For example, the SJC has upheld, under rational basis review, the constitutionality of a state statute that deemed ineligible for financial and medical assistance persons without children who the Department of Public Welfare deemed to be employable.[265] Importantly, it made this determination "in light

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261. Although the SJC has not abrogated its flexibility language of *Moe*, in some cases it speaks as if it has. For example, in *Murphy* the court claimed that "the standard of review for equal protection is identical under the State and Federal Constitutions." *Murphy*, 711 N.E.2d at 152 n.3. But such a claim belies the court's analysis in other cases. For example, in *Planned Parenthood League v. Attorney General*, the court reiterated its use of the balancing of interest approach of *Moe* when analyzing a statute that impinged on a fundamental right, explicitly noting that it had rejected the federal strict scrutiny formulation. *See* Planned Parenthood League v. Attorney Gen., 677 N.E.2d 101, 103 (Mass. 1997) (reaffirming *Moe* and noting that "*[w]e rejected the position* that the State can justify regulations imposing such a burden *only by demonstrating* that the regulations serve *a compelling* State interest, *preferring a more flexible, less mechanical balancing of interests*") (emphasis added).

262. *See* Moe v. Sec'y of Admin. & Fin., 417 N.E.2d 387, 402-04 (Mass. 1981) (explaining and applying the interest balancing approach).

263. Opinion of the Justices to the House of Representatives, 333 N.E.2d 388, 398 (Mass. 1975).

264. *Cf. id.* at 399.

265. *Id.*

of the Commonwealth's asserted inability to provide assistance to all those in financial need."[266]

But the legitimacy of the state's interest in deciding how best to use its limited resources is based on a false assumption, namely, that its resources are insufficient to enact a universal insurance program that is more comprehensive, more efficient, and *less expensive* than its current programs combined. In 1998, two studies found that a single-payer system, rather than the present multi-payer system, could "achieve the goal of universal, comprehensive, health care *while reducing the total cost* of health care in the Commonwealth."[267] One study was performed by the Lewin Group, Inc.[268] and the other by the Boston University School of Public Health.[269] The studies compare the current multi-payer Massachusetts' programs and their projected future costs with a single-payer program modeled on the Canadian system. Under the single-payer system, all residents would be covered under a single government-financed insurance program where the benefits package would cover long-term care, preventive care, acute and chronic care, including mental health, and it would have no out-of-pocket costs such as co-payments and deductibles.[270] Hospitals would be placed on annual budgets to control the growth of hospital costs.[271] The Boston University study found that savings would begin in the first year, while the Levin Group study found that savings would begin in the sixth.[272]

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266. *Id.*; *see also* Fitzgerald v. Commonwealth, No. CA 957599, 1996 WL 1185109, at *1 (Mass. Super. June 25, 1999) (denying equal protection challenge from administrative decision to deny certain root-canal treatments because plaintiff not eligible pursuant to applicable regulations, given "that the money available for all publicly assisted health care is not unlimited").

267. MASSCARE, UNIVERSAL SINGLE PAYER HEALTH CARE: A FISCALLY RESPONSIBLE APPROACH, *at* http://www.masscare.org/summary.htm (emphasis added).

268. *See* LEWIN GROUP, INC., MASSACHUSETTS COMPARATIVE PROJECTED HEALTH EXPENDITURE MODEL (1998), *at* http://www.masscare.org/lewin.pdf; *see also*, LEWIN GROUP, INC., ANALYSIS OF THE COSTS AND IMPACT OF UNIVERSAL HEALTH CARE MODELS FOR THE STATE OF MARYLAND: THE SINGLE-PAYER AND MULTI-PAYER MODELS 4 (2000), *at* http://www.healthcareforall.com/lewin.pdf (performing the same comparative study for the state of Maryland, and finding that single payer would cover all Marylanders and reduce total health spending by $345.8 million, or 1.7%).

269. SOLUTIONS FOR PROGRESS, INC., & THE ACCESS & AFFORDABILITY MONITORING PROJECT OF THE BOSTON UNIV. SCH. OF PUB. HEALTH, UNIVERSAL COMPREHENSIVE COVERAGE: MODELING THE COST OF HEALTH CARE REFORM IN MASSACHUSETTS (1998) *at* http://www.masscare.org/solutions.pdf.

270. MASSCARE, *supra* note 267, at 1.

271. *Id.*

272. *Id.* Similar findings were determined for the United States health care system when the Congressional Budget Office conducted a similar study by comparing a

Given these facts, a single-payer program actually promotes the state's interest in acting fiscally responsible and doing the most it can with its limited resources.[273] Given the realities associated with unmet health care needs, and their impact on one's normal opportunity range, the scales tip quickly toward the plaintiff's interest in his right to have his normal opportunity range non-discriminatorily funded.

## CONCLUSION

State constitutions do not offer much help for health care advocates in the form of explicit or even indirect provisions for expanding access to health care. However, since access to health care institutions is vital for meeting health care needs, and failing to meet health care needs adversely impacts one's normal opportunity range, an advocate may have success exploring whether a state constitution protects fair equality of opportunity. If it does, one may convince a court to include access to health care institutions as one type of institution, like education, essential for guaranteeing fair equality of opportunity. Since every state constitution has an educational clause, this is good evidence that state constitutions may protect an interest in fair equality of opportunity, since certain resources are a prerequisite for the rights and liberties that the particular constitution secures.

This analysis requires an interpretation of the Massachusetts Constitution that would include an interest in fair equality of opportunity, which would in turn require protecting an individual's normal opportunity range. Moreover, given its penchant to go beyond the Federal Constitution in expanding individual rights, one might convince the SJC to find that the state's health care financing laws indirectly interfere with this constitutionally protected interest. Since the state has chosen to undertake financing health care for some, the state violates its equal protection guarantees because the laws are not applied neutrally. Finally, the state has also gone beyond the Federal Constitution in using a more flexible standard of review. It is important, therefore, to convince the court to balance the plaintiff's right to have his interest non-discriminatorily funded

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single-payer plan with various multi-payer proposals in the context of the health care reform debate of 1993. *See* CONGR. BUDGET OFFICE, ESTIMATES OF HEALTH CARE PROPOSALS FROM THE 102ND CONGRESS (1993).

273. For an example of a single-payer program for Massachusetts, see MASS CAMPAIGN FOR SINGLE PAYER HEALTH CARE, MASSACHUSETTS HEALTH CARE TRUST BILL, *at* http://www.masscare.org/masstrust.htm.

against the state's interest in deciding how to use its limited budget for providing medical assistance. The plaintiff's right would prevail because the state's interest is vacuous in light of the evidence that universal, comprehensive health insurance programs exist which are more efficient and less expensive than existing challenged ones.