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# Dying for Dollars: Health Equity in the Age of Reform

## **Cover Page Footnote**

This paper received the Joseph Bernstein Prize for most significant legal writing in 2011.

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**DYING FOR DOLLARS:  
HEALTH EQUITY IN THE AGE OF REFORM**

MAX D. SIEGEL \*

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (“ACA”)<sup>1</sup> into law.<sup>2</sup> Almost instantly, fourteen state attorneys general joined together to file suit to challenge ACA in federal courts in Virginia and Florida.<sup>3</sup> These states took action amid widespread political rhetoric that condemned Congress for shattering its constitutional limits by invading citizens’ private decisions to purchase health insurance.<sup>4</sup> The rhetoric appears to have worked<sup>5</sup>: Public opinion polls have never shown a majority of U.S. citizens in favor of ACA,<sup>6</sup> and decrying reform has become a common tactic in American politics.<sup>7</sup>

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.).

2. Mike Sacks, *Lawsuits to Undo Key Parts of Health-Care Law Move Forward, So Far*, CHRISTIAN SCIENCE MONITOR, Sept. 29, 2010, at 8.

3. *Id.*

4. *See id.* (noting that state challenges to ACA hinge on the argument that Congress exceeded its powers under the Commerce Clause by forcing Americans to purchase health insurance they may not want).

5. Polling suggests widespread support for repeal of ACA. *See, e.g., Kaiser Health Tracking Poll–November 2010*, KAISER FAMILY FOUND. (Nov. 9, 2010), <http://www.kff.org/kaiserpolls/8120.cfm> (finding that fifty-six percent of voters in the November 2010 midterm election favored repeal of ACA in total or in part).

6. *See* Robert J. Blendon & John M. Benson, *Public Opinion at the Time of the Vote on Health Care Reform*, 362 NEW ENG. J. MED. e55(1), e55(1), e55(6) (Apr. 22, 2010), <http://www.nejm.org/doi/pdf/10.1056/NEJMp1003844> (mining data from thirty-three independent polls and finding that the majority of Americans have never been in support of the health care reform law).

7. *See, e.g., King on Obamacare: “It’s All Got to Go,”* FOX NEWS (Jan. 17, 2011, 4:29 PM), <http://video.foxnews.com/v/4499519/king-on-obamacare-its-all-got-to-go> (providing video of statements by Representative Steve King (R-IA), describing health care reform as “a malignant tumor that threatens to metastasize” and claiming that “it’s all got to go, pull it all out by the roots”). *But see* Dan Joseph, *Pelosi: Repealing Obamacare Would Do “Very Serious Violence to the National Debt,”* CNSNEWS.COM (Jan. 5, 2011), <http://www.cnsnews.com/news/article/pelosi-repealing-obamacare-would-have-do> (providing video of statements by Representative Nancy Pelosi (D-CA), observing that her colleagues would cause “very serious violence to the national debt and deficit” by repealing health care reform).

Few political trends are as divisive as the changing role of government in private health care coverage decisions. While many provisions of ACA are popular, including the law's intervention in private industry, ACA's call for individuals to purchase health insurance<sup>8</sup> remains a major cause of voter hostility.<sup>9</sup> Now, more than twenty states have issued legal challenges to ACA on the basis of its minimum essential coverage provision.<sup>10</sup> This provision would impose a "penalty" in the form of a tax on individuals who fail to purchase health insurance and who are not exempted in light of certain exceptions.<sup>11</sup> Virginia Attorney General Kenneth Cuccinelli successfully leveraged the minimum essential coverage provision in the United States District Court for the Eastern District of Virginia to assert that Congress exceeded its powers under the Commerce Clause<sup>12</sup> by using a tax on citizens to regulate beyond its constitutional powers.<sup>13</sup> Virginia's

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8. See 42 U.S.C.A. § 18091 (West 2010) (setting out the individual responsibility requirement), held *unconstitutional* by Florida *ex rel.* Bondi v. U.S. Dep't of Health & Human Servs., No. 3:10-cv-91-RV/EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011).

9. See *Kaiser Health Tracking Poll–November 2010*, *supra* note 5 (finding that although the majority of voters favored key provisions of ACA, such as financial subsidies that enable "low and moderate income" citizens to purchase insurance and the prohibition against denial of coverage based on preexisting conditions or medical history, voters widely disfavored the individual mandate, with "two-thirds of the general public" supporting its repeal).

10. See Sacks, *supra* note 2 (explaining that the suit filed in federal district court in Florida by the state's attorney general challenging the minimum essential coverage provision of ACA has been joined by nineteen other states, as well as the National Federation of Independent Business and two individuals from Florida and Washington). Although other proceedings continue to move forward, federal judges have upheld ACA on two occasions and dismissed twelve other cases on procedural grounds. Karen Pallarito, *Court Fight Over Health-Care Reform Shifts to Florida*, USA TODAY, Dec. 16, 2010, <http://www.healthscout.com/news/68/647579/main.html>.

11. 26 U.S.C.A. § 5000A (West 2010), held *unconstitutional as not severable* by Bondi, 2011 WL 285683. The provision sets out that "[a]n applicable individual shall for each month beginning after 2013 ensure that the individual, and any dependent of the individual who is an applicable individual, is covered under minimum essential coverage for such month." *Id.* § 5000A(a). Exemptions are available for individuals who are unable to pay, who have religious views that conflict with purchasing health insurance, who are incarcerated, and who enjoy Native American tribal membership. *Id.* § 5000A(d)–(e).

12. The Constitution provides Congress with the power "[t]o regulate Commerce with foreign Nations, and among the several States, and with the Indian Tribes." U.S. CONST. art. I, § 8, cl. 3.

13. Virginia v. Sebelius, 728 F. Supp. 2d 768, 771–72, 781–82 (E.D. Va. 2010). States such as Virginia have averred that all of ACA must be deemed invalid because the minimum essential coverage provision is an essential and non-severable piece of the act. Complaint for Declaratory & Injunctive Relief at 6, *Sebelius*, 728 F. Supp. 2d 768 (No. 3:10CV188). According to the district court in *Sebelius*, Virginia's position relied in large part on the fact that Secretary of the Department of Health and Human Services Kathleen Sebelius has repeatedly stated that the minimum coverage requirement is a fundamental aspect of ACA. See *Sebelius*, 728 F. Supp. 2d at 789 (noting "the Secretary's frequent contention that [the minimum coverage provision] is the linchpin of the entire health care regimen underlying the ACA"). In his decision for the Northern District of Florida in *Bondi*, Judge Roger Vinson found all of ACA unconstitutional because the minimum essential coverage provision, which he held was an unconstitutional violation of the Commerce Clause, is non-severable. See *Bondi*, 2011 WL 285683, at \*39 ("I must conclude that

winning assertion tracked closely with arguments from other states<sup>14</sup>: If Congress cannot tax a citizen's choice to abstain from interstate commerce,<sup>15</sup> and if a refusal to purchase health insurance constitutes abstinence from interstate commerce,<sup>16</sup> then the minimum essential coverage provision is unconstitutional.<sup>17</sup>

Regardless of whether courts uphold ACA, the American debate continues to be distracted by marketplace rhetoric.<sup>18</sup> This preoccupation with the business of health thwarts meaningful exploration of health equity—a term this Comment employs as a proxy for the social determinants of health.<sup>19</sup> By challenging the process of health care

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the individual mandate and the remaining provisions [of ACA] are all inextricably bound together in purpose and must stand or fall as a single unit. The individual mandate cannot be severed.”).

14. See Pallarito, *supra* note 10 (noting that challengers across the country have made similar arguments about the constitutionality of ACA's minimum essential coverage provision).

15. See Complaint for Declaratory & Injunctive Relief, *supra* note 13, at 5 (arguing that “thus far in our history, it has never been held that the Commerce Clause, even when aided by the Necessary and Proper Clause, can be used to require citizens to buy goods or services”); see also Memorandum of the Cato Institute et al. as Amici Curiae Supporting Plaintiff's Opposition to Defendant's Motion to Dismiss at 21, *Sebelius*, 728 F. Supp. 2d 768 (No. 3:10CV188) (“Finding the mandate constitutional would be the first interpretation of the Necessary and Proper Clause or the taxing power to permit the regulation of inactivity—in effect requiring an individual to engage in an economic transaction.”). *But see* Brief Amici Curiae of the March of Dimes Foundation et al. in Support of Motion to Dismiss at 2, *Sebelius*, 728 F. Supp. 2d 768 (No. 3:10CV188) (arguing that taxing individuals who abstain from purchasing health insurance is a necessary and proper means to address the substantial effect that insurers' prohibition against covering individuals with preexisting medical conditions has on interstate commerce).

16. See Complaint for Declaratory & Injunctive Relief, *supra* note 13, at 1–2, 5 (arguing that “[t]he status of being a citizen or resident” of Virginia triggers compliance with ACA's individual mandate but “arises from an absence of commerce, not from some sort of economic endeavor”). A citizen's refusal to purchase health insurance, however, might also be construed as strongly tied to interstate commerce because the uninsured citizen is likely to one day require health services and will then shift costs of services to other consumers. See Brief Amici Curiae of the March of Dimes Foundation et al. in Support of Motion to Dismiss, *supra* note 15, at 1 (noting that uninsured individuals still utilize health care services and shift billions of dollars of costs to third parties).

17. See Complaint for Declaratory & Injunctive Relief, *supra* note 13, at 5–6 (suggesting that “permit[ting] the national government to require the purchase of goods or services would deprive the Commerce Clause of any effective limits . . . and would create powers indistinguishable from a general police power in total derogation of our constitutional scheme of enumerated powers”); see also *Sebelius*, 728 F. Supp. 2d at 771–72 (“The Commonwealth maintains that the failure, or refusal, of its citizens to elect to purchase health insurance is not economic activity historically subject to federal regulation under the Commerce Clause.”).

18. See John P. Geyman, *Myths as Barriers to Health Care Reform in the United States*, 33 INT'L J. HEALTH SERVICES 315, 316 (2003) (claiming that during the five serious attempts to universalize coverage in the United States over the last century, health care stakeholders have persistently used “disinformation and obfuscation to confuse and mislead the public,” including the American Medical Association repeatedly labeling national health insurance ““socialized medicine”” and the insurance industry raising fears of decreased options for choosing physicians).

19. Health equity is further distinguishable from public health, which relates to “the science and art of preventing disease, prolonging life, and promoting physical health and efficiency

financing and administration rather than focusing on more systemic forces in society, current health care reform<sup>20</sup> ignores the most influential factors in health, such as preexisting socioeconomic differentials and basic social conditions.<sup>21</sup> In Part I, this Comment will extricate ACA's regulatory outcome from the politics surrounding it.<sup>22</sup> Part I then will place the law within the United States's legal framework for addressing social determinants of health<sup>23</sup> and will provide context for comparing health systems in Europe and the United States.<sup>24</sup> In Part II, this Comment will scrutinize the depreciative impact of state challenges on the civic value of the American debate.<sup>25</sup> Using the German health system as a point of comparison, this Comment then will analyze ACA's limited potential to foster health equity<sup>26</sup> before concluding that ACA will fall short as a vehicle for enhanced solidarity in American health.<sup>27</sup> Finally, to protect citizens' health, the country's international reputation, and the integrity of the democratic process,<sup>28</sup> this Comment will urge policymakers to implement incremental, multisectoral advancements toward better health in the American body politic.<sup>29</sup>

## I. BACKGROUND

This Part provides a foundation for understanding ACA's effect in the broader context of health equity. First, this Part sets out ACA's underlying regulatory philosophy: Health care can be improved by shifting

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through organized community efforts." C.E.A. Winslow, *The Untilled Fields of Public Health*, 51 SCIENCE 23, 30 (1920).

20. This Comment distinguishes health care reform from health reform on the basis of whether legislative and policy fixes have a meaningful impact on the social determinants of health. Later, this Comment will argue that ACA is a matter of health care reform because, at its core, ACA is a cost-containment mechanism that does not adequately contribute to improved health equity. See *infra* Part II.B.

21. Cf., e.g., Paula M. Lantz et al., *Socioeconomic Factors, Health Behaviors, and Mortality: Results from a Nationally Representative Prospective Study of US Adults*, 279 JAMA 1703, 1707 (1998) (finding that the elimination of behavioral risk factors, as well as increased health promotion and prevention efforts, would not be enough to curb the deleterious impact of socioeconomic differentials on mortality); Bruce G. Link & Jo Phelan, *Social Conditions As Fundamental Causes of Disease*, 35 J. HEALTH & SOC. BEHAV. 80, 80 (1995) (arguing against a myopic focus on the "proximal causes of disease" and in favor of paying "greater attention . . . to basic social conditions" in an effort to optimize the positive impact of reform).

22. See *infra* Part I.A.

23. See *infra* Part I.B.

24. See *infra* Part I.C.

25. See *infra* Part II.A.

26. See *infra* Part II.B.

27. See *infra* Part II.C.

28. See *infra* Part II.D.

29. See *infra* Part II.E.

responsibility and transactional dynamics among consumers and their business partners.<sup>30</sup> Second, this Part analyzes the preexisting legal framework for actuating health equity in the United States.<sup>31</sup> Finally, this Part examines the basis for comparisons between health in the United States and Europe and offers Germany as a prototype for the warring political philosophies governing health in the Western world.<sup>32</sup>

### A. *Unpacking the Regulatory Philosophy Behind ACA*

The most politicized aspects of the journey to health care reform have often been the least indicative of the final law's lasting impact.<sup>33</sup> Controversies over hot button issues like abortion and the Stupak-Pitts Amendment<sup>34</sup> are contrary to the statutory framework underlying the final product of the reform efforts because restrictions on federal funding betray

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30. See *infra* Part I.A.

31. See *infra* Part I.B.

32. See *infra* Part I.C.

33. For example, ACA and an associated executive order set forward rules for abortion that largely coincide with the Hyde Amendment, including rules prohibiting federal funding for abortion and allowing states to forbid abortion coverage in health plans offered through state-operated exchanges. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1303, 124 Stat. 119, 168-71 (2010); Exec. Order No. 13,535, 75 Fed. Reg. 15,599 (Mar. 24, 2010) (establishing an enforcement mechanism to ensure that federal funds dispersed under ACA are in accordance with the preexisting federal statutory restriction known as the Hyde Amendment). The Hyde Amendment refers to a long-running legislative provision restricting federal funding of abortion that has been attached to annual appropriations bill for the Department of Health and Human Services since 1976. See, e.g., NAT'L ABORTION FED'N, PUBLIC FUNDING FOR ABORTION: MEDICAID AND THE HYDE AMENDMENT 1 (2006), available at [http://www.prochoice.org/pubs\\_research/publications/downloads/about\\_abortion/public\\_funding.pdf](http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/public_funding.pdf) (explaining that in the three years between the United States Supreme Court's decision in *Roe v. Wade*, 410 U.S. 113 (1973), and passage of the Hyde Amendment in 1976, Medicaid funds covered abortion care without restriction); NAT'L COMM. FOR A HUMAN LIFE AMENDMENT, THE HYDE AMENDMENT 1 (Apr. 2008), available at <http://www.nchla.org/datasource/ifactsheets/4FSHydeAm22a.08.pdf> (observing that the Hyde Amendment has taken various forms since 1976 and noting that the United States Supreme Court affirmed its constitutionality in *Harris v. McRae*, 448 U.S. 297, 325-27 (1980)). Under ACA, states may choose to prohibit abortion coverage in health plans operating within state-operated exchanges. See 42 U.S.C.A. § 18023(a) (West 2010), held unconstitutional as not severable by Florida *ex rel.* Bondi v. U.S. Dep't of Health & Human Servs., No. 3:10-cv-91-RV/EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011).

34. The Stupak-Pitts Amendment, offered to amend the House's health care bill, the Affordable Health Care for America Act of 2010, H.R. 3962, 111th Cong. (2009), sought to apply the Hyde Amendment to the public option by prohibiting federal funding:

[T]o pay for any abortion or to cover any part of the costs of any health plan that includes coverage of abortion, except in the case where a woman suffers from a physical disorder, physical injury, or physical illness that would, as certified by a physician, place the woman in danger of death unless an abortion is performed, including a life-endangering physical condition caused by or arising from the pregnancy itself, or unless the pregnancy is the result of an act of rape or incest.

111 CONG. REC. H12921 (daily ed. Nov. 7, 2009) (statement of Rep. Bart Stupak).

the more gradual, externalized changes ACA stands to make.<sup>35</sup> This Section describes health care reform's overarching regulatory philosophy by detailing the transformative economic role lawmakers intended ACA to play in shaping the behavior of states, private insurers, and employers,<sup>36</sup> as well as consumers of health services across the country.<sup>37</sup>

1. *ACA Reforms Health Care by Changing the Business of Accessing Services*

ACA compels insurers and employers to cover a wider array of individuals and conditions for less by restricting the ability of insurers and employers to limit coverage or turn away potential consumers.<sup>38</sup> In the process, ACA taps states to provide oversight of private health insurance coverage.<sup>39</sup>

Increasingly, health insurance companies must cover more health services for a larger variety of individuals. In September 2010, ACA began prohibiting health insurers from offering policies that limit lifetime benefits.<sup>40</sup> That same month, ACA forbade annual limits in policies restricting benefits that the Secretary of Health and Human Services ("the Secretary") deemed essential.<sup>41</sup> In addition, health insurers could no longer

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35. Cf. Jonathan Oberlander, *A Vote for Health Care Reform*, 362 NEW ENG. J. MED. e44(1), e44(2) (Apr. 1, 2010), <http://www.nejm.org/doi/pdf/10.1056/NEJMp1002878> (emphasizing the political risks involved in passing health care reform that is implemented slowly over a period of four years).

36. See *infra* Part I.A.1.

37. See *infra* Part I.A.2.

38. See Christopher C. Jennings, *Implementation and the Legacy of Health Care Reform*, 362 NEW ENG. J. MED. e51(1), e51(2) (Apr. 15, 2010), <http://www.nejm.org/doi/pdf/10.1056/NEJMp1003709> (cataloguing ACA's regulatory changes to the insurance and small-business market, including its prohibition against rescissions and lifetime ceilings on insurance payouts, its expansion of coverage to young adults under twenty-six, and its provision of tax credits to small employers that provide employee coverage).

39. Cf. Sara Rosenbaum, *Can States Pick Up the Health Reform Torch?*, 362 NEW ENG. J. MED. e29(1), e29(3) (Mar. 11, 2010), <http://www.nejm.org/doi/pdf/10.1056/NEJMp1001439> (describing how both the House and Senate health care reform bills balanced the need for increased federal regulation in health care delivery against the understanding that meaningful improvements required national efforts).

40. 42 U.S.C.A. § 300gg-11(a)(1)(A) (West 2010) (prohibiting group health plans and health insurance issuers from placing "lifetime limits on the dollar value of benefits for any participant or beneficiary"), held *unconstitutional as not severable* by Florida *ex rel.* Bondi v. U.S. Dep't of Health & Human Servs., No. 3:10-cv-91-RV/EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011).

41. *Id.* § 300gg-11(a)(2) ("With respect to plan years beginning prior to January 1, 2014, a group health plan and a health insurance issuer offering group or individual health insurance coverage may only establish a restricted annual limit on the dollar value of benefits for any participant or beneficiary with respect to the scope of benefits that are essential health benefits . . . as determined by the Secretary.").



rescind coverage once initiated,<sup>42</sup> and going forward, all insurers must cover uninsured individuals with preexisting conditions<sup>43</sup> and children under the age of twenty-six.<sup>44</sup>

Similar provisions represent how ACA limits employers' ability to turn away or disqualify individuals from coverage. Currently, ACA bars sponsors of group health plans from generating plans that discriminate in favor of employees who earn higher wages.<sup>45</sup> Likewise, in January 2014, providers of group health insurance plans will face a prohibition against exclusions due to preexisting conditions.<sup>46</sup> ACA also supports the establishment of a Small Business Health Options Program to assist small businesses in covering their employees.<sup>47</sup>

With ACA, Congress called upon the states to ensure that individuals seeking coverage would be empowered both when purchasing health insurance as individuals and when relying on their employers to facilitate group coverage. Specifically, ACA tasks each state with establishing an American Health Benefit Exchange—a governmental or nonprofit entity that helps carry out ACA's mandates.<sup>48</sup> By January 2014, states will operate exchanges that facilitate the purchase of health plans, and these exchanges must implement procedures to determine which health plans

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42. *Id.* § 300gg-12 (prohibiting health insurance rescission except in instances of fraud or intentional misrepresentation of material fact), *held unconstitutional as not severable by Bondi*, 2011 WL 285683.

43. *Id.* § 18001(d) (defining individuals eligible under the Act as citizens, nationals, or individuals otherwise lawfully present in the United States who have not been covered in the previous six months through the high risk pool and who have a preexisting condition), *held unconstitutional as not severable by Bondi*, 2011 WL 285683.

44. *Id.* § 300gg-14 (extending dependent coverage until the child turns 26), *held unconstitutional as not severable by Bondi*, 2011 WL 285683.

45. *Id.* § 300gg-16 (restricting discrimination in favor of highly compensated individuals for group health plans other than self-insured plans), *held unconstitutional as not severable by Bondi*, 2011 WL 285683.

46. *Id.* § 300gg-3(a), (b) (prohibiting exclusion based on preexisting condition and defining "preexisting condition exclusion" as "a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date"), *held unconstitutional as not severable by Bondi*, 2011 WL 285683.

47. *Id.* § 18031(a), (b) (enabling the Secretary to make awards to states to establish an American Health Benefit Exchange, which includes a Small Business Health Options Program "that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State"), *held unconstitutional as not severable by Bondi*, 2011 WL 285683.

48. *See id.* § 18031(b), (d) (calling for each state to establish an American Health Benefit Exchange no later than January 1, 2014, to facilitate the purchase of health plans, assist employers in fostering employee coverage, and generally make available qualified health plans to individuals and employers).

qualify under ACA.<sup>49</sup> States may even demand that health plans offer benefits beyond the “essential health benefits package” required by the Secretary to be deemed “qualified” and may require that any health plan seeking certification submit a justification for premium increases.<sup>50</sup> As a result, Congress delegated considerable oversight of health insurance companies to the states; because these oversight powers require states to regulate private industry and simultaneously improve citizens’ access to coverage, lawmakers have fostered a health care paradigm in which consumers may look to external entities for support without limiting their capacity for personal decision making.<sup>51</sup>

## 2. *ACA Strives to Improve Health Through Risk Pooling and Preparation*

Beyond new federal and state regulations controlling access to health care,<sup>52</sup> lawmakers expected ACA to change the function of citizens in the American health care system. Congress anticipated that individuals would contribute to healthier communities by purchasing insurance based on the controversial minimum essential coverage provision, which seeks to enable insurance coverage of those most in need of care by shifting costs to healthier third parties in their communities.<sup>53</sup> Simultaneously, Congress hoped that new funding and incentives would bolster prevention and wellness programs in both the public and private sectors.<sup>54</sup>

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49. See *id.* § 18031(d) (describing minimum requirements for American Health Benefits Exchanges, including “procedures for the certification, recertification, and decertification . . . of health plans as qualified health plans,” as well as “operation of a toll-free telephone hotline to respond to requests for assistance” and maintenance of “an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans”).

50. See *id.* § 18021(a) (defining qualified health plan), *held unconstitutional as not severable by Bondi*, 2011 WL 285683; *id.* § 18022(a)–(b) (defining and setting forth the requirements of essential health benefits package), *held unconstitutional as not severable by Bondi*, 2011 WL 285683; *id.* § 18031(d)(3)(B), (e) (setting forth required and permissible actions by state Exchanges).

51. See Jonathan Oberlander, *Beyond Repeal—The Future of Health Care Reform*, 363 NEW ENG. J. MED. 2277, 2277–78 (2010) (discussing states’ oversight of ACA’s key provisions and the risk that repeal poses to newly insured citizens).

52. See *supra* Part I.A.1.

53. See 42 U.S.C.A. § 18091(a) (asserting the congressional finding that, without essential coverage requirements, many individuals would wait to purchase health care until completely necessary and insurance providers would continue to engage in adverse selection), *held unconstitutional by Bondi*, 2011 WL 285683.

54. See, e.g., *id.* § 280g-13(a)–(b) (empowering the Secretary to act through the Centers for Disease Control and Prevention to enhance surveillance of congenital heart disease and identify opportunities for educational outreach and prevention), *held unconstitutional as not severable by Bondi*, 2011 WL 285683; *id.* § 280g-14(a) (calling for the creation of a national diabetes prevention program), *held unconstitutional as not severable by Bondi*, 2011 WL 285683; *id.*

State challenges to the minimum essential coverage provision grounded in arguments that ACA unfairly deprives citizens of wealth belie congressional intent because, like restrictions on employer or insurer cost-containment mechanisms,<sup>55</sup> the minimum essential coverage provision is intended to empower individuals by shifting costs to third parties. Lawmakers anticipated that the minimum essential coverage provision—and various other provisions of ACA—would expand the health insurance pool and ensure that more healthy individuals receive coverage.<sup>56</sup> The law states that the minimum essential coverage provision “is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.”<sup>57</sup> Accordingly, lawmakers decided to balance new, more costly enrollees with cheaper, healthier enrollees in order to help lower health insurance premiums and increase access to care.<sup>58</sup> This provision has an immediate negative effect on the minority of U.S. citizens who do not have health insurance because it penalizes their refusal to purchase coverage; the provision has a beneficial effect, however, on previously disqualified individuals who will come to rely on the participation of those newly insured, healthier individuals in order to pool risk and maintain access to care.<sup>59</sup>

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§ 280m(a) (designating the Secretary to conduct a national education campaign to increase public awareness about breast health and cancer); *id.* § 300u-14(a) (authorizing grants to health departments and Indian tribes to carry out community interventions, screenings, and clinical referrals for individuals between the ages fifty-five and sixty-four), *held unconstitutional as not severable by Bondi*, 2011 WL 285683; *id.* § 713(a)–(b) (authorizing the Secretary to provide allotments to states, or three-year grants to local organizations and entities in nonparticipating states, that implement evidence-based sexuality education programs), *held unconstitutional as not severable by Bondi*, 2011 WL 285683; *id.* § 280l (setting out provisions to improve utilization of wellness programs in the workplace).

55. *See supra* Part I.A.1.

56. *See* 42 U.S.C.A § 18091 (stating that the requirement to maintain essential coverage, along with other provisions, “will add millions of new consumers to the health insurance market” and that this requirement will encompass healthy individuals while expanding the insurance risk pool).

57. *Id.*

58. *See id.* (explaining that the minimum essential coverage provision will add millions of consumers to the insurance market while increasing the supply of and demand for health services, increasing the number and share of insured Americans, and lowering health insurance premiums by broadening the health insurance risk pool).

59. Comparison with Massachusetts’s “early experience with health care reform” provides support for this conclusion. *See generally* Amitabh Chandra et al., *The Importance of the Individual Mandate—Evidence from Massachusetts*, 364 NEW ENG. J. MED. 293, 293–95 (2011). After its individual mandate took full effect, Massachusetts saw an increase in healthy enrollment of “residents with incomes between 150 and 300% of the poverty level” despite the availability of state insurance subsidies during the phase-in of the mandate; this increase evidenced a causal connection between the Massachusetts mandate and improved risk selection. *Id.* The Massachusetts example suggests that the mandatory coverage under ACA is likely to play an even

ACA also works to improve health more directly by fostering behavioral improvements and preventing disease. Under ACA, health plans are likely to cover a variety of preventive services.<sup>60</sup> This renewed focus on prevention extends to small business owners, who may be eligible for grants to implement prevention-focused workplace wellness programs.<sup>61</sup> ACA also requires increased governmental intervention focused on improving public health, such as the development of a National Prevention and Health Promotion Strategy that prioritizes ways to actuate lifestyle behavioral modifications.<sup>62</sup> At the same time, potential health care consumers will have new incentives to make better health care decisions.<sup>63</sup> Enhanced disease prevention could reshape the impact of participants in the health care system by decreasing the frequency of emergency medical procedures and the incidence of costly lifestyle diseases.<sup>64</sup>

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more significant role in encouraging healthy enrollment because the subsidies available under ACA are smaller than those available under the Massachusetts statute. *Id.* at 295.

60. For instance, ACA currently requires all new plans to cover preventive services and immunizations recommended by the U.S. Preventive Services Task Force and the Centers for Disease Control and Prevention, as well as child preventive services and women's preventive care and screening recommended by the Health Resources and Services Administration. 42 U.S.C. § 300gg-13(a), *held unconstitutional as not severable by Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, No. 3:10-cv-91-RV/EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011). By September 30, 2013, the Secretary is required to report on the demonstrated potential of community prevention and wellness programs to help Medicare beneficiaries make healthier lifestyle choices and reduce their risk for disease, disability, and injury. *Id.* § 300u-14(b), *held unconstitutional as not severable by Bondi*, 2011 WL 285683. ACA also tasks the Secretary with designating essential health benefits for insurance plans that include preventive and wellness services and chronic disease management. *Id.* § 18022(a)-(b), *held unconstitutional as not severable by Bondi*, 2011 WL 285683. Other essential services may include mental health and substance abuse disorder services, hospitalization, emergency services, prescription drugs, and pediatric services. *Id.*

61. *Id.* § 280l note, *held unconstitutional as not severable by Bondi*, 2011 WL 285683. The workplace wellness programs must be consistent with evidence-based standards, including the Guide to Community Preventive Services and the Guide to Clinical Preventive Services. *Id.*

62. *Id.* § 300u-10 (calling for the President to establish a "National Prevention, Health Promotion and Public Health Council" to coordinate prevention, wellness, and health promotion efforts and the public health system, develop and subsequently report on a national strategy, provide recommendations to the President and Congress, consider and propose transformative models of prevention and health promotion, and carry out other activities as designated by the President), *held unconstitutional as not severable by Bondi*, 2011 WL 285683.

63. For example, no later than January 1, 2019, the Secretary may establish an incentives program for Medicare beneficiaries who utilize high quality physicians. *Id.* § 1395w-5(h), *held unconstitutional as not severable by Bondi*, 2011 WL 285683.

64. See, e.g., James F. Fries et al., *Reducing Health Costs by Reducing the Need and Demand for Medical Services*, 329 NEW ENG. J. MED. 321, 321 (1993) (suggesting expanded health promotion and preventative care as ways of limiting health care costs in the United States). So-called "lifestyle" diseases are "chronic, noncommunicable . . . diseases like cardiovascular disease and diabetes." Lindsay F. Wiley, *Adaptation to the Health Consequences of Climate Change as a Potential Influence on Public Health Law and Policy: From Preparedness to Resilience*, 15 WIDENER L. REV. 483, 496 (2010); see also P. Zimmet, *Globalization, Coco-Colonization, and*

Ultimately, ACA transforms health care by redistributing the financial weight and reach of an individual's health outcomes. Insurers and employers will find it increasingly difficult to save money by avoiding responsibility for the costs of those most in need of care, and vulnerable populations will have more reasons to rely on their states to ensure providers are operating within the regulations.<sup>65</sup> In the future, citizens will stand to gain more than just their health by taking affirmative steps to ensure their personal wellbeing, and promoting positive health outcomes will be a matter of business strategy—for virtually everyone.<sup>66</sup>

### *B. The State's Idle Monopoly on Health Equity*

Simultaneous to the political pursuit of improved health equity, the judiciary has rejected individual attempts to assert affirmative rights, such as a right to welfare,<sup>67</sup> while allotting broad deference to the states' promotion of health.<sup>68</sup> This Section explores the absence of positive rights in American jurisprudence and balances this absence against the tendency of courts to subjugate individual liberty interests to governmental attempts to contain medical costs and improve public health and safety.

#### *1. No Right to Health Equity in American Constitutional Law*

United States citizens do not have a constitutionally guaranteed right to governmental assistance to meet their most basic needs.<sup>69</sup> Consequently, state interventions that address social determinants of health are byproducts

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*the Chronic Disease Epidemic: Can the Doomsday Scenario Be Averted?*, 247 J. INTERNAL MED. 301, 305 (2000) (listing cancer and heart disease as examples of "lifestyle" diseases).

65. See *supra* Part I.A.1.

66. Jonathan Gruber, *The Cost Implications of Health Care Reform*, 362 NEW ENG. J. MED. 2050, 2051 (2010) (asserting that ACA wisely employs a rich variety of cost-control mechanisms and represents an essential step toward improved financial efficiency and reduction of the federal deficit).

67. See *infra* Part I.B.1.

68. See *infra* Part I.B.2.

69. For a discussion of Supreme Court cases that rejected rights to welfare, housing, public education, and medical services in the U.S. Constitution, see Robert Doughten, *Filling Everyone's Bowl: A Call to Affirm a Positive Right to Minimum Welfare Guarantees and Shelter in State Constitutions to Satisfy International Standards of Human Decency*, 39 GONZ. L. REV. 421, 426–28 (2004) (citing *Dandridge v. Williams*, 397 U.S. 471 (1970); *Lindsey v. Normet*, 405 U.S. 56 (1972); *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1 (1973); *Harris v. McRae*, 448 U.S. 297 (1980)); see also *DeShaney v. Winnebago County Dep't Soc. Servs.*, 489 U.S. 189, 196 (1989) (“[O]ur cases have recognized that the Due Process Clauses generally confer no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests of which the government itself may not deprive the individual.”).

of the political process rather than constitutionally motivated judicial intervention.<sup>70</sup>

The Constitution limits and empowers government. Generally, the Constitution does not create positive rights.<sup>71</sup> For example, in *DeShaney v. Winnebago County Department of Social Services*,<sup>72</sup> the Supreme Court of the United States found that governmental obligations could arise from political processes but not the Constitution.<sup>73</sup> The citizen only possesses affirmative rights in limited contexts, such as state-imposed detention.<sup>74</sup> In such instances, the government's constitutional obligation to the individual emanates "from the limitation which it has imposed on his freedom to act on his own behalf" rather than "the State's knowledge of the individual's predicament."<sup>75</sup>

The Supreme Court does not recognize an affirmative right to welfare<sup>76</sup> despite cases like *Shapiro v. Thompson*,<sup>77</sup> in which the Court noted that durational residential requirements for welfare benefits cut to the

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70. *But see* Sarah C. Carey, *A Constitutional Right to Health Care: An Unlikely Development*, 23 CATH. U. L. REV. 492, 492 (1973) (examining the formation of a legislative system of health care through state and federal legislation and applying constitutional guarantees within that system); Doughten, *supra* note 69, at 426 ("The recent trend in cutting welfare benefits indicates that the poor in the United States cannot rely on the democratic process to protect their interests. In fact, the poor have been categorized as a 'forgotten group' who are virtually invisible in a democratic system primarily driven by the desires of the wealthy.").

71. *See* Jackson v. City of Joilet, 715 F.2d 1200, 1203 (7th Cir. 1983) (Posner, J.) ("[T]he Constitution is a charter of negative rather than positive liberties."); *see also, e.g.*, Michael J. Gerhardt, *The Ripple Effects of Slaughter-House: A Critique of a Negative Rights View of the Constitution*, 43 VAND. L. REV. 409, 409–10 (1990) (discussing the ways in which the judiciary's refusal to impose affirmative duties on the state, such as the duty to protect against private violence or the duty to assist women in receiving abortions, reinforces the general notion that the Constitution only requires the government to *refrain* from certain actions).

72. 489 U.S. 189. The plaintiff in *DeShaney* had been repeatedly beaten by his father to the point of lifelong mental impairment. *Id.* at 191, 193. The boy and his mother filed suit against the county department of social services, alleging that the office had clear knowledge about the abuse and did not act to remove the child. *Id.* at 192–93. The Supreme Court held that the State does not have a constitutional obligation to protect citizens from private violence. *See id.* at 200, 203 (distinguishing a "State's affirmative act of restraining [an] individual's freedom to act on his own behalf," which triggers Due Process protections, from the State's "failure to act to protect [an individual's] liberty interests against harms inflicted by other means").

73. *Id.* at 195–96, 203.

74. *Id.* at 200.

75. *Id.* at 199–200.

76. *See supra* note 69.

77. 394 U.S. 618 (1969), *overruled in part by* Edelman v. Jordan, 415 U.S. 651 (1974). In *Shapiro*, the Supreme Court considered three district court judgments separately holding laws in Connecticut, Pennsylvania, and the District of Columbia that "denie[d] welfare assistance to residents of the State or District who have not resided within their jurisdictions for at least one year immediately preceding their applications for such assistance" unconstitutional. *Id.* at 621–27. The Supreme Court affirmed the district court decisions on the grounds that the statutes infringed on welfare recipients' constitutional right to travel. *Id.* at 629–31.

core of “the ability . . . to obtain the very means to subsist—food, shelter, and other necessities of life.”<sup>78</sup> Advocates for legal reform urged the Court to construe decisions like *Shapiro* to create a fundamental interest in welfare.<sup>79</sup> Despite these urgings, the Court has repeatedly rejected state-mediated welfare as a constitutionally protected fundamental interest.<sup>80</sup>

The absence of constitutionally guaranteed welfare rights has garnered significant attention on the national stage, but it has failed to produce substantive change in the structure of the law in the United States. President Franklin Delano Roosevelt’s proposal of a “Second Bill of Rights” was among the most notable historical moments in the struggle for guaranteed access to welfare.<sup>81</sup> Importantly, “[t]he right to adequate medical care and the opportunity to achieve and enjoy good health” took its place in President Roosevelt’s proposal.<sup>82</sup> Yet, President Roosevelt sought legislative action to embody his Second Bill of Rights<sup>83</sup> and fell short of promoting constitutional amendments or judicial enforcement that could have transformed welfare rights in today’s legal system.<sup>84</sup>

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78. *Id.* at 627.

79. In 1977, Professor Tribe stated that no “recent decision provides a clear indication that the Supreme Court regards basic governmental services as constitutional rights of individuals.” Laurence H. Tribe, *Unraveling National League of Cities: The New Federalism and Affirmative Rights to Essential Government Service*, 90 HARV. L. REV. 1065, 1078–79 (1977). Yet, Professor Tribe maintained that “the cases do not foreclose such an approach” either and was “convinced that, despite its difficulties, a doctrine will ultimately emerge that recognizes under the fifth and fourteenth amendments constitutional rights to decent levels of affirmative governmental protection in meeting the basic human needs of physical survival and security, health and housing, employment and education.” *Id.* at 1065–66, 1078–80; see also Frank I. Michelman, *Welfare Rights in a Constitutional Democracy*, 1979 WASH. U. L.Q. 659, 686 app. A (highlighting that the Supreme Court “found it significant that the challenged requirement [in *Shapiro*] operated to ‘[deny] welfare aid upon which may depend the ability of families to obtain the very means to subsist’” (second alteration in original) (quoting *Shapiro*, 394 U.S. at 627)).

80. See *Richardson v. Belcher*, 404 U.S. 78, 83–84 (1971) (finding constitutional a provision of the Social Security Act that limited disability benefits based on receipt of workers’ compensation but not based on receipt of private insurance); *Dandridge v. Williams*, 397 U.S. 471, 485–86 (1970) (holding that the Constitution only requires states to show a “reasonable basis” for denying welfare services).

81. See CASS R. SUNSTEIN, *THE SECOND BILL OF RIGHTS: FDR’S UNFINISHED REVOLUTION AND WHY WE NEED IT MORE THAN EVER* 12–13 (2004) (noting that President Roosevelt proposed his now famous Second Bill of Rights to urge Americans to find “a new basis of security and prosperity . . . regardless of station, race, or creed”).

82. *Id.* at 13 (articulating the components of President Roosevelt’s Second Bill of Rights).

83. See, e.g., *id.* at 15 (asserting that the G.I. Bill was among the most prominent legislative fixes attributable to the Second Bill of Rights). The “G.I. Bill” refers to the Servicemen’s Readjustment Act of 1944, Pub. L. No. 78-346, 58 Stat. 284, which provided educational and vocational opportunities, as well as unemployment compensation, to World War II veterans.

84. See SUNSTEIN, *supra* note 81, at 14 (recalling Roosevelt’s assertion that “it is definitely the responsibility of the Congress” to execute the Second Bill of Rights).

2. *The State Has Broad Power to Regulate Health and Contain Medical Costs*

Without the constitutional or legal infrastructure necessary to support citizens' assertions of positive rights to welfare,<sup>85</sup> the State has justified health laws as matters within its police power, often motivated by an interest in cost-containment.<sup>86</sup> Concurrent with broad governmental acts to promote health,<sup>87</sup> courts have rejected citizens' attempts to evade or compel health laws.<sup>88</sup>

The Supreme Court has long recognized an individual liberty interest in being free from unwanted medical treatment, but states' concerns have often outweighed the interests of citizens. The Supreme Court's reasoning in *Jacobson v. Massachusetts*<sup>89</sup> demonstrated the liberal standard the judiciary has applied when assessing the public health efforts of other branches of the government.<sup>90</sup> In *Jacobson*, the Court considered a compulsory Massachusetts law that required state residents to pay a penalty if they refused vaccination.<sup>91</sup> The Court attempted to "reconcil[e] individual interests in bodily integrity with collective interests in health and safety."<sup>92</sup> This individual liberty interest, however, could not outweigh the larger community's right to defend itself against disease.<sup>93</sup> As a result, the *Jacobson* Court analyzed the state's encroachment on a liberty interest by

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85. See *supra* Part I.B.1.

86. See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11, 24–25 (1905) ("The authority of the state to enact [a mandatory vaccination] statute is to be referred to what is commonly called the police power—a power which the state did not surrender when becoming a member of the Union under the Constitution."); see also *State v. Solomon*, 260 A.2d 377, 378–80 (Vt. 1969) (upholding a state mandatory motorcycle helmet law as within the state's police power and acknowledging that "self-injury may be of such a nature to also invoke a general public concern"). This dimension of American constitutional law is in sharp contrast with treatment of welfare in other countries. See, e.g., S. AFR. CONST., 1996 s. 27 ("Everyone has the right to have access to (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance.").

87. See James G. Hodge, *Implementing Modern Public Health Goals Through Government: An Examination of New Federalism and Public Health Law*, 14 J. CONTEMP. HEALTH L. & POL'Y 93, 93–94 (1997) (observing that public health regulation has emanated from governmental powers and become increasingly expansive throughout American history).

88. See notes 107–111 and accompanying text.

89. 197 U.S. 11.

90. See *id.* at 26 ("[T]he liberty secured by the Constitution of the United States to every person within its jurisdiction does not import an absolute right in each person to be, at all times and in all circumstances, wholly freed from restraint. There are manifold restraints to which every person is necessarily subject for the common good.").

91. *Id.* at 12.

92. Lawrence O. Gostin, *Jacobson v. Massachusetts at 100 Years: Police Power and Civil Liberties in Tension*, 95 AM. J. PUB. HEALTH 576, 577 (2005); see also *Jacobson*, 197 U.S. at 26.

93. *Jacobson*, 197 U.S. at 26–27.



looking for a real or substantial link to public health or, alternatively, “a plain, palpable invasion of rights secured by the fundamental law.”<sup>94</sup> In the end, the Court found that the statute was not in palpable conflict with the Constitution and that the legislature, in mandating vaccination under threat of criminal penalty, did not employ methods that lacked a real or substantial relation to public health.<sup>95</sup>

Compulsory vaccination is just one of many examples illustrating the government’s capacity to transform citizens’ lives. Judicial approval of health laws conforms to the underlying policy interest of the United States in remaining a safe, ordered society.<sup>96</sup> Later courts frequently employed the *Jacobson* rationale<sup>97</sup> and further reinforced the doctrinal underpinnings of the decision.<sup>98</sup> As the Court pointed out in *Jacobson*, an individual’s personal wishes, finances, and physical safety are all forfeited the moment the individual is drafted into the military.<sup>99</sup> Accordingly, as the Court noted in *Crowley v. Christensen*,<sup>100</sup> individual liberty interests necessarily bend to “such reasonable conditions as may be deemed by the governing authority of the country essential to the safety, health, peace, good order and morals of the community.”<sup>101</sup>

Despite the State’s established capacity to intervene in citizens’ health choices, courts have frequently analyzed health laws in the context of cost-containment. For example, the State has often provided cost-containment as a justification for compulsory helmet laws.<sup>102</sup> In accepting these justifications, courts have repeatedly quoted an observation made by Constitutional Law Professor Laurence Tribe: “In a society unwilling to

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94. *Id.* at 31.

95. *Id.*

96. *Id.* at 29.

97. See James Colgrove & Ronald Bayer, *Manifold Restraints: Liberty, Public Health, and the Legacy of Jacobson v. Massachusetts*, 95 AM. J. PUB. HEALTH 571, 571 (2005) (discussing the weight *Jacobson* carried in various challenges to vaccination laws and hundreds of other decisions alluding to the state’s authority to constrain behavior).

98. See, e.g., *New Orleans Gaslight Co. v. La. Light Co.*, 115 U.S. 650, 661 (1885) (suggesting that “the public health, the public morals, or the public safety” may rely on a police power among the states). A state’s police power must yield, however, in case of conflict, to the power invested in the federal government by the Constitution. *Gibbons v. Ogden*, 22 U.S. (9 Wheat.) 1, 42 (1824).

99. *Jacobson*, 197 U.S. at 29.

100. 137 U.S. 86 (1890).

101. *Id.* at 89.

102. See *Picou v. Gillum*, 874 F.2d 1519, 1522 (11th Cir. 1989) (construing Florida law) (explaining that a motorcyclist who fails to wear a helmet is more likely to suffer serious injury, costing the State more money in ambulance and police services, hospitalization costs, and public assistance, than it might had the motorcyclist not failed to wear a helmet); *Robotham v. State*, 488 N.W.2d 533, 541 (Neb. 1992) (analyzing lawmakers’ intentions to contain costs through a compulsory helmet law); *Benning v. State*, 641 A.2d 757, 762 (Vt. 1994) (accepting financial costs resulting from failure to wear a helmet as one basis for compulsory helmet laws).

abandon bleeding bodies on the highway, the motorcyclist or driver who endangers himself plainly imposes costs on others.”<sup>103</sup> Courts have even evoked health care reform to underscore the importance of compulsory helmet laws as mechanisms for medical cost-containment.<sup>104</sup> This focus on the economics of health is not necessarily the fault of the culture developed by American health jurisprudence and could be due, in part, to poor guidance from public health experts, who at times focus exclusively on access to health services and behavioral change,<sup>105</sup> as well as insufficient data about the effectiveness of health interventions.<sup>106</sup>

Citizens have also been unable to leverage potential liberty interests to compel increased health regulation. Courts have found no fundamental right to be free from non-naturally occurring radiation,<sup>107</sup> toxic chemicals,<sup>108</sup> or tobacco in the air.<sup>109</sup> Further, individual challenges to water fluoridation laws have failed to implicate fundamental rights to bodily integrity and privacy under the Ninth and Fourteenth

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103. *Picou*, 874 F.2d at 1522 (alteration omitted) (quoting LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 15-12, at 1371–72 (2d ed. 1988)) (internal quotation marks omitted); see also, e.g., *Benning*, 641 A.2d at 762 (same).

104. According to the Supreme Court of Vermont in *Benning*:

This rationale is particularly apparent as the nation as a whole, and this state in particular, debate reform of a health care system that has become too costly although many do not have access to it. Whether in taxes or insurance rates, our costs are linked to the actions of others and are driven up when others fail to take preventive steps that would minimize health care consumption. We see no constitutional barrier to legislation that requires preventive measures to minimize health care costs that are inevitably imposed on society.

641 A.2d at 762.

105. See S. Leonard Syme et al., *Incorporating Socioeconomic Factors into U.S. Health Policy: Addressing the Barriers*, 21 *HEALTH AFF.* 113, 114–15 (2002) (observing that public health experts in the United States fail to act on socioeconomic determinants of health due to their self-limiting organization around particular diseases).

106. See M. Gregg Bloche, *The Invention of Health Law*, 91 *CALIF. L. REV.* 247, 266–70 (2003) (charting the failure of the United States’s health system to practice evidence-based medicine).

107. See *Concerned Citizens of Neb. v. U.S. Nuclear Regulatory Comm’n*, 970 F.2d 421, 426–27 (8th Cir. 1992) (rejecting the argument that freedom from non-naturally occurring radiation is a fundamental right because such a right is not rooted in U.S. history or tradition).

108. See *In re Agent Orange Prod. Liab. Litig.*, 475 F. Supp. 928, 934 (E.D.N.Y. 1979) (dismissing plaintiffs’ argument for a constitutional right to be free from toxic chemicals because the alleged right has never been recognized under the Fifth, Ninth, or Fourteenth Amendments).

109. See *Gasper v. La. Stadium & Exposition Dist.*, 577 F.2d 897, 899 (5th Cir. 1978) (rejecting a constitutional argument for including the courts in tobacco cessation efforts).

Amendments.<sup>110</sup> Simply, courts have told citizens that they cannot control prophylactic measures taken by states to protect health and safety.<sup>111</sup>

Health regulations have expanded with modern society, and throughout this expansion the judiciary has repeatedly declared its profound deference to other branches of government.<sup>112</sup> While the State may compel individuals to improve their personal health and safety, citizens' notions of public welfare can never supersede the opinions of the State.<sup>113</sup> Thus, courts have stripped citizens of their power to demand health from their government as a matter of law in favor of total reliance on the political process, which has focused on cost-containment rather than citizens' most basic needs.<sup>114</sup>

### C. Comparative Health Reform and the German Model

Comparisons between health programs in the United States and models in Europe have served as rallying cries for political support.<sup>115</sup> This Section establishes the boundaries of such comparisons based on the theoretical foundations for health systems in European countries and the United States, as well as the regulatory synthesis of community solidarity and personal responsibility applied in both systems.<sup>116</sup> Grounds for

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110. *Coshov v. City of Escondido*, 34 Cal. Rptr. 3d 19, 29–31 (Cal. Ct. App. 2005) (concluding that there is no explicit or implicit constitutional right to water free from fluoridation).

111. *See Quiles v. City of Boynton Beach*, 802 So. 2d 397, 398–400 (Fla. Dist. Ct. App. 2001) (holding that a citizen could not successfully challenge the prophylactic measures taken by a municipality to prevent tooth decay).

112. *See supra* Part I.B.1.

113. *See supra* notes 86–111 and accompanying text. Although this Comment speaks to the state's monopoly on health and safety laws as a uniform condition, the American health paradigm has a varying impact on different segments of the U.S. population. *See, e.g.*, Vernellia R. Randall, *Slavery, Segregation and Racism: Trusting the Health Care System Ain't Always Easy! An African American Perspective on Bioethics*, 15 ST. LOUIS U. PUB. L. REV. 191, 191–93 (1996) (asserting that slavery, segregation, and racism function as intervening variables in the normative application of bioethical principles).

114. This preoccupation with finances carries over to potential avenues for reform, including reform of the civil justice system. *See generally, e.g.*, Dick Thornburgh, *America's Civil Justice Dilemma: The Prospects for Reform*, 55 MD. L. REV. 1074, 1076 (1996) (arguing that monetary interests rise to the forefront of any debate about reforming the legal system).

115. *See, e.g.*, Michael Goldfarb, *Where the Health Care Debate Seems Bizarre: Europeans Live Longer, Shake Heads over US Attitudes Toward Universal Health Care*, GLOBALPOST (July 21, 2009, 6:32 PM), <http://www.globalpost.com/dispatch/health/090721/comparing-healthcare-us-germany-france> (arguing that opponents of health reform in the United States proliferated “lies, damned lies” about health systems in Europe); Guillaume Vuilleme & Philip Stevens, Op-Ed., *Obamacare Failed in Europe*, WASH. EXAMINER (June 30, 2009, 12:00 AM), <http://washingtonexaminer.com/op-eds/2009/06/obamacare-failed-europe> (leveraging the health systems in Britain and France to assert that President Obama's plan for a public option would worsen financial and quality control problems in the United States).

116. *See infra* Part I.C.1.

comparison are especially strong in Germany, where incentive<sup>117</sup> programs are increasingly used to actuate shared regulatory principles that reflect a global shift toward the use of business strategies to improve health.<sup>118</sup>

### 1. *Understanding the German Comparison*

American and European health outcomes are driven by different theories but similar political dualities. The principles shared between American and European health systems provide a limited basis for comparison.<sup>119</sup> In particular, Germany is a prototype for the liberal and conservative political duality galvanizing Western health because the German health system combines leftist notions of solidarity with a conservative emphasis on personal responsibility.<sup>120</sup>

While grounds for comparison exist, Western health systems are far from identical. On the surface, European systems emerge from a different theoretical framework than systems in the United States.<sup>121</sup> European scholars call for a triad of “Responsibility, Solidarity and Subsidiarity” in health and view solidarity in particular as “deeply rooted in European culture and supported by secular . . . and Christian ethical positions.”<sup>122</sup> Yet, in both the United States and Europe, health care represents an amalgamation of leftist ideology, which attributes poor health to the environment and living conditions, combined with the ideology of the right, which focuses on individual behaviors and the link between entitlements and personal responsibility.<sup>123</sup> Accordingly, the political divide in the

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117. This Comment employs the terms bonus and incentives interchangeably and adopts the narrow definition of an incentive as “a material or idealistic benefit conditional on certain voluntary health related behaviour.” Harald Schmidt et al., *What Can We Learn from German Health Incentive Schemes?*, 339 BRIT. MED. J. 725, 727 (2009).

118. See *infra* Part I.C.2.

119. See Peter T. Sawicki, *Communal Responsibility for Health Care—The Example of Benefit Assessment in Germany*, 361 NEW ENG. J. MED. e42(1), e42(2)–(3) (Nov. 12, 2009), <http://www.nejm.org/doi/pdf/10.1056/NEJMp0908797> (remarking that Germany’s prioritization of individuals’ health and rights over government costs is a reaction to the Third Reich’s abuse of the concept of “public health,” but nonetheless suggesting the advantages a more community-based approach might offer in the United States).

120. See *id.* at e41(1) (observing that while the German health system’s emphasis on solidarity may seem socialist, a conservative German political figure first introduced the model more than a century ago).

121. See *id.* (explaining that many Germans are bewildered by debate over health care in the United States because most European people recognize strong community as the driving force for a successful health system and a prosperous society).

122. Hans-Martin Sass, *The New Triad: Responsibility, Solidarity and Subsidiarity*, 20 J. MED. & PHIL. 587, 587 (1995).

123. See Harald Schmidt, *Health Responsibility, the Left, and the Right*, BIOETHICS F. (July 6, 2007),

American health debate reflects disparate philosophies across the world, and tapping European systems is an appropriate method for analyzing the potential impact of Americans' contentious political ideologies on their country's health care.<sup>124</sup>

Germany's health system is ripe for a transatlantic comparison<sup>125</sup> because Germany's public health philosophy is a paradigmatic hybrid of personal responsibility and community solidarity. Article I of Book V of the German Social Security Code (Sozialgesetzbuch—SGB)<sup>126</sup> is titled "solidarity and responsibility."<sup>127</sup> Article I states that the purpose of statutory health insurance is to enhance the health of the individual while recognizing that insured citizens share responsibility for their health.<sup>128</sup> Germany expects its citizens to take responsibility for their health through "a health conscious lifestyle, through early involvement in health care measures, and through active participation in treatment or rehabilitation to help with the onset of illness and disability."<sup>129</sup> Accordingly, Germany's statutory health insurance attributes health outcomes to both the individual and "a caring society."<sup>130</sup>

Germany's belief in shared responsibility is not without limits. In explicit statutory language, Germany discourages overutilization and abuse of health services.<sup>131</sup> Article II of Book V speaks to "necessity, cost effectiveness, and personal responsibility."<sup>132</sup> Here, German insurers are told to provide coverage "with due respect to cost-effectiveness."<sup>133</sup> Coverage extends "insofar as the need for services is not attributable to the personal responsibility of the insured," and the insured must guarantee cost-effectiveness while seeking services "insofar as necessary."<sup>134</sup> Thus, while Germany designed its statutory insurance system to improve health

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<http://www.thehastingscenter.org/Bioethicsforum/Post.aspx?id=440> (detailing the ramifications of the polarizing discourse about personal responsibility in health emanating from both the political right and the political left).

124. See *infra* Part II.C.

125. See *infra* Part II.B–C.

126. Book V of the German Social Code (Sozialgesetzbuch—SGB) regulates the provision of statutory health care by German sickness funds, which provide care to approximately ninety percent of the German population. Harald Schmidt, *Bonuses as Incentives and Rewards for Health Responsibility: A Good Thing?*, 33 J. MED. & PHIL. 198, 200 (2008).

127. Sozialgesetzbuch V Gesetzliche Krankenversicherung [SGB] [SOCIAL CODE], art. I (Ger.) [hereinafter German Social Code, Book V].

128. *Id.*

129. *Id.*

130. *Id.*

131. Schmidt, *supra* note 126, at 200–01 (discussing and translating Article II, Book V of the German Social Code).

132. *Id.* at 200 (internal quotation marks omitted).

133. *Id.*

134. *Id.* at 200–01.

outcomes in light of community and personal autonomy, governmental support does not extend to especially irresponsible Germans.<sup>135</sup>

## 2. *Health Incentives That Eliminate Costs but Not Inequality*

Germany has balanced the health needs of diverse populations and the economic demands of quality care through innovative strategies to improve public health, including incentive programs aimed at modifying individual behavior.<sup>136</sup> Similar programs in the United States have been generally successful at promoting economic efficiency, but private market mechanisms such as incentive programs have not solved the problem of unequal access to health care across socioeconomic classes.<sup>137</sup>

Germany's focus on fostering community health has not been without attention to the financial bottom line. Providers in the German health system are particularly concerned with innovations that contain costs because they are legally obliged to use savings in their own programs to pay for bonuses and administrative overhead.<sup>138</sup> Thus, in 1994, Germany opened its insurance market to private providers with the hope of increasing overall efficiency.<sup>139</sup> Providers throughout Germany have increasingly adopted market mechanisms to stay competitive.<sup>140</sup> Since 2004, insurance providers have offered a range of bonuses for different health behaviors.<sup>141</sup> These bonuses are natural extensions of the German health system's emphasis on personal responsibility and are a response to the growing incidence and prevalence of lifestyle diseases.<sup>142</sup> Now, virtually every major insurer in Germany offers bonus systems to improve health outcomes and reduce overall costs.<sup>143</sup>

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135. For example, coverage does not extend to Germans when they engage in unnecessary bodily modifications, and amendments made in 2007 amplified Article 52, Book V of the German Social Code, which sets out conditions under which statutory sickness funds may limit covered services. *Id.* at 201. Under the 2007 amendments, insurers may ask for equivalent contributions for complications arising from "cosmetic surgery, tattoos[,] . . . piercings, or another non-medically indicated measures." *Id.* (internal quotation marks omitted).

136. See Schmidt et al., *supra* note 117, at 725–28 (explaining that Germany has used various incentive schemes to improve population health, efficiency, and competition).

137. See Harald Schmidt et al., *Carrots, Sticks, and Health Care Reform—Problems with Wellness Incentives*, 362 NEW ENG. J. MED. e3(1), e3(1) (Jan. 14, 2010), <http://www.nejm.org/doi/pdf/10.1056/NEJMp0911552> (cautioning against giving incentives an ethical free pass and warning that incentives pose a risk of inequity by further disadvantaging vulnerable populations).

138. German Social Code, Book V, *supra* note 127, § LXVa(3).

139. Schmidt, *supra* note 126, at 199.

140. *Id.*

141. *Id.*

142. *Id.*

143. *Id.*

These incentive programs have attained cost savings by attracting and retaining clients in similar ways to airlines or supermarkets that use loyalty schemes.<sup>144</sup> German insurance providers may offer “bonuses,” including cash, reductions in insurance contributions, and in-kind benefits for participation in health promotion, screening, and medical checkups.<sup>145</sup> For instance, individuals who participate in counseling sessions for cervical, bowel, and breast cancer and then do not refuse treatment can halve applicable co-payments.<sup>146</sup> Germany’s sickness funds offer participants bonus points for engaging in various medical activities, such as immunizations and checkups for chronic diseases.<sup>147</sup> Participants who redeem points may be eligible for in-kind bonuses like access to personal Internet-based electronic health records, backpacks, cycle helmets, kitchenware, sports watches, and partial funding of a short wellness holiday.<sup>148</sup> Conducting a preliminary evaluation, researchers found that incentives resulted in considerable savings, further supporting the staying power of these programs in the German health market.<sup>149</sup>

While financially successful, efforts to save have not benefited every German citizen. Bonuses have curbed overall health care costs,<sup>150</sup> and providers in various countries have shown interest in using incentive programs.<sup>151</sup> Yet, curbing costly chronic illnesses demands a more multifaceted approach.<sup>152</sup> For example, wealthier socioeconomic classes may have better access to workout facilities than poorer groups, which comparatively enhances the likelihood that wealthier citizens will meet targets for incentives such as healthier body mass indexes or lower

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144. *Id.* at 198–99, 208–12.

145. *Id.* at 208–09 (discussing Section 65a, Book V of the German Social Code).

146. *Id.*

147. Stephanie Stock et al., *Preliminary Analysis of Short Term Financial Implications of a Prevention Bonus Program: First Results from the German Statutory Health Insurance*, 53 INT’L J. PUB. HEALTH 78, 80 tbl.1 (2008).

148. *Id.* at 79; *see also* Schmidt, *supra* note 126, at 208.

149. Stock et al., *supra* note 147, at 83.

150. *Id.* at 78 (presenting data that suggests participation in health bonus plans decreased costs).

151. *See* KAREN JOCHELSON, KING’S FUND, PAYING THE PATIENT: IMPROVING HEALTH USING FINANCIAL INCENTIVES 3 (Dec. 2007), *available at* <http://www.wpro.who.int/NR/rdonlyres/BCC2F5C3-B685-4FF1-AE77-39C52F4ED247/0/payingthepatient.pdf> (describing health interventions in England, South Africa, Latin America, and the Caribbean that utilize financial incentives).

152. COMM’N ON THE SOC. DETERMINANTS OF HEALTH, WORLD HEALTH ORG., CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH 1 (2008), *available at* [http://whqlibdoc.who.int/publications/2008/9789241563703\\_eng.pdf](http://whqlibdoc.who.int/publications/2008/9789241563703_eng.pdf).

cholesterol.<sup>153</sup> Accordingly, participation in German incentive programs among the top socioeconomic quintile has been nearly double the participation among those in the lowest socioeconomic quintile.<sup>154</sup> Moreover, incentives pose varying degrees of value to different segments of the population.<sup>155</sup> If the German health system were able to eliminate barriers to equal utilization across socioeconomic strata, incentives may be so disproportionately advantageous to poorer individuals that participation in incentive programs could become unduly coercive or even involuntary.<sup>156</sup> Consequently, while incentives save money by encouraging the wealthier class to improve their lives, they intensify the consequences of poor health among less affluent citizens.<sup>157</sup>

In many respects, the history of German health care represents an inverse of the shift away from absolute private control toward greater public regulation in the United States because the German health system was once universally public and has become increasingly privatized.<sup>158</sup> Both systems will move forward as a blend of strong public regulation and private sector cost-containment mechanisms, with the United States uniquely poised to learn from Germany and, in particular, from the fate of its mutually supportive community model at the hands of market necessity.<sup>159</sup>

## II. ANALYSIS

While ACA's historical and international framework will not delimit its trajectory in American courts, this background denotes the law's limited capacity to improve American health. This Part argues that state challenges to ACA stall progress in the debate in the United States on health reform.<sup>160</sup> This Part then examines the equalizing effect ACA may have on the lives of citizens and concludes that more sweeping initiatives are necessary to

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153. See Schmidt et al., *supra* note 137, at e3(1) (explaining that targets for incentives such as achievement of a specific body mass index or cholesterol level are designed around the assumption that anyone "can achieve these targets if they try").

154. *Id.* at e3(2).

155. See *id.* at e3(3) (arguing that incentive schemes become problematic when those unable to reach targets are most in need of an award).

156. See *id.* ("Proponents emphasize that wellness incentives are voluntary. But . . . voluntariness can become dubious for lower-income employees, if the only way to obtain affordable insurance is to meet the targets.").

157. In addition, incentives may impair the provision of health care regardless of patients' socioeconomic contexts. See *id.* (observing that German health officials rejected statutory incentive schemes on the grounds that these schemes would compromise their therapeutic relationships by forcing them to police their patients).

158. See *supra* Part I.C.1.

159. See *infra* Part II.B–C.

160. See *infra* Part II.A.



address the social determinants of health.<sup>161</sup> Next, this Part explores ACA's limited potential to spark progress in American health principles<sup>162</sup> and asserts that prolonging the American status quo compromises the country's wellbeing, international standing, and democratic process.<sup>163</sup> Finally, this Part recommends practical solutions for cultivating better health equity in the United States.<sup>164</sup>

*A. State Challenges Detract from Meaningful Discourse About Health*

Challenges to ACA push dialogue about health away from health equity and toward a faceless investigation into what constitutes interstate commerce.<sup>165</sup> These challenges denigrate individual health outcomes and have a depreciative impact on the civic value of the American debate because they focus exclusively on the power of government to finance a new health care system.<sup>166</sup>

Current state challenges to ACA wrongly emphasize the power of government instead of focusing on the need for sweeping changes in citizens' lives. As in *Jacobson v. Massachusetts*,<sup>167</sup> a court that hears a challenge to ACA must consider the government's capacity to impose a penalty tax on citizens who refuse to participate in health care.<sup>168</sup> But unlike *Jacobson*, in which the claimant implicated a personal liberty interest because involuntary vaccination would violate his bodily integrity,<sup>169</sup> challenges to health care reform hinge on the minimum essential coverage provision and on whether government has the power to penalize abstinence from interstate commerce.<sup>170</sup> Regardless of the outcome of these

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161. See *infra* Part II.B.

162. See *infra* Part II.C.

163. See *infra* Part II.D.

164. See *infra* Part II.E.

165. See Sara Rosenbaum, A "Broader Regulatory Scheme"—*The Constitutionality of Health Care Reform*, 363 NEW ENG. J. MED. 1881, 1881–82 (2010) (dissecting legal challenges to ACA and analyzing their reliance on the Commerce Clause).

166. See Oberlander, *supra* note 51, at 2278 (observing that "[d]ivisions [about ACA] reflect ideological and partisan disagreements over the appropriate scope of government and markets").

167. 197 U.S. 11, 12 (1905) (examining Massachusetts's power to impose a monetary penalty on a citizen who refused vaccination).

168. See *Virginia v. Sebelius*, 728 F. Supp. 2d 768, 770–71 (E.D. Va. 2010) (considering Congress's power under the Commerce Clause to tax citizens who do not purchase health insurance).

169. *Jacobson*, 197 U.S. at 25–26.

170. *Sebelius*, 728 F. Supp. 2d at 771.

challenges, they temporarily neutralize the more sweeping reforms necessary to remedy the driving forces behind poor health outcomes.<sup>171</sup>

The federal government's power to override citizens' personal health decisions is already clear. The Constitution vests power to promote health and safety in every level of government,<sup>172</sup> and the State's monopoly on health regulation forces citizens to rely on governmental initiatives such as the minimum essential coverage provision to foster health equity.<sup>173</sup> Citizens do not have a constitutionally protected positive right to welfare,<sup>174</sup> but courts understand the vital impact of citizens' welfare on the State.<sup>175</sup> The government can impose penalties on individuals who avoid vaccination because, in an ordered society, the rights of the few cannot subordinate the common welfare.<sup>176</sup> Similarly, the government can regulate nutrition labeling,<sup>177</sup> the decision whether to wear a helmet,<sup>178</sup> and the chemicals in drinking water.<sup>179</sup> Moreover, the charge of the government to preserve public health implicates more than the community's right to defend against diseases<sup>180</sup> and includes the right to call upon citizens to sacrifice themselves in war.<sup>181</sup> The State has a long history of leveraging public health and safety to subordinate individual rights in a way that is akin to the economic liberties implicated by the essential minimum coverage provision.<sup>182</sup> Consequently, challengers' framing of the debate echoes the ultimately redundant abortion controversy that erupted during the passage of health care reform; those currently challenging the law fail to

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171. See, e.g., COMM'N ON THE SOC. DETERMINANTS OF HEALTH, *supra* note 152, at 1 (opining that "urgent and sustained" action is required at multiple levels of government to address inequities in power and economic distribution that degrade health equity).

172. LAWRENCE O. GOSTIN, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 6 (2000) ("The constitutional design reveals a plain intent to vest power in government, at every level, to protect community health and safety.")

173. See *supra* Part I.B.

174. See *supra* note 80 and accompanying text.

175. See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11, 26 (1905) ("There are manifold restraints to which every person is necessarily subject for the common good. On any other basis organized society could not exist with safety to its members. Society based on the rule that each one is a law unto himself would soon be confronted with disorder and anarchy.")

176. *Id.* at 28–29 (observing that the safety of the general public may require restraints on individual rights).

177. See, e.g., Nutrition Labeling and Education Act of 1990, Pub. L. No. 101-535, 104 Stat. 2353 (amending the Federal Food, Drug, and Cosmetic Act to require nutrition labeling).

178. See, e.g., *Benning v. State*, 641 A.2d 757, 758 (Vt. 1994).

179. See, e.g., *Coshov v. City of Escondido*, 34 Cal. Rptr. 3d 19, 29–31 (Cal. Ct. App. 2005); *Quiles v. City of Boynton Beach*, 802 So. 2d 397, 398–400 (Fla. Dist. Ct. App. 2001).

180. See *Jacobson*, 197 U.S. at 28 (noting the state's power to pass laws preserving sanitation, life, liberty, health, and property "within its limits").

181. See *id.* at 29 (observing that despite the liberty guaranteed under the Fourteenth Amendment, individuals can be compelled by force to die in the country's defense).

182. See *supra* Part I.B.2.

understand that the final product in the push for reform stands to make more gradual, externalized changes to health care.<sup>183</sup> Notwithstanding the judiciary's final decision on ACA, the current challenges stand, at most, to contribute to the rewriting of history rather than debate the future of laws that have far-reaching consequences in virtually every aspect of life.<sup>184</sup>

*B. ACA Is a Cost-Containment Measure When Americans Need Health Reform*

ACA does not signify the sweeping change in American health policy that is necessary to meaningfully address social determinants of health. ACA's underlying regulatory philosophy of improving health by changing health care costs could redefine the connection between health outcomes and employers and insurers, as well as the individuals to whom the health outcomes most directly belong.<sup>185</sup> Improving access to health services is an important step toward better health equity because it facilitates more universal coverage, but ACA falls short as a matter of true health reform.<sup>186</sup>

New regulation of employers and insurance companies and enhanced state oversight will force private entities to absorb the costs of individuals' poor health. ACA stands to drastically increase the number of insured in the United States.<sup>187</sup> To accomplish this goal, ACA pits private insurers against public entities, such as the states' American Health Benefit Exchanges,<sup>188</sup> because state and federal governments and nonprofits will

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183. See *supra* notes 33–35 and accompanying text.

184. Congressional attempts to kill ACA have been similarly shortsighted. See Joseph R. Antos, *Reforming Health Care Reform in the 112th Congress*, 364 NEW ENG. J. MED. 1, 2 (2011) (suggesting that while the House might successfully repeal ACA, a repeal bill will not pass the Senate, and arguing, additionally, that the Senate is likely to reject any language intended to stifle implementation of the law in a continuing resolution). Antos's first argument proved to be correct. See Mark Arseneault, *Congress Gears Up for Elections with Flurry of Votes*, BOS. GLOBE, May 6, 2011, at 2 ("Almost immediately after taking power in January, House Republicans passed legislation to repeal Obama's health care overhaul. . . . The Senate, as expected, quickly squashed the measure.").

185. See *supra* Part I.A.

186. See Bruce Siegel & Lea Nolan, *Leveling the Field—Ensuring Equity Through National Health Care Reform*, 361 NEW ENG. J. MED. 2401, 2401 (2009) (commenting that proposals to expand coverage would not be an entire solution to the health care problem and arguing that reform "[w]ithout an explicit focus on equity . . . [would] leave millions of Americans behind").

187. The Congressional Budget Office estimates the number of uninsured residents will drop by thirty-two million as a result of health care reform. Letter from Douglas W. Elmendorf, Dir., Cong. Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives and Attachments (Mar. 18, 2010), available at <http://www.cbo.gov/ftpdocs/113xx/doc11355/hr4872.pdf>.

188. 42 U.S.C.A. § 18031(a)–(b), (d) (West 2010) (enabling the Secretary to make grants for the creation of American Health Benefit Exchanges, which are governmental agencies or nonprofit entities that make available qualified health plans to citizens), held unconstitutional as not severable by Florida *ex rel.* Bondi v. U.S. Dep't of Health & Human Servs., No. 3:10-cv-91-RV/EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011).

control premium rates and essential coverage.<sup>189</sup> This new tension between the public and private sectors extends to employers as well, who will face broader coverage requirements for their employees.<sup>190</sup> Because an individual's health status cannot be a qualifier for coverage,<sup>191</sup> and because insurers can no longer engage in price gouging<sup>192</sup> or employers in salary-based coverage,<sup>193</sup> this new system transforms health into a business goal by resituating optimal financial gains behind improved health.

Thus, to keep their beneficiaries out of long-term care and to save money, private entities might contribute to prevention efforts emerging simultaneously from local and federal governmental entities, nonprofits, employers, and health insurers. ACA signals a step forward in the government's willingness to promote public health through preventive measures,<sup>194</sup> some of which private insurers will be required to cover.<sup>195</sup> Further, insurers could encourage employers to promote health among employees because employers are important gatekeepers to a large number of beneficiaries in the context of fixed premiums<sup>196</sup> and more universal coverage requirements.<sup>197</sup>

Employers and private insurers in the United States might also rely on incentive programs to promote their beneficiaries' health. As in Germany,

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189. *Id.* § 18031(d)(3), (e)(2) (empowering state-operated exchanges to require benefits beyond the essential health benefits designated by the Secretary).

190. *See id.* § 300gg-16 (prohibiting the limiting of coverage based on employees' salaries and the consideration of premium rates when determining whether to offer health plans), *held unconstitutional as not severable by Bondi*, 2011 WL 285683.

191. *Id.* § 18001 (establishing a system for "[i]mmediate access to insurance for uninsured individuals with a preexisting condition"), *held unconstitutional as not severable by Bondi*, 2011 WL 285683.

192. *See id.* § 18031(e)(2) (requiring insurers to submit justifications for any premium increase before implementation).

193. *See supra* note 190.

194. *See supra* Part I.A.2.

195. 42 U.S.C.A. § 300gg-13 (requiring group and individual insurers to cover at a minimum evidence-based items or services recommended by the United States Preventive Services Task Force, immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, and the Health Resources and Services Administration's recommended preventive care and screenings for children, youth, and women), *held unconstitutional as not severable by Bondi*, 2011 WL 285683.

196. *Id.* § 18031(e)(2) (requiring health plans to justify premium increases before implementation).

197. *See, e.g., id.* § 300gg-3 (prohibiting exclusions based on preexisting condition "or other discrimination based on health status"), *held unconstitutional as not severable by Bondi*, 2011 WL 285683; *id.* § 300gg-11 (prohibiting "lifetime limits" or "annual limits on the dollar value of benefits for any participant or beneficiary"), *held unconstitutional as not severable by Bondi*, 2011 WL 285683; *id.* § 300gg-14 (extending "dependant coverage of children . . . until the child turns 26 years of age"), *held unconstitutional as not severable by Bondi*, 2011 WL 285683; *id.* § 300gg-16 (prohibiting "discrimination in favor of highly compensated individuals"), *held unconstitutional as not severable by Bondi*, 2011 WL 285683.

incentive programs stand to improve the overall cost efficiency of the American health system.<sup>198</sup> Likewise, incentive programs could alleviate some of the financial burden endemic to covering treatment for lifestyle diseases.<sup>199</sup> In addition, when insurance providers uniformly offer all essential benefits at a fixed premium,<sup>200</sup> these providers need incentive programs to attract enrollees and distinguish themselves from their competitors.<sup>201</sup>

Incentive programs and broader coverage could spark a new legacy of improved access and contribute to better health equity. Fixed bonuses, such as those made in-kind using predetermined catalogues of goods or resulting in set dollar amounts,<sup>202</sup> are likely to provide more convincing incentives to seek out health care in poorer communities, which are less likely to be saturated with the latest goods and financial benefits being proffered as incentives than wealthier communities.<sup>203</sup> At the same time, providers could find new monetary motivations to engage underserved communities because poorer individuals will be more likely to possess coverage than in the past, and, at least within the first few years of ACA's implementation, poorer communities will need more serious medical care due, in large part, to current health inequity in the United States.<sup>204</sup> Thus, even if reform will not benefit everyone equally, ACA harnesses the private sector to foster improved health equity by giving insurance providers and health care professionals new reasons to reach out to underserved populations.<sup>205</sup>

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198. See, e.g., Stock et al., *supra* note 147, at 81–83 (finding that individuals enrolled in bonus schemes are more likely to enjoy health care savings than individuals who are not enrolled in such schemes).

199. See *id.* at 83 (finding that in the context of medications, hospitals, and additional treatment for individuals seventy-five years and older, “a sickness fund prevention-based program could result in a decrease in health care costs”).

200. 42 U.S.C.A. § 18031(d)–(e) (requiring plans within governmental or nonprofit exchanges to provide certain essential benefits and to provide justification for premium increases before implementation).

201. See Schmidt et al., *supra* note 117, at 725 (offering enhanced competition between sickness funds as a rationale for incentive systems in Germany and explaining that these programs attract and retain clients in ways similar to traditional loyalty schemes).

202. See *supra* text accompanying notes 145–149.

203. See Schmidt et al., *supra* note 137, at e3(2)–(3) (reviewing the disproportionate value of health attainment bonuses between different segments of the population).

204. See generally N.H. Antia, *Health Economics or the Economics of Health?*, 3 J. HEALTH MGMT. 159 (2001) (detailing the continuation of health disparities among the American poor).

205. See Linda J. Blumberg & John Holahan, *The Individual Mandate—An Affordable and Fair Approach to Achieving Universal Coverage*, 361 NEW ENG. J. MED. 6, 6 (2009) (asserting that required coverage would eliminate adverse selection and thus dispose of “such policies as exclusion periods for coverage of preexisting conditions, benefit riders that permanently exclude particular types of care, higher premium rates or cost-sharing requirements for people with health problems, and outright denials of coverage”).

Yet, incentives and coverage will have a limited reach. Like in Germany, private industry intervention to improve health outcomes is likely to disproportionately benefit wealthier classes, and subjectively valued incentives might even burden poorer communities.<sup>206</sup> Moreover, these programs will be even less advantageous in the United States because ACA will not result in coverage for everyone<sup>207</sup> and because insurance providers will have little reason to offer incentives to uninsured populations who will not immediately contribute to health care costs. Providers could also experience “social loafing”<sup>208</sup> and could resist engaging in prevention initiatives due to the diffusion of responsibility for consumers’ health created by ACA; because many other entities—employers, nonprofits, and governmental actors—will be newly enlivened to promote health, providers could deny their own responsibility to consumers’ health.<sup>209</sup> Similarly, curbing the incidence and prevalence of chronic illnesses requires special attention to environmental contributors to poor health<sup>210</sup> that insurance providers are unlikely to meaningfully address. These limitations reflect the pivotal flaw in ACA’s design: Unaccompanied private market intervention will not holistically reform health in the United States.<sup>211</sup>

### *C. ACA Contributes to Limited Improvements in American Health Principles*

Financial efficiency is the inherent goal of any cost-containment mechanism.<sup>212</sup> ACA may contribute to the appearance of enhanced

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206. See *supra* Part I.C.2.

207. The Congressional Budget Office estimates that twenty-three million individuals, including undocumented citizens, will remain without coverage under ACA. See Letter from Douglas W. Elmendorf, *supra* note 187.

208. Social loafing refers to the phenomenon of individuals exerting less effort when they work in a group than when they work individually. See generally Steven J. Karau & Kipling D. Williams, *Social Loafing: A Meta-Analytic Review and Theoretical Integration*, 65 J. PERSONALITY & SOC. PSYCHOL. 681 (1993) (defining social loafing and describing it as a robust phenomenon across different populations and tasks).

209. See *supra* Part I.A.2.

210. COMM’N ON THE SOC. DETERMINANTS OF HEALTH, *supra* note 152, at 1 (“The poor health of the poor, the social gradient in health within countries, and the marked health inequities between countries are caused by the unequal distribution of power, income, goods, and services, globally and nationally . . .”).

211. ACA’s preoccupation with the private market is also the crux of state challenges to the law. See Wendy K. Mariner et al., *Can Congress Make You Buy Broccoli? And Why That’s a Hard Question*, 364 NEW ENG. J. MED. 201, 202 (2011) (attributing the constitutional controversy surrounding ACA to conservative legislators’ insistence that reform preserve the private insurance industry because broadening access while preserving private industry control necessitates the minimum essential coverage provision).

212. But see Michael E. Porter, *What Is Value in Health Care?*, 363 NEW ENG. J. MED. 2477, 2477–81 (2010) (arguing to expand the use of the term “value,” defined as “health outcomes

solidarity by redistributing the consequences of personal health to third parties, but it still mistakenly rests on the principle of personal responsibility to transform individual lives.<sup>213</sup>

Current health care reform could signify an important redistribution of American values because the law does not directly inspire personal initiatives to improve health. The newly diffused economic consequences of health outcomes may give the European principle of solidarity new roots in the United States—at least to the extent employers and insurers will have profound financial interests in protecting individuals' health—but the emerging American system lacks the statutory framework cautioning citizens against overutilization of health care that exists in Germany.<sup>214</sup> Unlike the German system, the limits on beneficiaries' health coverage will not be delineated until the Secretary designates essential benefits,<sup>215</sup> and even then, essential benefits will be subject to state-initiated expansions.<sup>216</sup> The minimum essential coverage provision is one source of personal responsibility in ACA, but even assuming it survives its judicial challenges, the provision is likely to face congressional erosion in light of its well-established unpopularity.<sup>217</sup> Regardless, the minimum essential coverage provision is less likely to contribute to personal responsibility in the long term anymore than the current insurance system because coverage rescission,<sup>218</sup> as well as annual and lifetime caps on essential coverage, will

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achieved per dollar spent," beyond financial concerns to include patient-centered health care accountability measures).

213. See David R. Williams et al., *Beyond the Affordable Care Act: Achieving Real Improvements in Americans' Health*, 29 HEALTH AFF. 1481, 1481 (2010) (asserting that ACA will reduce the proportion of uninsured people and improve access to health care, but explaining that creating a healthy nation will also "require individuals to accept responsibility for their own health and to make healthy choices").

214. Schmidt, *supra* note 126, at 200–01 (discussing and translating Section II, Book V of the German Social Code on "necessity, cost-effectiveness, and personal responsibility" and requiring insurers to provide coverage "with due respect to cost effectiveness" (internal quotation marks omitted)).

215. 42 U.S.C.A. § 18022 (West 2010), held *unconstitutional as not severable* by *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, No. 3:10-cv-91-RV/EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011).

216. *Id.* § 18031(d)(3)(B)(i) (explaining that exchanges can require insurers to offer benefits in addition to federally-mandated essential benefits), held *unconstitutional as not severable* by *Bondi*, 2011 WL 285683.

217. See *Kaiser Health Tracking Poll—November 2010*, *supra* note 5 (finding that two-thirds of voters in the November 2010 midterm election favored repeal of the minimum essential coverage provision).

218. 42 U.S.C.A. § 300gg-12 (prohibiting rescission of existing coverage unless an enrollee has engaged in fraud or made "an intentional misrepresentation of material fact" prohibited by the terms of the coverage), held *unconstitutional as not severable* by *Bondi*, 2011 WL 285683.

be prohibited.<sup>219</sup> In general, citizens will be less at risk for serious financial loss as a result of falling ill than ever before and the efforts of private, nonprofit, and governmental actors will be the force defining the future of personal responsibility as a guiding principle in the new American health system.<sup>220</sup>

Shifting the monetary consequences of poor health cannot erase the American health system's legacy of unequal access to services, nor will ACA transform the country's tradition of saving money at the cost of community wellbeing. The more highly privatized roots of the American system are likely to reinforce providers' prioritization of competitiveness over population health, and providers will be less likely to share best practices or focus utilization on approaches that produce better health outcomes at a higher expense.<sup>221</sup> Further, ACA cannot remove all preexisting systemic barriers to better health in poorer communities, including limited access to nutritious foods<sup>222</sup> and racially imbalanced health care institutions.<sup>223</sup> Clearly, the multifaceted approach necessary to address all contributors to illness in the United States would require legislation that is far more comprehensive than ACA.<sup>224</sup>

Better access to care could enhance disease prevention and contribute to improved personal responsibility among communities most at risk for illness, but detrimental daily living conditions outside the individual's control are unlikely to improve. Preexisting health disparities,<sup>225</sup> along

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219. *Id.* § 300gg-11 (prohibiting the establishment of lifetime or annual limits), held unconstitutional as not severable by *Bondi*, 2011 WL 285683.

220. See *supra* Part I.A.1.

221. See Schmidt et al., *supra* note 117, at 728 (noting that incentive programs can be counterproductive to population health by making insurance providers less likely to share experiences or use cash incentives, which are more effective than in-kind incentives but provide less financial return).

222. See Kameshwari Pothukuchi, *Community Food Assessment: A First Step in Planning for Community Food Security*, 23 J. PLAN. EDUC. & RES. 356, 360 (2004) (exploring the multidisciplinary approach needed to improve community nutrition).

223. See Susan J. Shaw, *The Logic of Identity and Resemblance in Culturally Appropriate Health Care*, 14 HEALTH 523, 523 (2010) (observing that improved diversity in the health care workforce is commonly identified as a means for addressing health disparities between minority and majority populations in the United States and examining the complicated impact of resemblance programs in the United States).

224. See Kevin Fiscella, *Health Care Reform and Equity: Promise, Pitfalls, and Prescriptions*, 9 ANNALS FAM. MED. 78, 83 (2011) (concluding that legislation in addition to ACA is necessary to address access for the remaining twenty-three million uninsured individuals in the United States); Elaine C. Jones & Michael Amery, *Health Care Reform: What It May Mean for Your Practice*, 75 NEUROLOGY S52, S54 (Supplement 1) (2010) (observing that ACA does little to reform the consequences of malpractice or flawed funding formularies).

225. See, e.g., COMM'N ON THE SOC. DETERMINANTS OF HEALTH, *supra* note 152, at 1 (proclaiming that "[h]ealth equity is an issue within all . . . countries").



with the minimum essential coverage provision<sup>226</sup> and new consumer protections,<sup>227</sup> could compel insurance providers to focus their efforts on poorer communities because the newly insured and chronically ill might stimulate market activity. In the process, ACA could compel the private industry to confront health inequity by increasing its interactions with vulnerable populations, and the limited capacity of insurers to change the many systemic barriers to health<sup>228</sup> could encourage insurers to concentrate their efforts on changing individual behavior.<sup>229</sup> In this way, ACA is a manifestation of well-calculated libertarian paternalism because it obliges private entities to work toward improving individual health care choices without diminishing individual choice.<sup>230</sup> Unfortunately, improved health is more than a simple matter of better choices,<sup>231</sup> and insurers and employers cannot single-handedly reshape every health outcome in vulnerable populations.<sup>232</sup> Moreover, based on the volatility of the current debate in the United States,<sup>233</sup> it is unrealistic to assume that ACA will imbue insurers and employers with a strong enough sense of solidarity to cultivate the political will necessary to move holistic reform forward.

*D. Health Is Vital to Life, International Influence, and the Democratic Process*

Because ACA relies on personal autonomy to improve health outcomes,<sup>234</sup> it fails to meaningfully address social determinants of health.

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226. 42 U.S.C.A. § 18091 (West 2010) (establishing the “minimum essential coverage” requirement), *held unconstitutional* by Florida *ex rel.* Bondi v. U.S. Dep’t of Health & Human Servs., No. 3:10-cv-91-RV/EMT, 2011 WL 285683 (N.D. Fla. Jan. 31, 2011).

227. The prohibition against disqualifying individuals based on preexisting conditions is among the most relevant consumer protections. *Id.* § 18001 (providing for “[i]mmediate access to insurance for uninsured individuals with a preexisting condition”), *held unconstitutional as not severable* by Bondi, 2011 WL 285683.

228. *See, e.g.*, COMM’N ON THE SOC. DETERMINANTS OF HEALTH, *supra* note 152, at 1 (discussing various obstacles to better health).

229. This Comment observes that ACA seeks to empower consumers through financial measures in the shadow of European nations, which have sought to involve the public through direct decision making about the governance of health systems. *See* Gillian M. Craig, Editorial, *Involving Users in Developing Health Services: Representation Is Not Enough; Voices Must Be Translated into Action*, 336 BRIT. MED. J. 286, 286–87 (2008) (noting that “[m]any European countries involve the public in decision making processes as part of health systems governance,” even though certain initiatives “amount to little more than an ‘empty ritual’”).

230. *See generally* RICHARD H. THALER & CASS R. SUNSTEIN, NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS 4–6 (2009) (defining libertarian paternalism as the process of designing policies that enhance freedom of choice while influencing institutions to improve the choices that individuals make).

231. *See infra* Part II.D.

232. *See supra* Part I.C.1.

233. *See supra* Part II.A.

234. *See supra* Part II.C.

In this instance, poor governance undermines the international reputation of the United States and the integrity of its democratic process.<sup>235</sup>

Improving daily living conditions requires more than better decision making because individuals often play passive roles in the conditions that negatively impact their lives. For example, urban air pollution<sup>236</sup> and unsafe water and sanitation<sup>237</sup> all have a major impact on health. Likewise, inadequate nutrition may have lifelong effects beginning as soon in life as gestation, and early undernutrition is associated with an increased risk for chronic disease<sup>238</sup> and lower overall developmental and cognitive aptitudes.<sup>239</sup> Poor nutrition and especially obesity later in life also have serious influences on health and wellness in the United States.<sup>240</sup> So-called lifestyle diseases and hunger are not entirely within the individual's control in light of systemic barriers that complicate access to quality foods.<sup>241</sup> Further, daily living conditions outside individual control also shape mental health and thus individuals' perception and ability to cope with daily living conditions of their own choosing throughout their lives.<sup>242</sup>

Health is also a major factor in the ability of the United States to influence the global community. The State's function in regulating health has burgeoned alongside health's enhanced political relevance,<sup>243</sup> and

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235. Although this Comment analyzes the deleterious effects of health inequity on America's domestic and international interests, it does not intend to downplay moral justifications for more holistic reform such as a shared interest in human flourishing. See J.P. Ruger, *Ethics and Governance of Global Health Inequalities*, 60 J. EPIDEMIOLOGY COMMUNITY HEALTH 998, 998–99 (2006) (exploring a moral foundation for addressing the ethical challenges that face the global health community and placing the Hobbesian tradition, John Rawls's relational perspective, and principles of cosmopolitanism in the philosophical framework for global health).

236. Aaron J. Cohen et al., *Urban Air Pollution*, in 2 COMPARATIVE QUANTIFICATION OF HEALTH RISKS: GLOBAL AND REGIONAL BURDEN OF DISEASE ATTRIBUTABLE TO SELECTED MAJOR RISK FACTORS 1353, 1354 (Majid Ezzati et al. eds., 2004).

237. Annette Prüss-Üstün et al., *Unsafe Water, Sanitation and Hygiene*, in 2 COMPARATIVE QUANTIFICATION OF HEALTH RISKS, *supra* note 236, at 1321, 1321.

238. Stephen M. Fishman et al., *Childhood and Maternal Underweight*, in 2 COMPARATIVE QUANTIFICATION OF HEALTH RISKS, *supra* note 236, at 39, 41.

239. *Id.* at 99.

240. Researchers have associated being overweight with increased risk for type II diabetes, heart disease, hypertensive disease, stroke, and certain cancers such as breast and colon cancer. W. Philip T. James et al., *Overweight and Obesity (High Body Mass Index)*, in 2 COMPARATIVE QUANTIFICATION OF HEALTH RISKS, *supra* note 236, at 497, 498.

241. See Pothukuchi, *supra* note 222, at 357 (observing four streams of food production and distribution that determine the availability of different foods in the community).

242. See Gavin Andrews et al., *Child Sexual Abuse*, in 2 COMPARATIVE QUANTIFICATION OF HEALTH RISKS, *supra* note 236, at 1851, 1851 (noting that researchers have widely attributed the cause of depression, panic disorder, alcohol abuse and dependence, drug abuse and dependence, and suicide to victimization experiences such as childhood sexual abuse).

243. See Ilona Kickbusch, Editorial, *Responding to the Health Society*, 22 HEALTH PROMOTION INT'L 89, 90 (2007) (discussing the pronounced role of the State in health as

increased regulation has been mediated by more health-focused leadership roles in government.<sup>244</sup> Simultaneously, leaders from nations around the world increasingly rely on one another to confront social determinants of health that are progressively beyond a single nation's domain.<sup>245</sup> By ignoring health equity, the United States damages its status on the international stage while the global community increasingly recognizes health as an essential element of responsible governance.<sup>246</sup> Population health emanates from careful policymaking that accounts for structures of political power and globalization.<sup>247</sup> Without meaningful reform, the United States destabilizes initiatives abroad because global health requires interdependence and because world leaders must work together to ensure health equity is financed and fairly resourced.<sup>248</sup>

The American approach also detracts from the health of its government. Personal health determines one's capacity to participate in the democratic process.<sup>249</sup> Without better health through proper reform, individuals are more likely to be passive members of representative democracies, and elected officials are less likely to embody the full range of constituent needs.<sup>250</sup> In the absence of proper representation, policy

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evidenced by new regulations such as the Spanish government's monitoring of fashion models' body mass indexes and the total ban on smoking in public places implemented in Ireland).

244. *See id.* at 91 (listing Canada, England, Sweden, and Australia as nations that have fostered health through meaningful health-focused roles for political officials).

245. *See id.* (emphasizing that a sense of collective responsibility is necessary to address health on the international stage and examining how a single nation's neglect of this responsibility could compromise the efforts of all other nations).

246. *See id.* at 89 (noting the increased attention paid to health in all levels of governance and offering health as a central factor in modern economies and a major component of citizens' expectations of government).

247. *See* Gro Harlem Brundtland, *Foreword* to HEALTH POLICY IN A GLOBALISING WORLD, at xix, xix (Kelley Lee et al. eds., 2002) (remarking that the health field exemplifies the shared consequences of globalization and suggesting that worsening health arises from increased marginalization).

248. *See* COMM'N ON THE SOC. DETERMINANTS OF HEALTH, *supra* note 152, at 13 (recommending that nations increase public financial support for social determinants of health, build on international financing for health equity using a social-determinants-of-health framework, and allocate governmental resources for action pursuant to these recommendations).

249. *See* Michelman, *supra* note 79, at 677 (arguing that participation in democratic society hinges on satisfying basic needs, such as health and shelter).

250. For a more extensive treatment of representative defects in the democratic process, look to the voluminous literature on *United States v. Carolene Products Co.*, 304 U.S. 144 (1938). *See, e.g.,* Bruce A. Ackerman, *Beyond Carolene Products*, 98 HARV. L. REV. 713, 715 (1985) (arguing that *Carolene Products* represents a line of cases through which "the court is trumping the statutory conclusions of the deeply flawed real-world legislature by appealing to the hypothetical judgment of an ideally democratic legislature"); Robert M. Cover, *The Origins of Judicial Activism in the Protection of Minorities*, 91 YALE L.J. 1287, 1289-92 (1982) (remarking that Justice Stone's opinion in *Carolene Products* "extend[ed] the scope of judicial review not in terms of the special value of certain rights but in terms of their vulnerability to perversions by the majoritarian process" (footnote omitted)). As Lewis F. Powell, Jr., explained in *Carolene*

continues to veer away from improved health equity because the United States's health policy is a necessary byproduct of its politics.<sup>251</sup> This process defect could stifle a number of transformative developments, including future historical moments akin to President Roosevelt's Second Bill of Rights,<sup>252</sup> while simultaneously eroding the likelihood of future reform.<sup>253</sup>

*E. A Different Approach to Health Reform*

Health does not observe the same boundaries as the medical profession.<sup>254</sup> Health is a factor of location, governance, financial resources, political action, and social justice.<sup>255</sup> Accordingly, true health reform demands a multitier approach.<sup>256</sup> Fortunately, ACA is not the final word in American reform; responsible health policy can emerge from incremental steps toward health equity and an enhanced understanding of health in various facets of government.<sup>257</sup>

Good health is a salient manifestation of justice in modern society because it represents responsible governance and the fair distribution of resources and action. Correspondingly, health reform calls for justice

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Products *Revisited*, 82 COLUM. L. REV. 1087 (1982), the revelatory justification underlying the use of strict scrutiny in judicial review emerged from Justice Stone's *Carolene Products* opinion:

The fundamental character of our government is democratic. Our constitution assumes that majorities should rule and that the government should be able to govern. Therefore, for the most part, Congress and the state legislatures should be allowed to do as they choose. But there are certain groups that cannot participate effectively in the political process. And the political process therefore cannot be trusted to protect these groups in the way it protects most of us.

*Id.* at 1088–89.

251. See *supra* notes 69–70 and accompanying text; cf. Carey, *supra* note 70, at 502 (asserting a constitutional right to health care and attempting to demonstrate unlawful discrimination against the poor in health service delivery in an effort to explain the failure of health policy reform).

252. See *supra* text accompanying notes 81–84.

253. But see Powell, *supra* note 250, at 1091 (observing that deciphering a process defect and its consequences may require a substantive, unverifiable vision for what the process should have yielded if not for the defect).

254. See Kickbusch, *supra* note 243, at 89 (delineating a boundary for the medical system while framing the territory of health as “ever less tangible and increasingly virtual”).

255. See COMM'N ON THE SOC. DETERMINANTS OF HEALTH, *supra* note 152, at 1 (attributing disparate health outcomes “between and within countries” to uneven distribution of power, money, access to goods and services, misdistribution of health care, climate change, and damaging life circumstances and health policies).

256. See, e.g., *id.* (asserting that economic “growth by itself, without appropriate social policies to ensure reasonable fairness in the way its benefits are distributed, brings little benefit to health equity”).

257. See Gail R. Wilensky, *Health Care Reform—Where Do We Go from Here?*, 362 NEW ENG. J. MED. e36(1), 36(3) (Mar. 18, 2010), <http://www.nejm.org/doi/pdf/10.1056/NEJMp1002211> (suggesting that a clear lesson from congressional enactment of ACA is that Americans prefer incremental reform).

through enhanced gender equality<sup>258</sup> and political empowerment for all community members.<sup>259</sup> Legislatures will never fully reform health by grounding their remedies in individual autonomy.<sup>260</sup> To improve daily living conditions and achieve true health reform, policymakers must transform childhood development and expand intervention early in life,<sup>261</sup> address environmental contributors to poor health,<sup>262</sup> foster fair employment opportunities,<sup>263</sup> and initiate social protection schemes that ensure individuals have enough income to lead healthy lives.<sup>264</sup> These improvements are necessary, in addition to efforts to ensure universal access to health care, which also must meaningfully address social determinants of health.<sup>265</sup>

Although poor health represents a defect in the democratic process,<sup>266</sup> it is not an insurmountable barrier to improving health policy. “The right to adequate medical care and the opportunity to achieve and enjoy good health” had a place in President Roosevelt’s Second Bill of Rights,<sup>267</sup> to which scholars have attributed major legislative developments such as the G.I. Bill.<sup>268</sup> Even without a constitutional guarantee to positive rights,<sup>269</sup> Congress has a moral imperative to pass laws that advantage its constituents.<sup>270</sup> Decades may elapse before lawmakers reunite their focus

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258. See COMM’N ON THE SOC. DETERMINANTS OF HEALTH, *supra* note 152, at 16 (asserting that nations must address gender inequities in the structure of society through increased investment in sexual and reproductive health services and programs).

259. See *id.* at 18 (evidencing the need to redistribute social power to improve health and offering a framework for achieving the “political empowerment that underpins social well-being and equitable health”).

260. See *supra* Parts II.C–D.

261. See COMM’N ON THE SOC. DETERMINANTS OF HEALTH, *supra* note 152, at 4 (calling for a comprehensive approach to early life that utilizes and extends existing programs and interventions).

262. See *id.* (advising policymakers to place health at the center of urban planning and governance, eliminate inequity in rural and urban areas, and ensure that economic and social responses to environmental degradation address health equity).

263. See *id.* at 6 (recommending full and fair employment policies that take into account a healthy work-life balance and safe working conditions).

264. See *id.* at 7 (noting that comprehensive social policies that support the provision of a sufficient income for healthy living are instrumental to the success of other development goals).

265. See *id.* at 9 (emphasizing the need to strengthen the capacity of health care systems and workforces to act on social determinants of health).

266. See *supra* Part II.D.

267. See SUNSTEIN, *supra* note 81, at 13 (articulating the various components of President Roosevelt’s Second Bill of Rights).

268. See *id.* at 15 (arguing that the G.I. Bill, “which offered an array of housing, medical, educational, and training benefits,” was among the most prominent legislative fixes attributable to the Second Bill of Rights); see also *supra* note 83 (describing the G.I. Bill).

269. See *supra* Part I.B.1.

270. See RUGER, *supra* note 235, at 1001 (arguing that global actors and institutions are obligated to address health inequities).

behind health, and it may take even longer for Americans to recast health as something more than a commodity, but strides on the international stage provide bases to anticipate progress in this arena.<sup>271</sup>

Lessons from the passage of ACA, the law's reception among the general public, and subsequent state challenges to the law suggest that dramatic improvements to American health will not take shape in a single measure in the near future. Improving health is a matter of recognizing its bidirectional relationship to most aspects of life and making it a priority at all levels of modern governance.<sup>272</sup> From social protection schemes to environmental regulation, health equity is ubiquitous in policymakers' daily work. Systemic fixes could accompany legislation designed to address issues that are contemporaneous to the American political consciousness, including safeguards to fair employment.<sup>273</sup> All actors should ensure health equity is financed and fairly resourced,<sup>274</sup> and global leaders must work together to achieve the goal of health equity.<sup>275</sup>

Thus, lawmakers must look beyond cost-containment and financial incentives to attain true reform. Improving health is a complex task that requires a coordinated approach among various sectors of numerous countries.<sup>276</sup> This task must be initiated at the state level because many social determinants of health are beyond individual control.<sup>277</sup> The likelihood of one sweeping package of reforms is remote,<sup>278</sup> but the

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271. See Anna Ritsatakis, *Equity and Social Determinants of Health at a City Level*, 24 HEALTH PROMOTION INT'L 181, 188 (2009) (Special Supplement on European Healthy Cities) (analyzing Phase III of the World Health Organization's European Healthy Cities Network and concluding that "an undeniable shift from rhetoric to action [occurred] in at least half the cities" included in the network, while acknowledging that the other "half still needed additional work to clarify the concept of equity in health and its implications for policy development").

272. See COMM'N ON THE SOC. DETERMINANTS OF HEALTH, *supra* note 152, at 11 (offering health as a marker of government performance and a shared value across government sectors).

273. See *id.* at 6 ("Through the assurance of fair employment and decent working conditions, government, employers, and workers can help eradicate poverty, alleviate social inequities, reduce exposure to physical and psychosocial hazards, and enhance opportunities for health and well-being. And, of course, a healthy workforce is good for productivity.").

274. See *id.* at 12 ("Public finance to fund action across the social determinants of health is fundamental to welfare and to health equity.").

275. See *id.* at 19 (exploring the unequal benefits of globalization and arguing in favor of multilateral efforts to address social determinants of health).

276. The government must meet its obligation to provide vital health services and regulate potentially hazardous materials while the private sector must honor this effort in economic agreements. See *id.* at 15 (calling for the State to provide basic services necessary for health and to regulate goods such as tobacco and alcohol, but noting that public leadership must be paired with the efforts of responsible actors in the private sector and civil society).

277. See *supra* Part II.C.

278. See Antos, *supra* note 184, at 3 (predicting that Congress will not pass any major health legislation for at least two years).

opportunity for daily improvements is directly proportional to the enormous potential for positive change in American health.

### III. CONCLUSION

Although the state challenges to the law should fail,<sup>279</sup> ACA is a cost-containment mechanism when the United States needs systemic reform.<sup>280</sup> ACA could contribute to a new era for health care by transforming business objectives and redefining the principles of personal responsibility and solidarity in the country's health system, but progress will be limited.<sup>281</sup> Additional legislation that addresses the social determinants of health is necessary to fortify the United States's international reputation and democratic integrity.<sup>282</sup> Moreover, health is a pivotal aspect of contemporary governance that requires careful policies, collaboration, and the fair representation of all voices because, in modern society, individual health is a matter of our shared reliance on social justice.<sup>283</sup> Because poor governance destroys lives, lawmakers have the moral imperative to confront health equity.<sup>284</sup>

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279. *See supra* Part II.A.

280. *See supra* Part II.B.

281. *See supra* Part II.C.

282. *See supra* Part II.D.

283. *See supra* Part II.E.

284. *See supra* Part II.E.