If a Right to Health Care is Argued in the Supreme Court, Does Anybody Hear it?

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Publication Citation
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W. DAVID KOENINGER *

INTRODUCTION

It would be difficult to conceive a vision of social equality that does not include access to health care. Access to health care is a cornerstone of social equality, a right of belonging1 that inheres in our citizenship. Unfortunately, that right has developed inconsistently in a health care system riddled with disparities. Following the enactment of the Patient Protection and Affordable Care Act of 2010 (the “Affordable Care Act” or “the ACA”),2 activists and public health advocates had high hopes that those disparities could be addressed and begin to be remedied. To a certain extent, those hopes were placed in abeyance while the litigation challenging the constitutionality of the Affordable Care Act worked its way up to the Supreme Court of the United States. But now, with the Court having upheld the Affordable Care Act in National Federation of Independent Businesses v.

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1 See REBECCA E. ZIETLOW, ENFORCING EQUALITY: CONGRESS, THE CONSTITUTION, AND THE PROTECTION OF INDIVIDUAL RIGHTS 6–8 (2006) (explaining that “rights of belonging” are “those rights that promote an inclusive vision of who belongs to the national community of the United States and that facilitate equal membership in that community. Legislation that defines and protects rights of belonging is the end product of a decision by the majority to embrace minorities and facilitate their inclusion in social and political institutions, as well as in the economic life of the country.”) More to the point, given the question: “Whither Social Equality?,” “rights of belonging are best understood as the set of entitlements that are necessary to ensure inclusion, participation, and equal membership in our diverse national community.” See id. at 6.
Sebelius, it seems appropriate to revisit those hopes and examine their continued vitality. The story of the federal government’s involvement in health care should be one of bringing the nation together to care for its own, but that story line is not yet the dominant one. Indeed, the Court’s awkward decision, upholding the individual mandate under the taxing power, and upholding the Medicaid expansion only as an option for states, suggests that the opposite is true.

Much of the debate leading up to and following the Supreme Court’s decision—including the much publicized oral arguments—has dwelt in abstraction, several steps removed from the practical effects of health care legislation in general, and of the Affordable Care Act in particular. A casual follower of the ACA cases before the Supreme Court could have been excused for thinking that the two key issues presented were whether the federal government could control our grocery shopping lists and whether the states were being attacked by that same federal government. Very little media time was spent discussing the ACA supporters’ hopes for a reformed health care system or discussing the ACA’s potential impact in terms of lessening human suffering by enabling our society to develop better (and more cost-effective) ways to care for its members. This Article attempts to counter this state of affairs by placing health care reform in context—that is, within an

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overarching narrative about Congressional attempts to address health care disparities—and to examine its practical effects and possibilities.

To develop that context, this Article touches on some of the history of our federal government’s involvement in health care matters. The Article begins with post-Civil War Reconstruction and then moves forward to examine some of the major health care enactments of the last sixty-five years: the Hill-Burton Act, the Medicaid and Medicare statutes, the Emergency Medical Treatment and Active Labor Act (“EMTALA”), and the Affordable Care Act. During the time leading up to the issuance of the Emancipation Proclamation, the federal government had done little to address the catastrophic health problems caused by the Civil War. These health problems became most obvious among, and were felt most acutely by, newly emancipated slaves who, without access to employment, also had no access to food, shelter, and clothing. Conditions became so dire that the federal government was forced to act. However, it did so in halting and, at times, ineffectual steps. In a very real sense, the federal government’s hesitant, incremental

10 Id. at 22 (Oliver O. Howard, leader of the Freedman’s Bureau, described emancipation as “[m]any thousands of blacks of all ages, clad in rags, with no possessions except the nondescript bundles of all sizes which the adults carried on their backs . . .”).
11 See ERIC FONER, RECONSTRUCTION: AMERICA’S UNFINISHED REVOLUTION, 1863–1877 151 (2002) (“The Freedman’s Bureau made heroic but limited efforts to remedy what can only be termed the post-emancipation crisis of health among the former slaves.”).
attempts to provide health care through the medical division of the Freedman’s Bureau seem all too familiar when considered alongside the last sixty-five years of attempts at federal regulation of health care in this country.\textsuperscript{12}

Because of the federal government’s ineffectiveness, freedpeople organized around the idea that access to health care was one of the rights that accompanied their newly-won citizenship.\textsuperscript{13} Indeed, all of the health care enactments discussed in this Article, at some level, can be considered incremental advances toward realizing the right to access health care that emancipated slaves believed was “embedded in the meaning of citizenship.”\textsuperscript{14} In particular, EMTALA gives individuals an explicit right to emergency medical treatment, regardless of ability to pay, by hospitals that participate in the Medicare program.\textsuperscript{15} EMTALA is particularly fascinating because it reflects a national belief in a right to health care—the “embedded social norm”\textsuperscript{16} that we all are entitled at least to emergency medical care.

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\textsuperscript{12} See, e.g., Nicole Huberfeld, Federalizing Medicaid, 14 U. PA. J. CONST. L. 431, 436–50 (2011) (describing how two themes—“the deserving poor” and “states’ rights”—have limited the success of the Medicaid program).
\textsuperscript{13} See Downs, supra note 9, at 154.
\textsuperscript{14} Id. at 167.
\textsuperscript{16} See NFIB v. Sebelius, 132 S. Ct. 2566, 2611 (2012). (Ginsburg, J., concurring in part, concurring in judgment in part, and dissenting in part) (noting that “embedded social norms require hospitals and physicians to provide care when it is most needed, regardless of ability to pay”).
\end{flushleft}
However, this legislative enactment, too, constitutes merely an incremental advance. EMTALA does not fund the cost of effectuating our deeply held societal norm.\textsuperscript{17} Thus, when uninsured persons receive emergency health care and cannot pay the bill, those who are insured help defray the costs to providers through cost sharing and higher premiums. Further, if the uninsured person is deemed to have been eligible for Medicaid, all taxpayers pay the cost in higher Medicaid expenditures.\textsuperscript{18} In such a system, it might seem obvious that broader access to health insurance would be a common and laudable goal, but that goal has remained elusive. There may be no better example of this than the Supreme Court’s ruling on the Medicaid expansion provision of the Affordable Care Act in \textit{NFIB v. Sebelius}.\textsuperscript{19} What was thought to be a broad expansion of access to health care that would ameliorate the effects of other half measures, such as EMTALA, has been transformed into yet another increment or half measure, thanks to the Supreme Court.

Part I of this Article reviews some of the history of the federal government’s involvement in the health care of American citizens, beginning with post-Civil War Reconstruction and moving forward through some of our country’s post-World War II federal legislative attempts to address particular disparities in our health care system.

\begin{footnotes}
\footnote{17 Indeed, the ACA’s individual mandate helps to create a funding stream to cover the requirements of EMTALA. See Theodore W. Ruger, \textit{Of Icebergs and Glaciers: The Submerged Constitution of American Healthcare}, 75 LAW \& CONTEMP. PROBS. 215, 222 (2012) (noting that the drafters of the Affordable Care Act might have been more accurate if they had called the minimum coverage requirement an “EMTALA risk adjustment payment”).}
\footnote{19 \textit{NFIB}, 132 S. Ct. at 2601–07.}
\end{footnotes}
Despite these attempts, two paths historically have defined access to health care in America: Americans either access health care through labor (that is, through employers) or through government programs aimed at those who can be classified as “dependent.” Part II discusses the Patient Protection and Affordable Care Act, and how its individual mandate and Medicaid expansion fit within the context of other major federal health care legislation, particularly as a response to the consequences of EMTALA. Both provisions of the ACA operate to develop a third path of access to health care, one connected neither to employment nor to dependency. Finally, Part III addresses the Supreme Court’s ruling in *NFIB v. Sebelius* and its effects.

The right to health care that went unheard by the Supreme Court was the same right that freedpeople sought to win for themselves—a right to health care detached from either labor or state-defined dependency. Indeed, this particular aspect of the Medicaid expansion seems to have doomed it in Justice Roberts’s eyes. Health care advocates always have anticipated that despite the enactment of the ACA, years of further reform will be needed.\(^\text{20}\) The Supreme Court’s ruling adds new complexity to the consideration of further reforms.\(^\text{21}\) As the ACA is implemented and those subsequent reforms are debated, the critical questions ought to be: will the reforms bring us closer to making access to health care a right of citizenship and, thus, will they enhance social equality?


I. THE FEDERAL GOVERNMENT AND HEALTH CARE: A HISTORY OF HALF-MEASURES

Throughout our history, Congress generally has chosen not to exercise the full extent of its powers when regulating matters of health.\(^{22}\) For example, in its earliest days, Congress was reluctant to exercise its authority to enact a national health statute.\(^ {23}\) Specifically, it resisted President John Adams’s repeated requests to enact federal quarantine legislation for ports of entry to the United States.\(^ {24}\) Instead, Congress passed legislation requiring the President to direct federal officials to aid in the execution of quarantine in accordance with state law.\(^ {25}\) This reticence would continue until the massive displacement of large groups of people during the Civil War compelled Congress to act.

A. The Civil War and Reconstruction

During the Civil War, change born of necessity, not philosophy, finally came to Congress’ manner of addressing public health matters. “The emancipation of four million slaves called into question the function of these institutions [state and local governments, and benevolent and charitable organizations] and demanded an institutional response beyond these otherwise diffused local and state measures.”\(^ {26}\) Though the Emancipation Proclamation was issued in 1863, Congress did not take steps to acknowledge and address

\(^{22}\) Ruger, supra note 17, at 224.
\(^{23}\) Id. at 226.
\(^{24}\) Id. Adams urged the Congress to “frame a [quarantine] system which, while it may tend to preserve the general health, may be compatible with the interests of commerce and the safety of revenue.” Id. at 226–27.
\(^{26}\) Downs, supra note 9, at 167.
some of the consequences of emancipation until 1865 when it established the Freedmen’s Bureau.  

In his groundbreaking book, *Sick From Freedom: African American Illness and Suffering During the Civil War and Reconstruction*, Jim Downs describes the federal government’s intervention in health matters in the South and two of its critical aspects. First, “[t]he federal government’s obsession with freedpeople’s labor . . . circumscribed how freedpeople’s health would be defined and who would define it.” That is, the federal government’s primary interest in the health of freed slaves was linked to its desire to take advantage of their labor power, and those who were not able-bodied were forcibly separated from those who could work. Second, because of the federal government’s obsession with freedpeople’s labor, every aspect of its medical program in the South gave rise to anxiety that providing government health care to able-bodied individuals would render them dependent on the federal government. This anxiety was so pervasive that in the end, the constant pressure to reduce relief and medical aid “undermined the operations of the first-ever federal health care program.”

27 See Downs, supra note 9, at 57–64.  
28 Id. at 64.  
29 Id. at 45.  
30 Id. at 46.  
31 Id. at 72.  
32 Id. at 73–74. Indeed, the congressional debates over the Freedman’s Bureau produced a curious tension that ultimately characterized the Bureau's work: a desire to help emancipated slaves mitigated by the longstanding congressional hesitancy to exercise full powers in health matters and by the concern that providing anything more than temporary assistance would engender dependence on the government among the emancipated. See id.
These themes—both the emphasis on tailoring benefit programs to aid those who are not able-bodied or (as with children) are not able to work and the corrosive anxiety about creating government dependence by providing assistance to the able-bodied—recur throughout the history of the United States’ federal health care programs. Furthermore, the federal government’s halting response to the health care needs of freedpeople led to the development of black political activism around health care issues. Freed slaves became the first advocates of federal health care. Thus, tracing the federal government’s involvement in health care from Reconstruction forward to the present day illuminates some of the controversy surrounding the Affordable Care Act and can inform the debate about its provisions.

In 1863, after President Lincoln issued the Emancipation Proclamation, able-bodied freedmen generally joined the Union Army, leaving behind their families. Those women and children likely had only the clothes on their backs, no place to live, no source of food, and nothing to protect them from the elements. Moreover, the process of escaping from

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33 See generally Huberfeld, supra note 12 (discussing the two themes of “the deserving poor” and “states’ rights”). Huberfeld locates the notion of the “deserving poor” within the tradition of the Elizabethan Poor Laws. See id. at 439. Downs’ work suggests that there is a long-standing racial component to the designation as well. See generally Downs, supra note 9.
34 See Downs, supra note 9, at 167.
35 See id. at 18–21. Black men who enlisted in the Union Army at Vicksburg, Mississippi, left behind more than 10,000 women and children. Id. at 26.
36 Id. at 19. Those living in border states also ran the risk of being identified as fugitives by the Union Army, since the Emancipation Proclamation applied only to the rebelling states, and not to the states that remained within the Union. Id. at 18–19.
the plantation, traveling for long periods to reach safety, and living without food, shelter, or
clothing led to widespread sickness among freedpeople.\textsuperscript{37}

As the war continued, this problem worsened.\textsuperscript{38} Despite the efforts of a variety of
entities—chiefly, the military and numerous charitable organizations\textsuperscript{39}—direct federal
intervention was required. Accordingly, in 1865 the federal government, in an
unprecedented action, established the Freedmen’s Bureau and within that bureau, a medical
division specifically tasked with addressing the health needs of freedpeople.\textsuperscript{40} The medical
division established hospitals in the South to provide food, shelter, clothing, and basic
medical care to freedpeople, marking the first time in U.S. history that federal officials were
placed “in direct and intimate contact with the bodies of ordinary people.”\textsuperscript{41} The
Freedmen’s Hospitals became the place for those who could not contribute to the labor
force because they were sick, aged, or orphaned.\textsuperscript{42} The federal government, however, was
not able to require that all of the established hospitals admit emancipated slaves.\textsuperscript{43}

Initially, Bureau leaders had expected that state-run hospitals in the South would
accept freedpeople for treatment.\textsuperscript{44} Unfortunately, these leaders soon learned that local

\textsuperscript{37} See id. at 22.
\textsuperscript{38} See id. at 25.
\textsuperscript{39} See id. at 52–57.
\textsuperscript{40} See id. at 62–64.
\textsuperscript{41} Id. at 12.
\textsuperscript{42} Id. at 63–64.
\textsuperscript{43} Id. at 66. In some instances, doctors simply refused to touch sick black people. Id. at 35.
\textsuperscript{44} Id. at 67.
If a Right to Health Care is Argued in the Supreme Court, Does Anybody Hear It?

2013

authorities would resist, arguing that they never had agreed to admit sick freedpeople,\footnote{Id.} nor would other “charitable” institutions offer assistance. “Most almshouses refused admission to freedpeople because state and local governments failed to recognize newly emancipated slaves as citizens.”\footnote{Id. at 68.} The same problem occurred when Bureau officials sought to have freedpeople admitted to state asylums and were refused, on some occasions in direct violation of the Civil Rights Act of 1866.\footnote{Id. at 150.}

It was not until an outbreak of smallpox in the autumn of 1866 that state officials in the South began to recognize black people as citizens entitled to quarantine along with whites in “pest homes.”\footnote{Id. at 153.} At about the same time, freedpeople began to participate in politics and to insist that medical provisions be included in campaigns to win the benefits of citizenship, along with suffrage and public education.\footnote{Id. at 154.} In this way, for freedpeople, “health became embedded in the meaning of citizenship.”\footnote{Id. at 167.} Unfortunately, as with so many of the benefits of citizenship for freedpeople, a right of access to health care would go largely unrecognized until the 1960s.\footnote{See infra notes 69–75 and accompanying text.}

As Reconstruction came to an end,

[S]ome state governments had assumed the responsibility for freedpeople's medical care, other freedpeople throughout the South continued to be denied support and admission to health facilities by local and state governments. Not having access to medical services during the Reconstruction period would, for a number of black
Southerners, serve as the beginning of a system of discrimination that would only worsen in the 1880s and beyond.\textsuperscript{52}

\textbf{B. Hill-Burton}

Theodore Roosevelt, running to return to the presidency in 1912, was the first national politician of the 20th century to raise the issue of national health insurance.\textsuperscript{53} Franklin Roosevelt later incorporated a right to adequate medical care in his “Second Bill of Rights.”\textsuperscript{54} Nevertheless, President Harry S. Truman was the first president to succeed in having any proposed health care reform legislation enacted into law.\textsuperscript{55}

The Hill-Burton Act, also known as the Hospital Survey and Construction Act, was signed into law in 1946.\textsuperscript{56} Hill-Burton was the first and only prong of President Truman’s three-pronged attempt to pass comprehensive health care reform that made it through Congress.\textsuperscript{57} Hill-Burton was intended to address the disparity in access to in-patient hospitals that existed in the country.\textsuperscript{58} The Act authorized matching federal grants for the construction of public and nonprofit private health facilities.\textsuperscript{59} Each state designated an

\textsuperscript{52} Id. at 155.
\textsuperscript{53} Lee Igel, \textit{The History of Health Care as a Campaign Issue}, \textit{Physician Executive} J. 12, 12 (2008).
\textsuperscript{54} PAUL STARR, \textit{THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE} 280 (1982) [hereinafter STARR, \textit{SOCIAL TRANSFORMATION}].
\textsuperscript{55} See id. at 280–83.
\textsuperscript{57} STARR, \textit{SOCIAL TRANSFORMATION}, supra note 54, at 281–83.
\textsuperscript{58} See id. at 348–51.
\textsuperscript{59} See id.
agency to administer the program, survey the state’s health facility needs, and develop a state plan acceptable to the federal government, revising the plan every two years.\textsuperscript{60}

As with the Freedmen’s Bureau medical division, federal funds and resources were directed to the states, but state and local authorities retained ultimate control over their use. Indeed, Hill-Burton specifically avoided interfering in the practice of medicine in the states.\textsuperscript{61} In fact, in yet another instance of the federal government stepping back from the opportunity to regulate health care directly, the law left discretion in the siting of hospitals and the awarding of federal funds to state, rather than federal, entities.\textsuperscript{62}

Predictably, the results produced by this national program administered by the states were less than uniform. Wealthier communities benefited more from the legislation due to the requirements that communities raise two-thirds of the construction costs on their own and show that the hospitals supported by federal grants would be financially viable.\textsuperscript{63} Thus, although Hill-Burton succeeded in equalizing hospital bed access across the country, within the states hospital construction funds went to fewer low-income communities.\textsuperscript{64} By 1971, the federal government had spent, through Hill-Burton, $3.7 billion developing a modern American hospital system, but not a system to which all Americans had access.\textsuperscript{65}

\textsuperscript{60} § 611, 60 Stat. at 1041.
\textsuperscript{61} See id.
\textsuperscript{62} See id.
\textsuperscript{63} STARR, SOCIAL TRANSFORMATION, \textit{supra} note 54, at 350.
\textsuperscript{64} Id.
\textsuperscript{65} Id.
Although Hill-Burton provided billions of dollars of federal funding to states to address the disparities in access to acute care, in-patient hospital facilities that existed across the country after World War II, the Act made no attempt to solve some of the access problems first experienced by freedpeople in the South.\textsuperscript{66} To the contrary, Hill-Burton enshrined the Jim Crow concept of “separate but equal” in a provision inserted by Senator Lister Hill of Alabama.\textsuperscript{67} The specific language stated that while facilities built with federal funds were to be available to all persons “without discrimination on account of race, creed or color, but an exception shall be made in cases where separate hospital facilities are provided for separate population groups, if the plan makes equitable provision on the basis of need for facilities and services of like quality for each such group.”\textsuperscript{68}

From 1947 until 1963, this language governed the construction and renovation of hospital facilities in the South. Finally, in 1963 the United States Court of Appeals for the Fourth Circuit ruled that Hill-Burton’s separate but equal provision was unconstitutional, and the Supreme Court denied certiorari, thereby upholding the lower court’s ruling.\textsuperscript{69}

At almost the same time, Congress enacted the Civil Rights Act of 1964.\textsuperscript{70} Then, in 1965, President Johnson signed into law the legislation that created Medicare (which

\textsuperscript{66} Id.  
\textsuperscript{67} JOHN DITTMER, THE GOOD DOCTORS 18 (2009). 
\textsuperscript{68} § 622, 60 Stat. at 1043. 
covered hospital care and physician services provided to the elderly) and Medicaid (which covered medical care provided to welfare recipients) with both programs set to begin operating on July 1, 1966.\footnote{Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended at 42 U.S.C. § 1395 (2006)).} This created an opportunity for activists to undo some of the problems wrought by Hill-Burton.

Relying on the newly enacted anti-discrimination provisions of Title VI of the Civil Rights Act of 1964, which outlawed discrimination by recipients of federal funds,\footnote{Civil Rights Act of 1964, Pub. L. No. 88-352, 78 Stat. 241, 252 (codified as amended at 42 U.S.C. § 2000d (2006)).} activists called on the Department of Health, Education, and Welfare (HEW) to force Southern hospitals to desegregate before they could receive Medicare payments for the services they provided. After receiving hundreds of complaints documenting discrimination in Southern hospitals,\footnote{DITTMER, supra note 67, at 134–35.} HEW launched a drive to bring more than 9000 hospitals across the country into compliance with Title VI before the Medicare program went into effect on July 1, 1966.\footnote{Id. at 136. Still, HEW did not have the resources to investigate individual doctors’ offices. Id. Thus, some white doctors in the South maintained segregated waiting rooms into the 1970s. Id.} Ultimately, most were cleared to receive Medicare funds by the deadline.\footnote{Id. at 139. By the early 1970s, the Southern hospitals were the most integrated facilities in their communities. Id.}

\textbf{C. Medicare and Medicaid}

The simplest way to think about Medicare and Medicaid is that Medicare is for older people (over age sixty-five), and that Medicaid is for poor people (depending on the
particular state’s definition of poverty). While the programs were being debated in Congress, it became popular to describe them as portions of a three-layer cake. The first layer was coverage of hospital care for the elderly (Medicare Part A). The second layer was coverage of out-patient care for the elderly (Medicare Part B). The third layer, added almost as an afterthought, was Medicaid—medical insurance for those dependent on government financial assistance, such as women and children deemed eligible for the Aid to Families with Dependent Children (AFDC) cash-assistance welfare program and single, adult males eligible for either Aid to the Permanently and Totally Disabled or Aid to the Aged, Blind, or Disabled. Strikingly, this layered-cake image illustrates how the structure of these programs tracks the lines drawn by the Freedmen’s Bureau for the administration of its aid during Reconstruction. Given the presumed link between free labor and access to health care, Medicaid and Medicare clearly were designed to assist those who, by necessity or by definition, were dependent on the government and not for those otherwise considered to be able-bodied.

While they remain among the most significant legislative accomplishments of the Johnson Administration, Medicaid and Medicare were far more limited when they first

76 See PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 46–47 (2011) [hereinafter STARR, REMEDY AND REACTION] (pointing out that because welfare eligibility standards differed among the states, it might be easier to qualify for Medicaid in a wealthier state like New York than in a comparatively poorer state like Mississippi).

77 STARR, SOCIAL TRANSFORMATION, supra note 54, at 369.

78 See id.

79 See id.

came into being than they are now. These were programs designed to provide health care access to only narrow segments of the population, not to implement a broad right to health care implicit in citizenship. Since their enactment, they have been amended numerous times. Long before the enactment of the ACA, Medicaid eligibility for children and pregnant women had been unlinked from eligibility for cash welfare assistance.\(^8^1\) Early on, the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit was added and then strengthened in later years to provide a broader range of services to children;\(^8^2\) during the Clinton administration, Medicaid was amended to allow states to cover more children at higher income levels;\(^8^3\) and, during the George W. Bush Administration, Medicaid was amended to allow states to amend their Medicaid plans to expand eligibility while providing less comprehensive “benchmark coverage.”\(^8^4\) Similarly, Medicare has added Part C (managed care)\(^8^5\) and Part D (prescription drugs)\(^8^6\) to its first two original layers of the three-layer cake.

The programs were, and continue to be, supported by different payment schemes, creating significant differences between them. The Medicaid Act offered states the option to


\(^{8^3}\) See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4901, 111 Stat. 251, 552–70 (enacting the Children’s Health Insurance Program (CHIP)).


participate in a program of cooperative federalism designed to improve the health access and status of poor Americans. More specifically, the Act created an entitlement for states to receive federal funding for at least half of the costs of both health care services and the administration of the program itself.

Once more, though, the Medicaid program illustrates the federal government’s long-standing reluctance to dictate health policy to the states—particularly when it comes to determining who is able-bodied or “at risk” of becoming dependent on the government. As a result of this deference, states were permitted to establish very different Medicaid eligibility levels. Even though, as an incentive to participate in the program, poorer states would qualify to receive funding at higher match rates than more prosperous states, those states with lower per-capita incomes tended to be more concerned with limiting dependence on the government. Thus, it became much easier to qualify for Medicaid in New York than in Mississippi. As a practical matter, then, despite Medicaid being targeted to help

88 Huberfeld, supra note 12, at 447.
90 42 U.S.C. §§ 1396b(a), 1396d(b) (2006).
91 See STARR, REMEDY AND REACTION, supra note 76, at 47 (noting that “states varied in their . . . willingness to cover others among the poor”).
92 See id. at 47; see also STARR, SOCIAL TRANSFORMATION, supra note 54, at 417 (noting that the “corridor” between private insurance and government-funded care “was especially wide in the states, many of them in the South, that severely restricted Medicaid eligibility”).
the uninsured poor in the poorest states, deference to state control has rendered the Medicaid program less successful than otherwise it might be.93

In contrast, Medicare was, and remains, almost wholly outside of state control. It is a freestanding program available to all who qualify for social security benefits and is administered by the federal government.94 It has never been associated with welfare programs.95 Medicare also always has had uniform national standards for eligibility and benefits.96 Medicare providers can charge higher rates than Medicaid providers.97 This, of course, has made Medicare far more attractive to providers than Medicaid.98 Thus, while some physicians were, and are, reluctant to participate in Medicaid, virtually every physician accepts Medicare.99

D. EMTALA: A Right to Health Care

On April 7, 1986, President Ronald Reagan signed into law the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).100 COBRA is likely familiar to many of us because it contains the law that requires employers and insurance companies to make insurance coverage available to employees who left their job or would have lost

93 See STARR, REMEDY AND REACTION, supra note 76, at 47.
94 See STARR, SOCIAL TRANSFORMATION, supra note 54, at 369–70.
95 See id. at 370.
96 Id.
97 Id.
98 See id.
99 STARR, REMEDY AND REACTION, supra note 76, at 48–49.
coverage for some other reason.\textsuperscript{101} During the 2008 recession, the American Recovery and Reinvestment Act (ARRA)\textsuperscript{102} made COBRA premium support payments available for individuals who had lost their jobs.\textsuperscript{103} In addition to establishing the provisions for continuing insurance coverage, COBRA also contained the four pages of the Emergency Medical Treatment and Active Labor Act (EMTALA), which sought to put an end to “patient dumping.”\textsuperscript{104}

Patient dumping, “the refusal to treat an emergency patient, even though the hospital has the ability to do so, simply because the patient may not be able to pay,”\textsuperscript{105} arose in part as a consequence of the differing payment rates provided by Medicaid, Medicare, and private insurance. While patients with private insurance were most favored for treatment, the uninsured and Medicaid patients were likely to be transferred to other facilities whenever possible.\textsuperscript{106} In some instances, patient dumping also occurred as a manifestation

\textsuperscript{101} See 29 U.S.C. §§ 1161–1169 (2006). Specifically, the law amended the Employee Retirement Income Security Act of 1974 (ERISA) to require the plan sponsor of each group health plan to provide that each qualified beneficiary who would lose coverage because of a qualifying event is entitled to elect continuation coverage. The law defines a qualifying event as: (1) the death of the covered employee; (2) the termination or reduction of hours of such employee’s employment; (3) the divorce of the employee; (4) the covered employee becoming entitled to Medicare benefits; or (5) a dependent child ceasing to be a dependent child under the generally applicable requirements of the plan. 29 U.S.C. § 1163.


\textsuperscript{103} Id. at 455–66.


\textsuperscript{106} Congress noted that patient dumping had become a more acute problem since the implementation of the Medicare prospective payment system in 1983. See H.R. REP. NO. 99-241 at 5 (1986), reprinted in 1986 U.S.C.C.A.N. 726–27. The prospective payment system pays a predetermined sum to a hospital based on the “DRG” (diagnosis-related group) in which a patient’s particular condition falls. STARR, REMEDY AND REACTION, supra note 76, at 64.
of race discrimination, with eligibility for Medicaid sometimes serving as a proxy for race.\textsuperscript{107} In this way, patient dumping was reminiscent of the problems freedpeople faced in obtaining access to hospitals, almshouses, and asylums. It also echoed the problems faced by individuals seeking treatment in the segregated South prior to the implementation of Medicare. Quite simply, after the incremental advances achieved through Hill-Burton, Medicare, and Medicaid, more was needed.

EMTALA addressed this problem by requiring all hospitals that have Medicare provider agreements and an emergency department to provide medical care to anyone who comes to the emergency department without regard to their ability to pay for the care they receive.\textsuperscript{108} Via a series of well-litigated terms of art, EMTALA requires that all individuals (documented or undocumented) who come to the emergency department must be given a screening examination.\textsuperscript{109} If an emergency condition\textsuperscript{110} or active labor is discovered, the

\begin{quote}
\textsuperscript{109} Id.
\textsuperscript{110} “Emergency medical condition” is defined as “a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in . . . \textit{inter alia} placing the health of the individual . . . in serious jeopardy.” 42 U.S.C. §§ 1395dd(e)(1)–(e)(1)(A)(i) (2006).
\end{quote}
hospital must “stabilize” the individual, even if stabilization means obtaining the assistance of on-call physician specialists outside the emergency department.

EMTALA is unusual in the landscape of American health care regulation because, within a narrow focus, it directly prescribes how medical professionals are to practice medicine. There is no deference to state control. When EMTALA became law, twenty-two states had some form of statute or regulation aimed at requiring hospitals to provide emergency care to patients in need of emergency medical treatment. Nevertheless, Congress chose not to defer to state efforts to address the problem, creating federal sanctions that could be enforced against non-compliant hospitals. Until Congress acted, nothing in federal law had prohibited hospital emergency rooms from transferring patients with no or less favored forms of insurance to county hospitals or other public institutions that would not or could not afford to refuse to see them.

This is as close as our country has come to the right to health care that freedpeople believed was embedded in citizenship. While there is no right to health care enshrined in the U.S. Constitution, EMTALA does create a limited right to health care by requiring

111 To “stabilize” means “to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility[.].” 42 U.S.C. § 1395dd(e)(3)(A) (2006). Thus, EMTALA did not prohibit transfers to other hospitals but sought to ensure the safety of patients during such transfers. “Transfer” is defined to include moving the patient to an outside facility or discharging him. See 42 U.S.C. § 1395dd(e)(4) (2006).
112 See 42 U.S.C. § 1395dd(d) (2006); See also Thornton v. Sw. Detroit Hosp., 895 F.2d 1131, 1135 (6th Cir. 1990) (stating that hospitals could not avoid the requirements of EMTALA by admitting the patient to the hospital before discharging her).
114 Id.
115 DOWNS, supra note 9, at 167.
hospitals to provide emergency medical treatment. Hospitals that fail to comply with EMTALA’s requirements can be fined,\textsuperscript{116} sued by other hospitals who assert that they have suffered a financial loss as a result of patients having been dumped on them,\textsuperscript{117} or sued in tort by any individual who suffers harm as a result of the hospital’s failure to comply.\textsuperscript{118} EMTALA does not provide a cause of action, however, against physicians.\textsuperscript{119}

Nevertheless, EMTALA remains another half-measure enacted by Congress. EMTALA was and always has been an unfunded mandate. It has been estimated that in 2009, cost-shifting to cover care provided to uninsured patients added $1100 to the annual cost of a family policy.\textsuperscript{120} Thus, even as EMTALA provides a limited right of access to emergency care for all, it drives up the cost of access to care for those with private insurance.\textsuperscript{121} Furthermore, to the extent that it encourages Medicaid recipients to seek non-emergency care at hospital emergency departments, it increases the costs of Medicaid.\textsuperscript{122}

\textbf{II. FILLING IN THE GAPS: THE ACA}

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\textsuperscript{116} 42 U.S.C. § 1395dd(d)(1).
\textsuperscript{117} 42 U.S.C. § 1395dd(d)(2)(B).
\textsuperscript{118} 42 U.S.C. § 1395dd(d)(2)(A).
\textsuperscript{119} Still, physicians can be subject to civil monetary penalties. 42 U.S.C. § 1395dd(d)(1)(B).
\textsuperscript{120} Ben Furnas & Peter Harbage, \textit{The Cost Shift From the Uninsured: American Family Health Premiums Cost $1,100 More Because Our System Doesn’t Provide Continuous Coverage For All}, CTR. FOR AM. PROGRESS 1 (2009), http://www.americanprogressaction.org/issues/2009/03/pdf/cost_shift.pdf.
\textsuperscript{121} See id.
Many commentators have attempted to explain why the United States has had such a slow and difficult path toward health care reform and a national framework for funding and administering health care. Paul Starr refers to this problem as “the American health policy trap”:

[A] system of employer-provided insurance that conceals its true costs from those who benefit from it; targeted government programs that protect groups such as the elderly and veterans, who are well organized and enjoy wide public sympathy and believe that, unlike other claimants, they have earned their benefits; and a financing system that has expanded and enriched the health-care industry, creating powerful interests averse to change.123

In a similar vein, Theodore Ruger argues that it is the enduring American tradition of public concern about “institutional intrusion on individualistic choice in medical care”124 that has so often contributed to opposition to health care reforms—both those generated by the government and those generated by the private sector. Arguably, both views simply incorporate vestiges of the Reconstruction-era issues identified by Downs: the odd-coupling of labor and health care and the ever-present anxiety about creating government dependence.125

A. Labor, Health Care and Dependency

During the Civil War era, some government officials believed that employment was the solution that would cure health problems.126 In the latter half of the twentieth century,

123 STARR, REMEDY AND REACTION, supra note 76, at 123.
124 Ruger, supra note 17, at 216.
125 See supra notes 28–32 and accompanying text.
126 DOWNS, supra note 9, at 27.
this literally became government policy, as lucrative tax breaks were provided to employers who provided health insurance to their employees, and most citizens were able to access health care through employer-provided insurance. 127 Unfortunately, the tax break given to those employers for providing health insurance to their employees allowed those employers to take on greater shares of health care costs than they might otherwise have done, insulating consumers from increases in the costs of services, which in turn drove up the cost of premiums for employers. 128

The enactment of the ACA was facilitated in part by a recessionary economy stripping away some of this insulation. 129 Combining a recessionary economy with a rise in health care costs that outpaces the rate of inflation forces employers to shift those costs to employees, who cease to be completely insulated from the real costs of their care. 130 Nowhere is this more evident than in the fact that many unemployed Americans cannot afford their COBRA premiums for continuing coverage. 131

128 See id. at 2301–02.
129 See generally MCDONOUGH, supra note 20, at 50–99.
131 Indeed, part of the American Recovery and Reinvestment Act of 2009 (ARRA) included subsidies provided to individuals to help them afford to pay the premiums for the continuing coverage made possible by COBRA. 26 U.S.C.A. § 6432 (West 2012). See also Cheryl Fish-Parcham, Getting Covered: Finding Health Insurance When You Lose Your Job, FAMILIES USA (2012) http://www.familiesusa.org/assets/pdfs/getting-covered.pdf (urging individuals who cannot afford COBRA coverage to contact their Congressional representatives).
For those who could not work and therefore had no access to health insurance, government programs were crafted carefully to include only the neediest individuals and to exclude those who might be able-bodied. In the case of Medicaid, the peculiar American anxiety over government dependence led to the development of a program that clearly takes a backseat to Medicare, the program for which workers qualify upon retirement. Moreover, by allowing individual states to set their own eligibility standards, the government allowed Medicaid access to differ significantly among the states.

Thus, as the policy trap implies, a few major reasons why individual choice in medical care is valued so highly may be that individuals know what their own benefits are, feel that they have earned them through their labor, and fear being forced into a non-labor related government program of inferior quality. The ACA guarantees that individuals will keep the insurance they have, and with good reason. Above all, in virtually every circumstance, individuals want the opportunity to opt in or opt out of an insurance program. The problem is that allowing that kind of choice in every circumstance makes for a terrible health care system.

B. The ACA as a Response to the Trap

132 Medicare also is linked to labor in that one must work and pay into the Social Security system in order to qualify for it, and in that Medicare is primarily available to those who have reached retirement age. 42 U.S.C. §§ 1395–1395aaa (2006). Reflecting once more anxiety about creating dependency, Medicare is available to those who become disabled, but only after they have completed a two-year waiting period. 42 U.S.C. §§ 1395–1395aaa (2006).

133 See supra notes 89–93 and accompanying text.
The ACA establishes a federal commitment to promote a right to health care—the kind of right that freedpeople thought was inherent in citizenship. It regulates private insurance markets so that individuals who work but do not receive health care through their employer can afford coverage. It expands eligibility for Medicaid. It requires all insurance programs, including Medicare and Medicaid, to provide the same essential health benefits, including covering preventive care. It expands Medicare Part D prescription coverage by eliminating the so-called “doughnut hole” in coverage. It prohibits all health care providers from discriminating on the basis of race, color, national origin, sex, disability, or age. It also seeks to improve efficiency and cut costs in the delivery of care through innovations in the Medicare program.

In short, the ACA can be seen as an effort to fill in the gaps left in our health care system by all of the prior legislation justified by the coupling of labor and health care and the anxiety over creating government dependence. Quite intentionally, the ACA attempts to

134 Rebecca E. Zietlow, Democratic Constitutionalism and the Affordable Care Act, 72 OHIO ST. L.J. 1367, 1389 (2011).
135 See supra text accompanying notes 49–51.
136 See generally MCDOUG, supra note 20, at 118–33.
137 See id. at 146.
138 See id. at 112–14.
139 For an in-depth explanation of how the doughnut hole is eliminated, see Richard L. Kaplan, Analyzing the Impact of the New Health Care Reform Legislation on Older Americans, 18 ELDER L.J. 213, 215-22 (2011).
140 See Patient Protection and Affordable Care Act, 42 U.S.C.A § 300gg-5 (West 2012).
141 See generally MCDOUG, supra note 20, at 156–64.
uncouple access to health care from labor\textsuperscript{142} and to make health insurance available to all without fear of creating dependence.

Thus, rather than scorning or marginalizing government dependence, the ACA, by its very nature, encourages individuals to turn to the government, at both the state and federal levels, to provide access to health care. It also challenges the individual’s fundamental desire to opt out of the system by incentivizing individuals to stay in it.\textsuperscript{143}

Chiefly, this incentive is created through the individual mandate. Now that it has been upheld by the Supreme Court, the individual mandate, come January 1, 2014, will require everyone under sixty-five to have minimum coverage either through an expanded Medicaid program, employer-based insurance, or the purchase of insurance through a state-operated insurance exchange. Lower-income persons who do not qualify for Medicaid will be entitled to receive subsidies distributed as advance tax credits.\textsuperscript{144} Those who opt out of

\begin{footnotesize}
\textsuperscript{142} The ACA contains incentives for employers to continue to provide coverage to employees and establishes exchanges, such as the Small Business Health Options Program (SHOP exchanges) through which small businesses will be able to purchase insurance for their employees. However, it also ensures that insurance is readily available to those outside the labor market. See Patient Protection and Affordable Care Act, 42 U.S.C.A. § 18031 (West 2012) (describing the range of options available to states in setting up exchanges, including SHOP exchanges).

\textsuperscript{143} The ACA amends 26 U.S.C. § 36B to make federal tax credits available to households with incomes between 133% and 400% of the federal poverty level so that they can buy insurance. Patient Protection and Affordable Care Act § 1401(a) (codified at 26 U.S.C. 36B(a), (c)). Those who do not find this incentive attractive enough will face the penalty for failing to obtain minimum coverage. 26 U.S.C. §§ 5000A(b)(1), (g)(1) (2010).

\textsuperscript{144} Patient Protection and Affordable Care Act, 26 U.S.C. §§ 36B(a), (c).
\end{footnotesize}
the mandate will be required to pay a tax collected by the IRS with their income tax
returns.\footnote{26 U.S.C. §§ 5000A(b)(1), (g)(1).}

Through the mandate, Congress sought to relieve some of the upward pressure on
health care prices and health insurance by spreading the costs of providing care to the
uninsured over a much wider pool of policyholders. In this way, the ACA fills in a major
gap in the current system. It solves the unfunded mandate problem of EMTALA by finding
a funding stream.

As originally written, the ACA included an expansion of Medicaid that was
intended to change the character of the program by making Medicaid available to single,
able-bodied adults for the first time. Beginning January 1, 2014, any citizen or legal
resident in a state that adopts the expansion will be eligible for Medicaid if his or her
income is less than 133\% of the federal poverty level. It has been estimated that this
expansion will cut state spending on uncompensated care for the uninsured in half, saving
in the aggregate from $26 billion to $52 billion, and will reduce state spending on
individuals with mental illness, saving in the aggregate between $11 billion and $22 billion,
during the time period from 2014–2019.\footnote{Matthew Buettgens, et al., Consider Savings as Well as Costs: State Governments Would Spend at Least $90 Billion Less with the ACA than Without it from 2014 to 2019, ROBERT WOOD JOHNSON FOUND. & URBAN INST. 1–2 (July 2011), http://www.urban.org/UploadedPDF/412361-consider-savings.pdf.} A more recent study, conducted by the Urban
Institute, Ohio State University, and the Health Policy Institute of Ohio, found that the state
of Ohio alone could save $1.03 billion by adopting the now-optional ACA Medicaid expansion.  

III. NFIB v. Sebelius

The Supreme Court’s decision in NFIB v. Sebelius surprised almost all observers. However, if proponents of the ACA thought their surprise victory would enable implementation to move forward smoothly to address some of the long-standing deficiencies of federal health care legislation—moving those programs beyond service refusals, inconsistencies among state programs, the labor-health care link, and anxiety about dependence on the government—they were wrong on almost every front. In his opinion, Justice Roberts takes each one of those issues and all but flings it back in the face of reformers.

A. The Individual Mandate

Although the Court upheld the individual mandate and preserved the Medicaid expansion (albeit as a voluntary expansion), the rhetoric of Chief Justice Roberts’s opinion closely matched the tone set by the Court’s conservative majority in oral argument. Thus,

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149 Other than one Vanderbilt law professor, no one seems to have accurately predicted the outcome of the case. See Outliers Asides and Insides, MODERN HEALTHCARE, July 16, 2012, at 36; see also Alyssa Creamer, James Blumstein, Vanderbilt University Law Professor, Has Medicaid Mandate Challenge Brief Cited in Supreme Court Ruling on Affordable Care Act, THE HUFFINGTON POST (July 5, 2012, 4:14 PM), http://www.huffingtonpost.com/2012/07/05/james-blumstein-vanderbilt-health-care-law_n_1651919.html.
for example, the Roberts opinion\textsuperscript{150} echoes Justice Anthony Kennedy’s questioning and concerns. At oral argument, Kennedy posed the now oft-repeated question:

\begin{quote}
I understand that we must presume laws are constitutional, but, even so, when you are changing the relation of the individual to the government in this, what we can stipulate is, I think, a unique way, do you not have a heavy burden of justification to show authorization under the Constitution?\textsuperscript{151}
\end{quote}

In his opinion, Roberts referenced this language finding that the government had not met this burden of justification and that the individual mandate could not be justified under the commerce power.\textsuperscript{152}

Yet, given the federal government’s history of regulatory attempts in the field of health care, this seems to be the wrong issue on which to focus. It would be more accurate to say that the focus of the ACA itself, and the individual mandate in particular, is to change the relationships between individuals, not solely or even primarily the relationship between the individual and the government. If access to health care may be seen as an attribute of citizenship, should not the government play the leading role in effectuating that promise? Moreover, should the choices of individuals be permitted to infringe or define the rights of citizenship for others? When we have a health care system that allows free riders to opt out or that excludes large numbers of people, the inevitable costs become unsustainable.\textsuperscript{153}

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\textsuperscript{153} See Ruger, supra note 17, at 216.
\end{flushleft}
While upholding the individual mandate, Justice Roberts’s language, invoking Justice Kennedy’s now-famous question, suggests that the rights of individuals are more highly valued than having a coherent, sustainable system that benefits everyone. Thus, the Roberts opinion likely will embolden those seeking to opt out of other aspects of the ACA. Many Catholic organizations already have filed suit seeking an exemption from the ACA’s requirement that the health insurance benefits they provide to employees include coverage for birth control. In another case, a federal judge in Colorado has held preliminarily that the same ACA requirement cannot be applied to a small business owned by a devout Catholic owner.

It is hard to predict where these types of cases will end or the effect they will have on implementation of the ACA. The examples above involve businesses opting out of insurance requirements. However, other opt-outs are possible as well. Providers may refuse to provide certain services to patients based on personal, moral, or religious objections. Patient dumping, of course, is a type of refusal, and EMTALA was enacted to prevent hospitals from opting out of providing emergency treatment to all, regardless of race or ability to pay. While supporters of refusal clauses and other restrictions view

156 See generally id.; Complaint, Roman Catholic Archbishop of Wash., Case No. 1:12-cv-00815.
them as matters of providers’ rights of conscience, they can have significant negative consequences for women’s health and lead to poorer health outcomes.\[159\] Again, the question is whether the interests of the individual trump our communal interest in taking care of each other. One could argue that what is at issue here is not socialism, but solidarity.

B. The Medicaid Expansion

If supporters of the ACA were unhappy with Justice Roberts’s rhetoric, but pleased with the Court’s ruling on the individual mandate, they could find no such solace in the Court’s ruling on the ACA’s Medicaid expansion. Though the Medicaid expansion was deemed constitutional as long as it was made optional for each state,\[160\] Justice Roberts’s ruling carries with it the potential to undo much of the good that the drafters of the expansion sought to achieve. Roberts, joined by six other Justices, held that the federal government could not link a state’s decision to implement the Medicaid expansion to continued funding for all Medicaid programs.\[161\] In doing so, he found that the Medicaid expansion was not an addition to the old Medicaid program, but an entirely new program.\[162\]

This, of course, is true in the sense that the Medicaid expansion represented an uncoupling of labor and health care. The expansion would have created near-uniform eligibility across the nation based on a single method of counting income and no more

\[159\] See Fogel & Weitz, *supra* note 157.
\[161\] See *id*.
\[162\] *Id.* at 2605–06.
categorical distinctions. Whether working or not, all individuals with family incomes below 133% of the federal poverty level would be eligible for benefits on an equal basis. Essentially, Justice Roberts reverts to the Freedman’s Bureau model, holding that a program to help the indigent and disabled is one thing, but a program in which able-bodied persons can access health care is of a “shift in kind, not merely degree.”

The consequences of an optional Medicaid expansion program are unclear. It may be that the federal reimbursement rates—100% initially and then gradually declining to 90%—will be too attractive to refuse, particularly in places where hospitals are currently providing large amounts of uncompensated care. Therefore, almost every state will be inclined to sign up. On the other hand, with some state governors vowing not to expand Medicaid in their states, it may simply be more of the same—the same disparities in

163 McDonough, supra note 20, at 152.
164 Id.
166 See Expanding Medicaid in Ohio: Preliminary Analysis of Likely Effects, supra note 147, at 24. Whether a state chooses to adopt the Medicaid expansion or not, its hospitals will be subject to a reduction in disproportionate share hospital (DSH) funding. See Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, §§ 1203, 124 Stat. 1029, 1053-55 (amending 42 U.S.C. § 1396r-4(f)); Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 2551(a), 10201(e)(1), 124 Stat. 119, 312-14, 920-22 (2010) (amending 42 U.S.C. § 1396r-4(f)). DSH money is an additional pot of Medicaid funds traditionally allocated to charitable or “safety-net” hospitals that serve a disproportionate share of poor and uninsured patients. DHS funds help to keep such hospitals open and preserve access to care for indigent populations. See Robert E. Mechanic, Medicaid’s Disproportionate Share Hospital Program: Complex Structure, Critical Payments, NAT’L HEALTH POL’Y F., 5–8 (Sept. 14, 2004), http://www.nhpf.org/library/background-papers/BP_MedicaidDSH_09-14-04.pdf, for a history of the Medicaid DSH program. The underlying theory of the health care reform law is that, if Medicaid is expanded and everyone else is subject to the individual mandate, hospitals should have less exposure for uncompensated care because they will have fewer patients who are unable to pay them. Hence, DSH funds can be reduced.
eligibility and coverage, the same stigma as being a program of last resort, and the same
difference between New York and Mississippi. Above all, what certainly seems clear is that
Justice Roberts has given states much more leverage with which to negotiate the terms of
their expansion.\footnote{See Nat’l Fed’n of Indep. Bus., 132 S. Ct. at 2605–06 (2012).} Depending upon how the states use that leverage, there could be wide
disparities among states and many, many more people remaining uninsured.

CONCLUSION

The debate over health care reform is and ought to be about how we propose to take
care of each other. A statute like EMTALA brings to the fore one major area of national
agreement in health care: the right to emergency medical care. Unfortunately, in doing so,
the statute shines a bright light on the gaping holes in our path-dependent health care
system, in which access to care, since Reconstruction, either has come through labor or
through a government program for the dependent. The ACA will close many of these holes,
but because of the Supreme Court’s Medicaid expansion decision in \textit{NFIB v. Sebelius}, it
will not do so as completely or as efficiently as it might have. In the end, the right to health
care detached from labor or dependency sought by freedpeople as a benefit of citizenship,
and which could have been enshrined in law through the Medicaid expansion, went unheard
in the Supreme Court.

\footnote{Schulte, \textit{Neb. Governor Vows to Fight Medicaid Expansion}, \textit{Bus. Wk.} (June 29, 2012),
http://www.businessweek.com/ap/2012-06-29/neb-dot-governor-vows-to-fight-medicaid-expansion.}
Still, the ACA portends real progress. It is true that the ACA does nothing explicit to rein in costs. However, it does a lot of things that will make us healthier in the long run, such as provide across-the-board access to preventive care and other essential health benefits. The ACA still will bring many more people into the system—though, thanks to the Supreme Court, not as many as might have been hoped. By bringing more people into the system, it makes health disparities a problem for all of us to address together and a bigger cost than the risk of dependency. If we are all in the system together, whether we can pay or not, then those of us who do pay have a lot of incentive to make sure that those who cannot pay get the best outcomes from the system as cheaply as possible. Bending the cost curve certainly will be a critical task for the future. Nevertheless, the ACA provides a reason to believe that, to paraphrase Dr. Martin Luther King, Jr.: the cost curve, like the arc of the moral universe, is long, but it bends toward justice.


170 In his speech, “Where Do We Go From Here?” given in August 1967 to the Southern Christian Leadership Conference, Dr. King said, “The arc of the Moral Universe is long, but it bends toward Justice”. Martin Luther King, Jr., Speech at the Southern Christian Leadership Conference (Aug. 1967). King himself was paraphrasing the abolitionist Theodore Parker who spoke of the inevitable success of the abolitionist cause: “I do not pretend to understand the moral universe; the arc is a long one, my eye reaches but little ways; I cannot calculate the curve and complete the figure by the experience of sight; I can divine it by conscience. And from what I see I am sure it bends towards justice.” 2THEODORE PARKER, THE COLLECTED WORKS OF THEODORE PARKER: SERMONS, PRAYERS 48 (Frances Power Cobbe ed., 1879).