



Health Care: Constitutional Rights and Legislative Powers

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Summary

The health care reform debate raises many complex issues including those of coverage, accessibility, cost, accountability, and quality of health care. Underlying these policy considerations are issues regarding the status of health care as a constitutional or legal right. This report analyzes constitutional and legal issues pertaining to a right to health care, as well as the power of Congress to enact and fund health care programs. Following the recent passage of the Patient Protection and Affordable Care Act, P.L. 111-148, legal issues have been raised regarding the power of Congress to mandate that individuals purchase health insurance, and the ability of states to “nullify” or “opt out” of such a requirement. These issues are also discussed.

The United States Constitution does not set forth an explicit right to health care. While the Supreme Court would likely find that the Constitution provides a right to obtain health care services at one’s own expense from willing providers, the Supreme Court has never interpreted the Constitution as guaranteeing a right to health care services from the government for those who cannot afford it. The Supreme Court has, however, held that the government has an obligation to provide medical care in certain limited circumstances, such as for prisoners.

While the United States Constitution and Supreme Court interpretations do not identify a constitutional right to health care for those who cannot afford it, Congress has enacted numerous statutes, such as Medicare, Medicaid, and the Children’s Health Insurance Program, that establish and define specific statutory rights of individuals to receive health care services from the government. As a major component of many health care entitlement statutes, Congress has provided funding to pay for the health services provided under law. Most of these statutes have been enacted pursuant to Congress’s authority to “make all Laws which shall be necessary and proper” to carry out its mandate “to ... provide for the ... general Welfare.” The power to spend for the general welfare is one of the broadest grants of authority to Congress in the U.S. Constitution. The Supreme Court accords considerable deference to a legislative decision by Congress that a particular health care spending program provides for the general welfare.

Recently, Congress enacted comprehensive health care reform legislation, P.L. 111-148, which includes a requirement that individuals purchase health insurance. Several lawsuits have been filed challenging the power of Congress to enact such a mandate under the Commerce Clause of the U.S. Constitution. In addition, several states have passed laws attempting to “nullify” or “opt out” of the federal individual health insurance mandate in Section 1501 of P.L. 111-148, which goes into effect in 2014. Direct conflicts between federal and state laws would raise constitutional issues which are likely to be resolved in favor of the federal law under the Supremacy Clause of the U.S. Constitution.

A number of state constitutions contain provisions relating to health and the provision of health care services. State constitutions may provide constitutional rights that are more expansive than those found under the federal Constitution since federal rights set the minimum standards for the states.

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Health Care Rights Under the U.S. Constitution

The health care reform debate raises many complex issues including those of coverage, accessibility, cost, accountability, and quality of health care. Underlying these policy considerations are issues regarding the status of health or health care as a moral, legal, or constitutional right. It may be useful to distinguish between a right to health and a right to health care.¹ An often cited definition of “health” from the World Health Organization describes health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.”² “Health care” connotes the means for the achievement of health, as in the “care, services or supplies related to the health of an individual.”³ For purposes of this report, discussion will be limited to constitutional and legal issues pertaining to a right to health care.

Numerous questions arise concerning the parameters of a “right to health care.” If each individual has a right to health care, how much care does a person have a right to and from whom? Would equality of access be a component of such a right? Do federal or state governments have a duty to provide health care services to the large numbers of medically uninsured persons? What kind of health care system would fulfill a duty to provide health care? How should this duty be enforced? The debate on these and other questions may be informed by a summary of the scope of the right to health care, particularly the right to access health care paid for by the government, under the U.S. Constitution and interpretations of the U.S. Supreme Court.⁴

Explicit Rights in the U.S. Constitution

The United States Constitution does not explicitly address a right to health care. The words “health” or “medical care” do not appear anywhere in the text of the Constitution. The provisions in the Constitution indicate that the framers were somewhat more concerned with guaranteeing freedom *from* government, rather than with providing for specific rights to governmental services such as for health care. The right to a jury trial, the writ of habeas corpus, protection for contracts, and protection against ex post facto laws were among the few individual rights explicitly set forth in the original Constitution.⁵ In 1791, the Bill of Rights was added to the Constitution, and additional amendments were added following the Civil War, and thereafter. Most constitutional amendments dealt with civil and political rights, not social and economic rights.⁶ However, there have been proposals to add a specific right to health care as an amendment to the U.S.

¹ See Lawrence O. Gostin, “Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America,” 39 St. Louis U. L.J. 7 (1994), and Lawrence O. Gostin, “The Right to Health: A Right to the Highest Attainable Standard of Health, 31 HASTINGS CENTER REPORT 29-10 (2001).

² Constitution of the World Health Organization (2006), available at http://www.who.int/governance/eb/who_constitution_en.pdf.

³ Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, 45 C.F.R. § 160.103.

⁴ This report does not analyze the scope of a right to health or health care under various international agreements or under the governing documents of other countries. For further information *see, e.g.*, Puneet K. Sandhu, “A Legal Right to Health Care: What Can the United States Learn From Foreign Models of Health Rights Jurisprudence?” 95 Cal. L. Rev. 1151 (2007); and Marcela X. Berdion, “The Right to Health Care in the United States: Local Answers to Global Responsibilities,” 60 SMU Law Review 1633 (2007).

⁵ W. Kent Davis, “Answering Justice Ginsburg’s Charge that the Constitution is ‘Skimpy’ in Comparison to our International Neighbors: A Comparison of Fundamental Rights in American and Foreign Law,” 39 S. Tex. L. Rev. 951, 958 (1998).

⁶ *Id.* at 958-959.

Constitution. For example, in 1944, President Franklin D. Roosevelt, in his State of the Union address, advanced his idea of a “Second Bill of Rights” which would include “[t]he right to adequate medical care and the opportunity to achieve and enjoy good health.”⁷ More recently, Representative Jesse L. Jackson Jr. introduced H.J.Res. 30 on March 3, 2009, a bill which proposes an amendment to the U.S. Constitution ensuring a right to health care. The proposed amendment reads, “Section 1. All persons shall enjoy the right to health care of equal high quality. Section 2. The Congress shall have power to enforce and implement this article by appropriate legislation.”

The Right to Health Care at the Government’s Expense

Even though the U.S. Constitution does not explicitly set forth a right to health care, the Supreme Court’s decisions in the areas of the right to privacy and bodily integrity suggest the Constitution implicitly provides an individual the right to access health care services at one’s own expense from willing medical providers.⁸ However, issues regarding access to health care do not usually concern access where a person has the means and ability to pay for health care, but rather involve situations where a person cannot afford to pay for health care. The question becomes, not whether one has a right to health care that one can pay for, but whether the government or some other entity has the obligation to provide such care to those who cannot afford it.

If the Supreme Court were to find an implicit right to health care for persons unable to pay for such care, it might do so either by finding that the Constitution implicitly guarantees such a right, or that a law which treats persons differently based on financial need creates a “suspect classification.” In either case, the Court would evaluate the constitutionality of legislative enactments that unduly burden such rights or classifications under its “strict scrutiny” standard of review, thus according the highest level of constitutional protection offered by the equal protection guarantees of the Constitution. Absent a finding of an implicit fundamental right to health care for poor persons under the Constitution, or that wealth distinctions create a “suspect class,” the Court would likely evaluate governmental actions involving health care using the less rigorous “rational basis” standard of review. Most health care legislation would likely be upheld, as it has been, so long as the government can show that the legislation bears a rational relationship to a legitimate governmental interest.

Substantive Due Process: Impact on Fundamental Rights

Despite the lack of discussion of health care rights in the Constitution, arguments have been made that the denial by the federal government of a minimal level of health care to poor persons transgresses the equal protection guarantees under the Constitution. While the equal protection clause of the Fourteenth Amendment applies only to the states, similar equal protection principles are applicable to the federal government through the Due Process Clause of the Fifth Amendment.⁹ A litigant challenging a federal action has the burden of proving that the

⁷ 12 Pub. Papers 41 (Jan. 11, 1944).

⁸ See *Roe v. Wade*, 410 U.S. 113 (1973) (constitutionally protected right to choose whether or not to terminate a pregnancy), and *Cruzan v. Missouri Department of Health*, 497 U.S. 261 (1990) (constitutional right to refuse medical treatment that sustains life), both of which involve a right to bodily integrity that may be extended to a person seeking health care services at his or her own expense.

⁹ See, generally, discussion regarding fundamental rights in CRS, *United States Constitution: Analysis and Interpretation*, by Kenneth R. Thomas, p. 1763 et seq.

governmental action places an undue burden on the exercise of an individual's fundamental right. The standard of review used in cases involving fundamental rights is called "strict scrutiny." Using this heightened standard of review, if the Court determines that a fundamental right has been unduly burdened, the governmental action will only be upheld if the government can demonstrate that the action is necessary to achieve a compelling governmental interest.¹⁰

The Supreme Court has held that the Due Process Clause of the Fourteenth Amendment provides constitutional protection for certain rights or "liberty interests" related to privacy.¹¹ Legislative enactments that implicate the right to privacy have been reviewed under the heightened strict scrutiny standard of review. Thus, the right to privacy has been held to include the right to procreate,¹² use contraception,¹³ have an abortion,¹⁴ and maintain bodily integrity.¹⁵

While the Supreme Court has held that the Constitution implicitly confers a fundamental right to privacy, the Court has not elevated health care to the status of a fundamental right. The Court has evaluated governmental actions involving health care using the less rigorous "rational basis" standard of review. Under this standard, a governmental action will be upheld if the action bears a rational relationship to a legitimate governmental interest.¹⁶ For example, in *Maher v. Roe*,¹⁷ the Supreme Court held that a state could refuse to provide public assistance for non-therapeutic abortions under a program that subsidized all medical expenses otherwise associated with pregnancy and childbirth. In other words, while the constitutional right to an abortion protected a woman's right to choose whether or not to terminate a pregnancy, it did not mean abortion was a health right.¹⁸

In *Harris v. McRae*,¹⁹ the Supreme Court held that the Medicaid program's refusal, under the Hyde Amendment, to pay for medically necessary abortions did not burden a woman's fundamental right to choose an abortion. The Court applied the rational basis standard of review and found that poor pregnant women were not denied equal protection of the laws because the abortion provisions were rationally related to a governmental "interest in protecting the potential life of the fetus."²⁰ The Court also noted that while the Due Process Clause of the Fourteenth Amendment affords protection against unwarranted government interference with freedom of choice regarding certain personal decisions, it "does not confer an entitlement to such funds as may be necessary to realize all the advantages of that freedom."²¹ The Court stated further,²²

¹⁰ See *San Antonio Indep. Sch. Dist. v. Rodriguez*, 411 U.S. 1, 33-35 (1973).

¹¹ *Griswold v. Connecticut*, 381 U.S. 479 (1965).

¹² *Skinner v. Oklahoma ex rel. Williamson*, 316 U.S. 535, 541 (1942).

¹³ See *Griswold v. Connecticut*, 381 U.S. 479, 485 (1965).

¹⁴ See *Roe v. Wade*, 410 U.S. 113, 153 (1973).

¹⁵ See *Washington v. Harper*, 494 U.S. 210, 221-22 (1990) and *Winston v. Lee*, 470 U.S. 753, 766-67 (1985).

¹⁶ It is noted that the Supreme Court has struck down state durational residence requirements for government benefits including health care services, but the constitutional right implicated was the right to travel, not a right to health care. See *Memorial Hospital v. Maricopa Cty.*, 415 U.S. 250, 269 (1974), where Arizona's one-year residency requirement for free medical care to indigents was held to violate equal protection guarantees and the right to travel.

¹⁷ 432 U.S. 464 (1977).

¹⁸ *Id.* at 473-474.

¹⁹ 448 U.S. 297 (1980).

²⁰ *Id.* at 324.

²¹ *Id.* at 318.

²² *Id.*

To translate the limitation on government power implicit in the Due Process Clause into an affirmative funding obligation would require Congress to subsidize the medically necessary abortion of an indigent woman even if Congress had not enacted a Medicaid program to subsidize other medically necessary services. Nothing in the Due Process Clause supports such an extraordinary result. Whether freedom of choice that is constitutionally protected warrants federal subsidization is a question for Congress to answer, not a matter of constitutional entitlement.

In other words, a woman has a constitutional right to terminate her pregnancy, but that right is not unduly burdened if she cannot afford an abortion.²³ More broadly, the Constitution does not obligate the states or the federal government to pay for medical expenses, even for the health care of poor persons.²⁴

The Court's use of the rational basis test for constitutional analyses of health care legislation extends to other, related areas, such as housing²⁵ and education.²⁶ In the welfare area, the Court has, at times, acknowledged the importance of public assistance to poor persons. In *Goldberg v. Kelly*,²⁷ where the Court held that due process rights attach to welfare benefits, the Court stated,²⁸

From its founding the Nation's basic commitment has been to foster the dignity and well-being of all persons within its borders.... Welfare, by meeting the basic demands of subsistence, can help bring within the reach of the poor the same opportunities that are available to others to participate meaningfully in the life of the community.... Public assistance, then is not mere charity, but a means to "promote the general Welfare, and secure the Blessings of Liberty to ourselves and our Posterity."

While the Court recognized the state's duty to meet the basic needs of its citizens, it declined to impose an affirmative duty to do so, making it clear that welfare is not a constitutional right, and the state does not have an obligation to provide resources to meet subsistence needs.²⁹

Equal Protection: Wealth as a "Suspect Class"

For a classification that treats people differently—such as health care services for some poor persons but not all who are in need—to rise to the highest level of constitutional protection, the classification must be found to be a "suspect classification" by the Supreme Court. According to the Court, the constitutional guarantee of equal protection is not a source of substantive rights, but rather a "right to be free from invidious discrimination in statutory classifications and other governmental activity."³⁰ In cases where the Court determines state or federal governmental

²³ See *Webster v. Reproductive Health Servs.*, 492 U.S. 490, 507 (1989), where the Court noted that the "Due Process Clause generally confers no affirmative right to governmental aid, even when such aid may be necessary to secure life, liberty, or property interests."

²⁴ *Maher v. Roe*, 432 U.S. 464, 469 (1977). See, also, *Youngberg v. Romeo*, 457 U.S. 307, 317 (1982) ("[A] State is under no constitutional duty to provide substantive services for those within its borders.")

²⁵ See *Lindsey v. Normet*, 405 U.S. 56, 74 (1972), where the Supreme Court held that housing was not a fundamental constitutional right.

²⁶ See *San Antonio School District v. Rodriguez*, 411 U.S. 1, 37 (1973), where the Supreme Court acknowledged the importance of public education but refused to accord it the status of a fundamental constitutional right.

²⁷ 397 U.S. 254 (1970).

²⁸ *Id.* at 264-65.

²⁹ See also *Jefferson v. Hackney*, 406 U.S. 535, 546-48 (1972); *Dandridge v. Williams*, 397 U.S. 471, 486-87 (1970).

³⁰ *Harris v. McRae*, 448 U.S. at 322.

classifications to be “suspect,” it will apply the strict scrutiny standard of review. Thus, the Court has applied the strict scrutiny test to suspect classifications based on race,³¹ ethnicity,³² and national origin.³³

The High Court, however, has not seen fit to consider financial need or distinctions on the basis of wealth as suspect classifications for purposes of its equal protection analysis.³⁴ For example, in *Dandridge v. Williams*,³⁵ the Court upheld a Maryland welfare distribution scheme whereby an upper limit was placed on the amount of assistance any one family could receive. This meant that larger families with greater need received less aid per child than smaller families. The Court stated the following:³⁶

In the area of economics and social welfare a State does not violate the Equal Protection Clause merely because the classifications made by its laws are imperfect. If the classification has some “rational basis,” it does not offend the Constitution simply because the classification “is not made with mathematical nicety or because in practice it results in some inequality.”

Thus, the Court concluded that while the Constitution may require procedural safeguards for the distribution of economic and social welfare benefits, as it held in *Goldberg v. Kelly*, it “does not empower this Court to second-guess state officials charged with the difficult responsibility of allocating limited public welfare funds among the myriad of potential recipients.”³⁷ The Court has reaffirmed this holding in subsequent cases.³⁸ In like manner, in the health care area, the Court has again applied the more deferential “rational basis” standard of review in assessing the constitutionality of distinctions or classifications in the provision of health care on the basis of wealth. Health care legislation will generally be upheld so long as the government can show a legitimate purpose and a rational basis for carrying out the program.

Exception: Under Government Control

The Supreme Court has held that, under certain circumstances, persons under governmental control, such that they are dependent upon the government for their basic needs, have a right to a minimal amount of medical care. However, the Supreme Court has not based its decisions defining a right to medical care for persons with limited freedoms on a fundamental right to health care.³⁹ Rather, in the case of prisoners, the Supreme Court has held that they are entitled to

³¹ See *Adarand Constructors, Inc. v. Peña*, 515 U.S. 200, 227 (1995); *McLaughlin v. Fla.*, 379 U.S. 184, 192 (1964).

³² See *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265, 290-91 (1978).

³³ See *Oyama v. Cal.*, 332 U.S. 633, 646 (1948); see, also, *Korematsu v. United States*, 323 U.S. 214, 216 (1944).

³⁴ The Court has acknowledged that “laws and regulations allocating welfare funds involve ‘the most basic economic needs of impoverished human beings,’” but still has upheld classifications based on wealth where the government can show a reasonable basis for the distinctions. *Maher*, 432 U.S. at 479, quoting *Dandridge v. Williams*, 397 U.S. 471, 485 (1970).

³⁵ 397 U.S. 471 (1970).

³⁶ *Id.* at 485.

³⁷ *Id.* at 487.

³⁸ *E.g.*, *United States v. Kras*, 409 U.S. 434 (1973); *Maher v. Roe*, 432 U.S. 464, 469 (1977); *Harris v. McRae*, 448 U.S. 297, 324 (1980).

³⁹ William P. Gunnar, “The Fundamental Law That Shapes the United States Health Care System: Is Universal Health Care Realistic Within the Established Paradigm?” 15 *Annals Health L.* 151, 164 (2006).

adequate food, clothing, shelter, and medical care as a component of the protections accorded by the Eighth Amendment.⁴⁰ “[D]eliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain,’ ... proscribed by the Eighth amendment,” said the Court, raising the possibility of pain and suffering that can amount to cruel and unusual punishment.⁴¹ In like manner, involuntarily confined mentally disabled patients have a right to safe conditions, including food, shelter, and medical care, as well as minimally adequate training to avoid placement in physical restraints, as part of their substantive liberty interests guaranteed by the Due Process Clause of the Fourteenth Amendment.⁴²

Federal Power to Provide for and Fund Health Care Programs

While the Constitution and Supreme Court interpretations do not identify a constitutional right to health care at the government’s expense, Congress has enacted numerous statutes which establish and define specific statutory rights of individuals to receive medical services from the government. In addition, other statutes such as Title VI of the Civil Rights Act of 1964,⁴³ which prohibits discrimination under federally funded programs, affect the manner of delivery of services under federal grants and programs. As a major component of many health care entitlement statutes, Congress has provided funding to pay for the health care services offered under law. Most of these statutes have been enacted pursuant to Congress’s authority to “make all Laws which shall be necessary and proper” to carry out its mandate “to ... provide for ... the general Welfare.”⁴⁴

Recently, Congress enacted comprehensive health care reform legislation, the Patient Protection and Affordable Care Act, P.L. 111-148. This statute imposes new requirements on individuals, employers, and the private health insurance market, and expands the Medicaid program, among

⁴⁰ *Farmer v. Brennan*, 511 U.S. 825, 832 (1994).

⁴¹ *Estelle v. Gamble*, 429 U.S. 97, 104 (1976) (citing *Gregg v. Georgia*, 428 U.S. 153, 173 (1976)). See also *West v. Atkins*, 487 U.S. 42, 56 (1988): “Contracting out prison medical care does not relieve the State of its constitutional duty to provide adequate medical treatment to those in its custody, and it does not deprive the State’s prisoners of the means to vindicate their Eighth Amendment rights.”

⁴² *Youngberg v. Romeo*, 457 U.S. 307, 315 (1982). By statute, Congress has mandated medical care for persons under a federal quarantine or isolation order, another example of the provision of medical care for persons with limited freedoms. 42 U.S.C. § 249(a).

⁴³ 42 U.S.C. §2000d. Specifically under Title VI, “[n]o person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance.” It has been suggested that Title VI “arguably was highly effective at eliminating segregation among physicians in hospitals, ending high prepayment requirements for black patients, and eliminating discriminatory routing of ambulances.” (*footnote omitted*) (Jennifer Gores, ed., “Health Care Law: Health Care Access,” 8 *Geo. J. Gender & L.* 837, 842 (2007)).

⁴⁴ U.S. CONST. Art. I, § 8, cl. 18 and cl. 3. Congress also has the power to regulate health care under its power to regulate interstate commerce, and has done so when it has directly regulated the health care industry. Examples include the Employee Retirement Income Security Act of 1974 (ERISA) which regulates employee benefits, including health insurance, 29 U.S.C. 1001 *et seq.*; the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), which provides for insurance continuation requirements for certain persons who lose employment-related health insurance benefits, 29 U.S.C. §§ 1161-1168; various health insurance plan mandates for childbirth delivery hospital stays, breast reconstruction payments for mastectomies, and certain mental health coverage annual and life-time limit requirements, 29 U.S.C. §§ 1185, 1185a, 1185b; and, most recently, an individual mandate, for most Americans, to have health insurance coverage, which begins in 2014, Section 1501 of P.L. 111-148.

other provisions. In doing so, Congress used its power to regulate interstate commerce, as well as its power to tax and spend for the general welfare.

The Taxing and Spending Power

The most frequently utilized grant of power in the Constitution for health care spending is that found in Article I, § 8, cl. 1, which states in part that “[t]he Congress shall have Power to lay and collect Taxes, ... to ... provide for the ... general Welfare of the United States.”⁴⁵ The last paragraph of this section provides that Congress shall have the authority “to make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers.” The “foregoing Powers” include this specific power, popularly known as the taxing and spending power. Other powers in § 8 for which Congress has the authority to enact “necessary and proper” laws include Congress’s power to provide for the common defense (cl. 1), to pay the debts of the United States (cl. 1), to borrow money (cl. 2), to regulate interstate commerce (cl. 3), to set citizenship requirements (cl. 4), to coin money (cl. 5), and to declare war (cl. 11).

The Supreme Court has recognized that Congress’s power to tax is extremely broad. In *United States v. Doremus*, the Court stated that “[i]f the legislation enacted has some reasonable relation to the exercise of the taxing authority conferred by the Constitution, it cannot be invalidated because of the supposed motives which induced it.”⁴⁶ In like manner, the power to spend for the general welfare is one of the broadest grants of authority to Congress in the United States Constitution.

The scope of the national spending power was brought before the United States Supreme Court in a landmark case in 1937 dealing with the newly enacted Social Security Act.⁴⁷ In *Steward Machine Co. v. Davis*,⁴⁸ the Court sustained a tax imposed on employers to provide unemployment benefits to individual workers. It was argued that the tax and a state credit that went with the state’s tax were “weapons of coercion, destroying or impairing the autonomy of the States.”⁴⁹ The Supreme Court, however, held that relief of unemployment was a legitimate object of federal spending under the “general welfare” clause, and that the Social Security Act, which also included old age benefits for individuals so they might not be destitute in their old age,⁵⁰ as well as provisions for child welfare and maternal child health projects, was a legitimate attempt to solve these problems in cooperation with the states.⁵¹

⁴⁵ It is noted that the Tenth Amendment provides that “powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.” While this language would appear to represent one of the most clear examples of a federalist principle in the Constitution, it has not had a significant impact in limiting federal powers. See, for a general discussion of constitutional federalism principles, CRS Report RL30315, *Federalism, State Sovereignty, and the Constitution: Basis and Limits of Congressional Power*, by Kenneth R. Thomas.

⁴⁶ 249 U.S. 86, 93 (1919). For a discussion of certain limitations that do apply to Congress’s power to tax, see, generally, CRS, *United States Constitution: Analysis and Interpretation*, coordinated by Kenneth R. Thomas, at <http://www.crs.gov/conan/default.aspx?mode=topic&doc=Article01.xml&t=1|1&s=8&c=1>.

⁴⁷ 42 U.S.C. 401 *et seq.*

⁴⁸ 301 U.S. 548 (1937).

⁴⁹ *Id.* at 591.

⁵⁰ See *Helvering v. Davis*, 301 U.S. 619 (1937), which upheld the old-age benefits provisions of Title II of the Social Security Act.

⁵¹ *Steward Machine Co. v. Davis*, 301 U.S. 548, 591 (1937). The Supreme Court has suggested that there are limits to (continued...)

Subsequent Supreme Court decisions have not questioned Congress's policy decisions as to what kinds of spending programs are in pursuit of the "general welfare," and so numerous programs have been funded in such diverse areas as education, housing, veterans' benefits, the environment, welfare, health care, scientific research, the arts, community development, and public financing of election campaigns. The Supreme Court accords great deference to a legislative decision by Congress that a particular spending program provides for the general welfare. Indeed, the High Court has suggested that the question whether a spending program provides for the general welfare is one that is entirely within the discretion of the legislative branch. Thus, in *Buckley v. Valeo*,⁵² the Supreme Court held that federal funding of election campaigns was a proper exercise of Congress's power to spend for the general welfare:⁵³

Appellants' "general welfare" contention erroneously treats the General Welfare Clause as a limitation upon congressional power. It is rather a grant of power, the scope of which is quite expansive, particularly in view of the enlargement of power by the Necessary and Proper Clause.... It is for Congress to decide which expenditures will promote the general welfare.... In this case, Congress was legislating for the "general welfare"—to reduce the deleterious influence of large contributions on our political process, to facilitate communication by candidates with the electorate, and to free candidates from the rigors of fundraising.... Whether the chosen means appear "bad," "unwise," or "unworkable" to us is irrelevant; Congress has concluded that the means are "necessary and proper" to promote the general welfare, and we thus decline to find this legislation without the grant of power in Art. I, §8.

Federally Funded Health Care Programs

The Medicare program, established in Title XVIII of the Social Security Act in 1965,⁵⁴ is the largest health care program enacted by Congress pursuant to its power to tax and spend for the general welfare. Medicaid (Title XIX),⁵⁵ also enacted in 1965, and the Children's Health Insurance Program (CHIP) (Title XXI),⁵⁶ enacted in 1997, are examples of voluntary federal/state partnership programs providing health care benefits to certain low-income persons. The Supreme Court has not taken a case challenging these health care programs as an unconstitutional exercise of Congress's taxing and spending power, possibly because the law on this point was settled by its

(...continued)

Congress's power under the Spending Clause to require states to meet grant conditions. For more information see CRS Report RL30315, *Federalism, State Sovereignty, and the Constitution: Basis and Limits of Congressional Power*, by Kenneth R. Thomas.

⁵² 424 U.S. 1 (1975).

⁵³ *Id.* at 90-91.

⁵⁴ Medicare is a health insurance program for persons aged 65 and older, and certain other groups of persons such as persons with disabilities, and persons living with end-stage renal disease. 42 U.S.C. § 1395 *et seq.* For more information on the Medicare program see CRS Report R40425, *Medicare Primer*, coordinated by Hinda Chaikind.

⁵⁵ Medicaid is a need-based program that provides low-income persons with broad coverage for medical services. 42 U.S.C. § 1396 *et seq.* The states may participate in this voluntary grant program by submitting a state plan meeting federal requirements to the Department of Health and Human Services. 42 U.S.C. § 1396a(b). The federal government and the states jointly share the costs of providing benefits under this program. See CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by Chris L. Peterson.

⁵⁶ CHIP is a federal matching block grant program that provides health care services for certain uninsured children without access to Medicaid. 42 U.S.C. § 1397 *et seq.* See, for more information, CRS Report R40444, *State Children's Health Insurance Program (CHIP): A Brief Overview*, by Elicia J. Herz, Chris L. Peterson, and Evelyne P. Baumrucker.

earlier 1937 decision, discussed above, upholding Title II (Old Age Benefits) and Title III (Unemployment Compensation) of the same act.

Another example of a health care program is the Hospital Survey and Construction Act⁵⁷ (Hill-Burton Act), enacted in 1946, which offers federal construction funds to hospitals, nursing homes, and other health facilities on the condition that the facilities provide a reasonable volume of services to indigent patients, and make their services available to all persons residing in the facility's area.⁵⁸ Congress has also created a statutory right to certain emergency services under the Emergency Medical Treatment and Active Labor Act (EMTALA).⁵⁹ EMTALA imposes a legal obligation on hospitals that participate in Medicare to provide screening, examination, and stabilization of emergency medical conditions and women in labor, prior to transferring them to another facility.⁶⁰

In addition, Congress has provided for health care services in many other contexts, including access to health care services for uninsured and underinsured persons through tax incentives to non-profit organizations such as hospitals for providing charitable care,⁶¹ and by grant programs that fund certain "safety net providers," such as community health centers, migrant health centers, and other health facilities that serve medically underserved populations.⁶²

The Individual Mandate to Purchase Health Insurance Under the Patient Protection and Affordable Care Act

On March 23, the President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (PPACA), P.L. 111-148,⁶³ a comprehensive health care reform bill. With regard to the private sector, Title I of PPACA imposes new requirements on individuals, employers, and health plans; restructures the private health insurance market; sets minimum standards for health benefits; and provides financial assistance to certain individuals and, in some cases, small employers.

Considerable attention has been paid to Section 1501 of Title I of PPACA, which imposes a mandate for most individuals to have health insurance or to pay a penalty for noncompliance, beginning in 2014.⁶⁴ Under this provision, individuals will be required to maintain minimum essential coverage for themselves and their dependents. Those who do not will be required to pay

⁵⁷ 42 U.S.C. §§ 291 to 291o-1.

⁵⁸ See HHS website on the Hill-Burton Act at <http://www.hrsa.gov/hillburton/default.htm>.

⁵⁹ 42 U.S.C. § 1395dd and regulations at 42 C.F.R. § 489.24. For more information on EMTALA, see CRS Report RS22738, *EMTALA: Access to Emergency Medical Care*, by Edward C. Liu.

⁶⁰ 42 U.S.C. § 1395dd(a)-(c).

⁶¹ See 26 U.S.C. § 501(c)(3), which provides for an exemption from federal income tax of corporations organized and operated exclusively for religious, charitable, or educational purposes, provided not part of the organization's net earnings inures to the benefit of any private shareholder or individual. Under Rev. Rul. 69-545, 1969-2 C.B. 117, the IRS recognized "promotion of health" as a charitable purpose when a "community benefit" standard is met. See CRS Report RL34605, *501(c)(3) Hospitals and the Community Benefit Standard*, by Erika K. Lunder and Edward C. Liu.

⁶² See CRS Report RL32046, *Federal Health Centers Program*, by Barbara English.

⁶³ It is noted that, on March 21, 2010, the House passed H.R. 4872, the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, which made amendments to PPACA.

⁶⁴ Section 1501 of P.L. 111-148.

a penalty for each month of noncompliance. Some individuals will be provided subsidies to help pay for their premiums and cost-sharing. Others would be exempt from the individual mandate.⁶⁵

Lawsuits Challenging the Constitutionality of the Individual Health Insurance Mandate

Several lawsuits have been filed in federal courts challenging the constitutionality of the individual health insurance mandate in PPACA. On March 23, 2010, 13 states filed a lawsuit in Florida contending “[t]he Act represents an unprecedented encroachment on the liberty of individuals living in the Plaintiffs’ respective states, by mandating that all citizens and legal residents of the United States have qualifying health care coverage or pay a tax penalty . . . By imposing such a mandate, the Act exceeds the powers of the United States under Article I of the Constitution and violates the Tenth Amendment to the Constitution.”⁶⁶ A separate lawsuit was filed by Virginia on the same day as the Florida lawsuit.⁶⁷ This lawsuit also challenges the individual health insurance mandate, but within the context of a recent Virginia law, discussed below, which arguably is inconsistent with the federal individual health insurance mandate by stating that no resident of Virginia “shall be required to obtain or maintain a policy of individual insurance coverage.”⁶⁸ A third lawsuit was filed by the Thomas More Law Center, a national public interest law firm, on behalf of itself and four individuals, alleging that “Congress lacks authority under the Commerce Clause of the Constitution to force private citizens, including Plaintiffs, under penalty of Federal law, to purchase health care coverage.”⁶⁹

Issues that the courts will face in assessing the constitutionality of the individual health insurance mandate include procedural issues such as standing, because states, which are not directly subject to the mandate, would be enforcing arguments about the rights of individuals, and ripeness, since

⁶⁵ These individuals include those with qualifying religious exemptions, those in a health care sharing ministry, individuals not lawfully present in the United States, and incarcerated individuals. No penalty will be imposed on those without coverage for less than 90 days (with only one period of 90 days allowed in a year), members of Indian tribes, individuals whose household income does not exceed 100% of the federal poverty level (FPL), or any individual who the Secretary of HHS determines to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan. For more information about this, and related, provisions, see CRS Report R40942, *Private Health Insurance Provisions in Senate-Passed H.R. 3590, the Patient Protection and Affordable Care Act*, by Hinda Chaikind et al.

⁶⁶ *Florida v. U.S. Department of Health and Human Services*, No. 3:10-cv-00091-RV-EMT, U.S. District Court for the Northern District of Florida (Pensacola). The complaint (in which the following states joined: AL, CO, ID, LA, MI, NE, PA, SC, TX, UT, WA) is available at [http://myfloridalegal.com/webfiles.nsf/WF/MRAY-83TKWB/\\$file/HealthCareReformLawsuit.pdf](http://myfloridalegal.com/webfiles.nsf/WF/MRAY-83TKWB/$file/HealthCareReformLawsuit.pdf). This lawsuit also contends that the financial burdens imposed on the states by the legislation’s expansion of Medicaid “commandeers” states to devote their financial resources to achieve federal aims, thereby violating the Tenth Amendment to the Constitution. This argument may not be viable because, even though it may be difficult as a practical matter for states to drop out, there is no requirement for states to participate in the Medicaid program. In addition, the Supreme Court has long upheld spending power programs, like Medicaid, that require states to comply with federal program requirements. See, e.g., *South Dakota v. Dole*, 483 U.S. 203 (1987).

⁶⁷ *Virginia ex rel. Cuccinelli v. Sebelius*, No. 3:10cv188, U.S. District Court for the Eastern District of Virginia (Richmond), complaint available at http://www.vaag.com/PRESS_RELEASES/Cuccinelli/Comm%20v.%20Sebelius%20-%20Complaint%20filed%20with%20Court%20_323_10.pdf.

⁶⁸ See, discussion, *supra*, “State Attempts to “Nullify” or “Opt Out” of Federal Health Care Reform Requirements,” and footnote 72. Ordinarily, federal law preempts state law; however, this lawsuit alleges that the Virginia statute should prevail because the federal law’s mandate to purchase health insurance is unconstitutional.

⁶⁹ *Thomas More Law Center v. Obama*, 2:10-cv-11156-GCS-RSW, U.S. District Court for the Eastern District of Michigan, complaint available at http://www.thomasmore.org/downloads/sb_thomasmore/TMLCFilesCourtChallengeMomentsAfterObamaHealth.pdf.

the mandate does not go into effect until 2014. In addition, the courts may address substantive issues such as Congress's power to enact an individual mandate under the Commerce Clause,⁷⁰ or Congress's power to impose a tax upon failure to comply with the mandate pursuant to its power to tax and spend to "provide for the common Defense and general Welfare of the United States."⁷¹ For a comprehensive analysis of these constitutional issues see CRS Report R40725, *Requiring Individuals to Obtain Health Insurance: A Constitutional Analysis*, by Jennifer Staman and Cynthia Brougher.

State Attempts to "Nullify" or "Opt Out" of Federal Health Care Reform Requirements

On March 10, 2010, Virginia became the first state in the nation to enact a statute which states that, as a matter of law in Virginia, no individual (with certain exceptions) "shall be required to obtain or maintain a policy of individual insurance coverage."⁷² This state statute is arguably inconsistent with Section 1501 of PPACA, which requires individuals to purchase health insurance coverage beginning in 2014. On March 17, 2010, Idaho enacted a similar law,⁷³ and a Utah bill, signed into law on March 22, also prohibits an individual health insurance mandate, and, in addition, prohibits any state agency from implementing federal health reform measures without the Utah legislature "specifically authorizing the state's compliance or participation in, federal health care reform."⁷⁴

While Virginia was the first state to pass a law relating to the federal requirement to purchase health insurance, legislators in at least 38 state legislatures have introduced bills to limit, change, or oppose various federal actions relating to health care reform, including the mandate to purchase health insurance or implementation of a single payer system.⁷⁵ Most measures seek to make or keep health insurance optional for individuals, and to ensure that individuals can purchase any kind of coverage they want. Some proposed state measures are in the form of state constitutional amendments which would have to be approved by a ballot vote;⁷⁶ others, like the

⁷⁰ U.S. Const., Art. I, §8, cl. 3. Section 1501(a) of PPACA contains extensive congressional findings to the effect that the individual health insurance mandate, "the individual responsibility requirement," substantially affects interstate commerce. For a general discussion of the Commerce Clause, see CRS Report RL32844, *The Power to Regulate Commerce: Limits on Congressional Power*, by Kenneth R. Thomas and Todd B. Tatelman. It is noted that the Commerce Clause is augmented by the Necessary and Proper Clause, which allows Congress "[t]o make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers ..." U.S. Const., Art. I, §8, cl. 18.

⁷¹ U.S. Const. Art. I, § 8, cl. 1.

⁷² Session Law, Chapter 106, available at <http://leg6.state.va.us/cgi-bin/legp604.exe?101+ful+CHAP0108+pdf>, and codified at Virginia Code Section 38.2-3430.1:1.

⁷³ Session Law, Chapter 46, establishing the Idaho Health Freedom Act, stating in part, "that every person in the state of Idaho is and shall be free to choose or decline to choose any mode of securing health care services without penalty or threat of penalty."

⁷⁴ HB67, enrolled copy available at <http://le.utah.gov/~2010/bills/hbillenr/hb0067.pdf>.

⁷⁵ For a comprehensive and continually updated survey of state activity in this area, see National Conference of State Legislatures, "State Legislation Challenging Certain Health Reforms, 2010," at <http://www.ncsl.org/default.aspx?tabid=18906>.

⁷⁶ For example, the Arizona legislature has passed a resolution to be placed on the November 2, 2010, ballot, for voter approval or rejection, that proposes an amendment to its state constitution "which provides that no law or rule shall compel any person or employer to participate in any health care system, ..." Arizona HCR 2014 of 2009, available at <http://www.azleg.gov/legtext/49leg/1r/bills/hcr2014h.pdf>.

Virginia, Idaho, and Utah statutes, are state laws that appear to exempt state residents from compliance with federal health care reform provisions.

A direct conflict between federal and state laws would raise constitutional issues which are likely to be resolved in favor of the federal law under the Supremacy Clause of the Constitution, which states: “This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; ... shall be the supreme Law of the Land; ... any Thing in the constitution or Laws of any State to the Contrary notwithstanding.”⁷⁷ When Congress legislates pursuant to its delegated powers, state laws, and even state constitutional provisions, must yield. For example, in *Cooper v. Aaron*, 358 U.S. 1 (1958), the U.S. Supreme Court upheld the federal law mandating desegregation of public schools in the face of Arkansas’s constitutional amendment which prohibited integration.⁷⁸

State Constitutions and the Provision of Health Care Services

On the state level, governmental obligations to provide health care services either generally or for particular groups of persons may be found in a number of state constitutions. Thirteen state constitutions contain provisions which specifically refer to health.⁷⁹ The constitutions of the states of Alaska, Hawaii, Michigan, North Carolina, New York, and Wyoming have provisions which require the state to promote and protect the public health.⁸⁰ For example, Alaska’s constitution provides that “[t]he legislature shall provide for the promotion and protection of public health.”⁸¹ And Wyoming’s constitution states, “As the health and morality of the people are essential to their well-being, ... it shall be the duty of the legislature to protect and promote these vital interests.”⁸² Other state constitutional provisions permit, and sometimes require, legislative action to fund health care services for specific activities or for certain groups, such as indigent persons. Mississippi has a constitutional provision that authorizes laws for the care of the indigent sick in state hospitals.⁸³ Arkansas’s constitution has a provision requiring the legislature to provide for the treatment of the insane.⁸⁴ By and large, however, state constitutional provisions authorize, but do not require, the provision of health care services.⁸⁵

⁷⁷ U.S. Const. Art. VI, cl. 2.

⁷⁸ See, also, *Gibbons v. Ogden*, 22 U.S. 9 Wheat. 11 (1824), *Douglas v. Seacoast Products, Inc.*, 431 U.S. 265 (1977), and Timothy S. Jost, “Can the States Nullify Health Care Reform?” 362 *New Eng. J. Med.* 869-871 (March 11, 2010), available at <http://content.nejm.org/cgi/content/full/362/10/869>. For a general discussion of the Supremacy Clause, see CRS, *United States Constitution: Analysis and Interpretation*, coordinated by Kenneth R. Thomas, at <http://www.crs.gov/conan/default.aspx?mode=topic&doc=Article06.xml&t=1|1&c=2>.

⁷⁹ See, discussion and survey of state constitutional provisions relating to health care in article by Elizabeth Weeks Leonard, “State Constitutionalism and the Right to Health Care” (updated August 13, 2009), available at http://works.bepress.com/elizabeth_weeks/3/.

⁸⁰ See Rory Weiner, “Universal Health Insurance Under State Equal Protection Law,” 23 *W. New Eng. L. Rev.* 327, 334 (2002).

⁸¹ ALASKA CONST. art. VII, § 4 .

⁸² WYO. CONST. art. 7, § 20.

⁸³ HAW. CONST. art. IX, § 3 and MISS. CONST. art. IV, § 86.

⁸⁴ ARK. CONST. art. 19, § 19.

⁸⁵ See, e.g., the constitution of New York, which states that “[t]he protection and promotion of the health of the (continued...) ”

Some state courts have liberally construed state constitutional provisions mandating care of the poor to include the provision of health care services. For example, in *Graham v. Reserve Life Ins. Co.*,⁸⁶ a provision in the North Carolina constitution mandating “beneficent provision for the poor” was held to require state provision of free medical treatment to indigent sick persons. And the constitutionality of Alabama’s Health Care Responsibility Act,⁸⁷ which imposed financial responsibility for the medical care of county indigents on counties, was upheld in part on the basis of Alabama’s constitutional provision requiring counties “to make adequate provisions for the maintenance of the poor.”⁸⁸ As a general matter, state constitutional rights may be more expansive than those found under the federal Bill of Rights, since federal rights set the minimum standards for the states. States are always free to provide for greater protections for their citizens than are provided on the national level.⁸⁹

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inhabitants of the state are matters of public concern and provision therefore shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine.” N. Y. CONST. art. 17, § 3. According to one author, state judicial decisions construing provisions of state constitutions “demonstrate a general reluctance to recognize affirmative, enforceable health rights.” *See, generally*, Leonard, Part II.B, at 22-40, *supra*, footnote 79.

⁸⁶ 274 N.C. 115, 161 S.E.2d 485 (1968).

⁸⁷ ALA. CODE §§ 22-21-290 – 22-21-297.

⁸⁸ Bd. of Comm’rs v. Bd. of Trs. of the Univ. of Ala., 483 So. 2d 1365, 1366 (Ala. Civ. App. 1985), and Marengo County v. Univ. of S. Ala., 479 So. 2d 48, 51 (Ala. Civ. App. 1985). *See also* discussion generally at 333-337, Weiner, *supra*, footnote 80.

⁸⁹ *See, e.g.*, Cruzan v. Dir., Mo. Dep’t of Health, 497 U.S. 261, 280-182 (1990), where the Court recognized that Missouri was entitled to accord stronger protection to preservation of life than federal law by requiring clear and convincing evidence to terminate life support.