

THE STRUGGLE TO ACHIEVE THE HUMAN RIGHT TO HEALTH CARE IN THE UNITED STATES

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I. INTRODUCTION

In 2010, the United States Congress enacted the Patient Protection and Affordable Care Act (PPACA), which President Obama signed into law on March 23, 2010.¹ The PPACA is the federal government's most recent attempt to address the patchwork health care system in the United States.² Since the 1930s, American policymakers have proposed and passed a number of policy reforms to address the costly, fragmented health care system that has plagued the country.³ A national insurance proposal was first considered by President Franklin Delano Roosevelt in the 1930s and was taken up again by President Harry Truman in 1948, as well as subsequent Presidents including President Richard Nixon.⁴ In the 1960s, the creation of the Medicare and Medicaid programs drastically improved access to health care for Americans over sixty-five and the lowest income Americans; however, these programs did not ensure universal health care coverage for all people living in the United States.⁵ Despite decades of discussions and significant programmatic achievements in health care for some, the health care system that existed in the early 2000s remained a disjointed system in which select vulnerable groups were eligible for publicly-funded insurance, while the majority of the population relied on private companies for health insurance or paid out-of-pocket for health care.⁶

According to the U.S. Census Current Population Survey Annual Social and Economic Supplement in 2010, approximately 49.9 million

1 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 21, 25, 26, 29, and 42 U.S.C.) [hereinafter PPACA]; Health Care and Education Reconciliation Act of 2010, Pub. L. 111-152, 124 Stat. 1029 (codified as amended in scattered sections of 20, 26, and 42 U.S.C.). The Health Care and Education Reconciliation Act, signed seven days later, amends the Patient Protection and Affordable Care Act, and these two statutes are collectively known as the Patient Protection and Affordable Care Act (PPACA).

2 For a history of the PPACA passage and implementation, see Stephanie Altman, *The Invisible Uninsured: Non-Citizens and Access to Health Care Coverage Under the Affordable Care Act*, 17 PUB. INT. L. REP. 230, 235-36 (2012); Vita Andrapalliyal, *Healthcare for All? The Gap Between Rhetoric and Reality in the Affordable Care Act*, 61 U.C.L.A. L. REV. DISCOURSE 58, 62-63, 67-70 (2013); Nicholas Bagley & David K. Jones, *No Good Options: Picking up the Pieces after King v. Burwell*, 125 YALE L.J. FORUM 13 (2015); Arthur Nussbaum, *Can Congress Make You Buy Health Insurance? The Affordable Care Act, National Health Care Reform and the Constitutionality of the Individual Mandate*, 50 DUQ. L. REV. 411, 412-22 (2012); David Pratt, *Health Care Reform: Will it Succeed?*, 21 ALB. L.J. SCI. & TECH. 493, 495-96 (2011); Sara Rosenbaum, *Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System*, 7 J. HEALTH & BIOMEDICAL L. 1, 2-4 (2011).

3 AUDREY CHAPMAN, HEALTH CARE REFORM: A HUMAN RIGHTS APPROACH 23-27 (Audrey Chapman ed., 1994).

4 *Id.* at 24; see also CATHERINE HOFFMAN, KAISER FAMILY FOUND., A BRIEF HISTORY OF REFORM EFFORTS IN THE U.S. 2-3, 6 (March 2009), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7871.pdf>.

5 CHAPMAN, *supra* note 3, at 23-27.

6 See Allison K. Hoffman, *A Vision of an Emerging Right to Health Care in the United States: Expanding Health Care Equity through Legislative Reform*, in THE RIGHT TO HEALTH AT THE PUBLIC/PRIVATE DIVIDE: A GLOBAL COMPARATIVE STUDY 348-51 (Colleen M. Flood & Aeyal Gross, eds., 2014).

people or 16.3 percent of the population were uninsured.⁷ The 2010 uninsured population included 7.8 million children—9.8 percent of the population of children in America.⁸ Approximately 256.2 million people living in the United States were insured in 2010.⁹ Of those with insurance, 169.3 million—55.3 percent of the total population—received employer-sponsored coverage while another 30.1 million—9.8 percent of the population—purchased health insurance directly on the individual market.¹⁰ Another 31 percent of the population received coverage through the publicly-funded Medicaid and Medicare programs. Medicare enrollees numbered 44.3 million people—14.5 percent of the population; Medicaid enrollees numbered 48.6 million—15.9 percent of the population.¹¹ Table 1 presents an overview of the segments of the U.S. population with and without health insurance in 2010.

<i>Type of Insurance</i>	<i>Total Number of people (millions)</i>	<i>Percentage of Population</i>
Total Uninsured	49.9	16.3%
Total Insured	256.2	83.7%
Insured with Employer-Sponsored Coverage	169.3	55.3%
Insured with Directly Purchased Insurance	30.1	9.8%
Insured through Medicaid	48.6	15.9%
Insured through Medicare	44.3	14.5%
Insured through other government programs (State Children's Health Insurance Program, military health care and individual state plans)	2.1	1% ¹³

7 CARMEN DENAVAS-WALT ET. AL., INCOME, POVERTY AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2010, 22–23, 25 (Sept. 2011), <http://www.census.gov/prod/2011pubs/p60-239.pdf>. The United States Census Bureau gathered this information through the Current Population Survey Annual Social and Economic Supplement which asks people about health insurance coverage in the previous year. The survey relies on people self-reporting their insurance coverage, and therefore, may be inaccurate in some respects. People were considered to be insured if they were covered in any part of the calendar year and could be insured by more than one kind of insurance each year. People were considered to be uninsured only if they were not covered by any type of coverage for the entire calendar year.

8 *Id.* at 24.

9 *Id.* at 23.

10 *Id.* at 22–24.

11 *Id.*

12 All figures in this table are from DENAVAS-WALT, *supra* note 7, at 22–24.

13 The number of CHIP enrollees cited by the Census Bureau here is contradicted by another Census Bureau report, which states the total number of CHIP enrollees in 2010 at 7,718,400. *See* U.S. CENSUS BUREAU, STATISTICAL ABSTRACT OF THE UNITED STATES: 2012, 106 tbl.145 (2011), <http://www2.census.gov/library/publications/2011/compendia/statab/131ed/2012-statab.pdf>.

The results of this system, particularly when compared to other developed countries, were disastrous. According to the Organisation for Economic Co-operation and Development (OECD), the United States spent \$7,960 per person on health care in 2009—over two times as much as the average OECD country of \$ \$3,233.¹⁴ Despite spending significantly more than other countries on health care, the United States health outcomes were among the worst. For example, in 2009, the United States—with an infant mortality rate of 6.5 deaths per 1,000 births—ranked 31st among OECD countries, falling behind countries such as Slovenia, the Czech Republic, Korea, Estonia, and Poland.¹⁵ In contrast, Iceland had the lowest infant mortality rate in the world—1.8 deaths per 1,000 births—but spent only \$3,538 per person, less than half of what the United States spent per person.¹⁶ The Slovak Republic, with an infant mortality rate similar to the United States, spent only \$2,084 per person.¹⁷ Additionally, the United States had fewer primary care physicians per capita than other OECD countries. In 2010, the OECD average was 3.1 practicing physicians per 1,000 people, whereas the United States had only 2.4 physicians per 1,000 people.¹⁸ A significantly larger proportion of Gross Domestic Product (GDP) is devoted to health care in the United States than in other OECD countries. In 2009, health care spending accounted for 17.4 percent of the U.S. GDP; in contrast, health care spending only accounted for 9.7 percent of Iceland's GDP, 10.3 percent of New Zealand's GDP, and 9.1 percent of the Slovak Republic's GDP.¹⁹

Despite this substantial spending, approximately 49.9 million U.S. residents, over 16 percent of the population, lacked health insurance in 2010.²⁰ Though access to health insurance is not the same as access to health care, health insurance coverage is strongly correlated with better health care outcomes.²¹ Prior to the passage of the PPACA, many uninsured adults suffered from a chronic illness; in turn, their chronic illnesses made it more difficult for them to purchase policies on the individual market due to pre-existing condition exclusions.²² Further, the

14 OECD, HEALTH AT A GLANCE 2011: OECD INDICATORS 37 (2011), <http://www.oecd.org/els/health-systems/49105858.pdf>.

15 *Id.*

16 *Id.* at 37, 149.

17 *Id.* at 149.

18 Jason Kane, *Health Costs: How the U.S. Compares With Other Countries*, PBS (Oct. 22, 2012, 10:30 AM), <http://www.pbs.org/newshour/rundown/health-costs-how-the-us-compares-with-other-countries/>.

19 HEALTH AT A GLANCE, *supra* note 14, at 151.

20 *Highlights: 2010*, U.S. CENSUS BUREAU, <https://www.census.gov/hhes/www/hlthins/data/incpovhlth/2010/highlights.html> (last visited Feb. 23, 2016).

21 Emily W. Parento & Lawrence O. Gostin, *Better Health, but Less Justice: Widening Health Disparities After National Federation of Independent Business v. Sebelius*, 27 NOTRE DAME J.L. ETHICS & PUB. POL'Y 481, 488 (2013).

22 *ObamaCare Pre-Existing Conditions*, OBAMACARE FACTS, <http://obamacarefacts.com/pre-existing-conditions/> (last visited Feb. 23, 2016). One report found that “among adults aged 55 to 64, nearly 50 percent have a diagnosed significant pre-existing condition. But even among young adults aged 18 to 24, nearly 20 percent have a diagnosed significant pre-existing condition. The percentage

uninsured are significantly less likely to seek needed medical care because they do not believe they can afford it; this tends to exacerbate chronic medical conditions.²³ Moreover, uninsured people are less likely to seek preventative care, resulting in higher costs when they ultimately seek care.²⁴

At the time of the passage of the PPACA, the vast majority of the nation's uninsured were low to moderate income people, and more than three-quarters of the uninsured were working.²⁵ Ethnic and racial minorities and non-citizens were much more likely to be uninsured than white citizens.²⁶ Women were significantly more likely to be uninsured than men; almost one in three women between the ages of nineteen and sixty-four (approximately twenty-seven million women) were uninsured in 2010.²⁷ Women, especially during their reproductive years, have more health care needs than men; prior to the passage of the PPACA, insurers routinely charged women more for health insurance or denied coverage for necessary services, such as maternity care.²⁸

In addition to the fifty million uninsured, many U.S. residents increasingly found themselves to be underinsured—meaning that while they technically had health insurance, they were still unable to access health care due to high deductibles and co-payments. The Commonwealth Fund defines the underinsured as those people spending more than 10 percent of their income on out-of-pocket medical expenses or 5 percent or more of their income on deductibles.²⁹ Between 2003 and 2010, the number of underinsured adults rose by 80 percent from sixteen million to twenty-nine million people.³⁰ Over half of the underinsured reported forgoing medical care in the previous year because they could not afford

risers to nearly 25 percent for adults aged 25-34 and to more than 30 percent for adults aged 35 to 44. By the age of 45, the percentage is closer to 40 percent.” Claire McAndrew & Kathleen Stoll, *Demographics of People with a Pre-existing Health Condition*, FAMILIES USA: BLOG (Mar. 6, 2014), <http://familiesusa.org/blog/2014/03/demographics-people-pre-existing-health-condition>.

23 MELISSA MAJEROL, KAISER FAMILY FOUND., *THE UNINSURED: A PRIMER: KEY FACTS ABOUT HEALTH INSURANCE AND THE UNINSURED IN AMERICA* 11 (Jan. 2015), <http://files.kff.org/attachment/the-uninsured-a-primer-key-facts-about-health-insurance-and-the-uninsured-in-america-primer>.

24 Dabney P. Evans, *The Right to Health: The Next American Dream*, in *THE RIGHT TO HEALTH: A MULTI-COUNTRY STUDY OF LAW, POLICY, AND PRACTICE* 233, 246 (Toebe et. al. eds., 2014).

25 MAJEROL, *supra* note 23, at 3–4.

26 *Id.* at 5.

27 RUTH ROBERTSON & SARA R. COLLINS, *REALIZING HEALTH REFORM'S POTENTIAL -- WOMEN AT RISK: WHY INCREASING NUMBERS OF WOMEN ARE FAILING TO GET THE HEALTH CARE THEY NEED AND HOW THE AFFORDABLE CARE ACT WILL HELP* 1 (May 2011), http://www.commonwealthfund.org/~media/Files/Publications/Issue%20Brief/2011/May/1502_Roberts_on_women_at_risk_reform_brief_v3.pdf.

28 *Id.* at 4.

29 CATHY SCHOEN ET AL., *How Many are Underinsured? Trends Among U.S. Adults 2003 and 2007*, THE COMMONWEALTH FUND (June 1, 2008), <http://www.commonwealthfund.org/Content/Publications/In-the-Literature/2008/Jun/How-Many-Are-Underinsured--Trends-Among-U-S--Adults--2003-and-2007.aspx>.

30 Press Release, The Commonwealth Fund, *Insured and Still at Risk: Number of Underinsured Adults Increased 80 Percent Between 2003 and 2010* (Sept. 8, 2011), <http://www.commonwealthfund.org/publications/press-releases/2011/sep/insured-and-still-at-risk>.

it.³¹ Together, the total uninsured and underinsured people in the United States in 2010 constituted over 25 percent of the population.

Health care bills often jeopardize the financial security of both the uninsured and the underinsured. In 2010, thirty million U.S. residents reported being contacted by a collections agency due to outstanding medical debts.³² In 2007, over 62 percent of personal bankruptcies in the United States were due to medical debt, largely incurred by middle-class people who had health insurance prior to the medical issue that led to the bankruptcy.³³

As these statistics make clear, at the time the PPACA came into law, the United States was overpaying for a system that provided fragmented, inadequate, or no health care to millions of U.S. residents, while providing excellent health care for some. The PPACA's goals were to expand access to health insurance to millions of residents, to end the worst abuses perpetrated by insurance companies on consumers, and to control and reduce health care spending.³⁴ While the PPACA has succeeded to some extent in meeting these goals, it has not achieved—nor did it envision—a truly universal health care system. Moreover, the new system fails to conform to the standards in international human rights law, which explicitly recognizes health care as a fundamental human right.³⁵

There are, however, other approaches, and there are models in many other countries to draw upon. In the United States, there are universal health care initiatives and grassroots movements at the federal level and in many states advocating for publicly-funded health care as a basic human right for all residents. These initiatives differ from the PPACA in many respects: in essence, they focus on universal health *care*, rather than simply health insurance *coverage*, and many employ international human rights standards and principles in both process and substance. This Article examines the PPACA and some of the alternative initiatives for universal health care from a human rights perspective. It is presented in five parts. Following this Introduction, Part II provides an outline of the right to health care under international law. Part III discusses the PPACA and critiques it from a human rights perspective. It also briefly overviews some federal initiatives for universal health care. Part IV documents state level universal health care initiatives and explores the impact that these initiatives may have in the future. Part V concludes that the United States is still in need of a truly universal and equitable health care system, despite the passage and

³¹ *Id.*

³² David U. Himmelstein et al., *Medical Bankruptcy - Fact Sheet*, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM, http://www.pnhp.org/new_bankruptcy_study/ (last visited Feb. 23, 2016).

³³ *Id.* See also Theresa Tamkins, *Medical bill prompt more than 60 percent of U.S. bankruptcies*, CNN, <http://www.cnn.com/2009/HEALTH/06/05/bankruptcy.medical.bills/>.

³⁴ Pratt, *supra* note 2, at 500–509.

³⁵ See, e.g., International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), art. 12(1), U.N. Doc. A/RES/21/2200A (Dec. 16, 1966) [hereinafter ICESCR] (recognizing the right to the highest attainable standard of physical and mental health).

implementation of the PPACA, and suggests we look to the states for solutions. The Article posits that state level human rights-based health care initiatives may move the United States toward publicly-funded universal and equitable quality health care more quickly and powerfully than action at the federal level.

II. THE INTERNATIONAL FRAMEWORK FOR THE RIGHT TO HEALTH CARE

Under international law, health care is a human right.³⁶ Under Articles 55 and 56 of the UN Charter, all members of the United Nations have pledged to promote health and human rights.³⁷ Further, the Universal Declaration of Human Rights adopted in 1948, which is also applicable to all UN members, enshrines the right to health care as part of the right to an adequate standard of living.³⁸ The Constitution of the World Health Organization recognizes more specifically that “[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.”³⁹

The most widely applicable international human rights provision on the right to health is Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). It provides, “The State parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.”⁴⁰ It further sets forth state obligations for realizing the right to health, including measures to: ensure healthy pregnancies, infants, and children; to improve occupational safety and healthy environments; to prevent and treat epidemics; and to ensure health care services for all.⁴¹ While Article 12 is

36 See, e.g., G.A. Res. 217 (III) A, art. 25, Universal Declaration of Human Rights (Dec. 10, 1948) (“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care”) [hereinafter UDHR]; ICESCR, *supra* note 35, art. 12(2)(d) (state parties shall take steps to achieve the full realization of the right to the highest attainable standard of health, including “[t]he creation of conditions which would assure to all medical service and medical attention in the event of sickness”); G.A. Res. 44/25, art. 24, International Convention on the Elimination of All Forms of Racial Discrimination (Dec. 21, 1965) [hereinafter ICERD]; G.A. Res. 34/180, art. 12(1), Convention on the Eliminations of All Forms of Discrimination Against Women (Dec. 18, 1979) [hereinafter CEDAW]; G.A. Res. 44/25, art. 24, United Nations Convention on the Rights of the Child (Nov. 20, 1989) [hereinafter CRC]; G.A. Res. 61/106, art. 25, Convention on the Rights of People with Disabilities (Dec. 13, 2006) [hereinafter CRPD]; G.A. Res. 45/158, art. 28, 43(1)(c), 45(1)(c), International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (Dec. 18, 1990) [hereinafter ICRMW].

37 U.N. Charter arts. 55–56 (all members of the UN pledge to take joint and separate action to achieve, among other goals, “solutions of international economic, social, health and related problems” and “universal respect for, and observance of, human rights and fundamental freedoms for all”).

38 UDHR, *supra* note 36, art. 25(1) (“Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care”).

39 WORLD HEALTH ORGANIZATION, CONSTITUTION OF THE WORLD HEALTH ORGANIZATION pmbl., at 1 (July 22, 1946).

40 ICESCR, *supra* note 35, art. 12(1).

41 ICESCR, *supra* note 35, art. 12(2)(a)–(d).

applicable to all people in the 164 countries that have ratified the ICESCR,⁴² numerous other international human rights treaties further enshrine the right to health for specific populations, including women,⁴³ children,⁴⁴ migrant workers and their families,⁴⁵ and people with disabilities.⁴⁶

Significantly, in 2000, the Committee on Economic, Social and Cultural Rights (CESCR), which is responsible for monitoring implementation of the ICESCR, issued General Comment 14, which provides greater detail than Article 12 about the right to health.⁴⁷ General Comment 14 clarifies that the right to health includes the right to “timely and appropriate health care” as well as the “underlying determinants of health,” such as potable water, adequate sanitation, nutritious food, safe housing, healthy workplaces, and access to health information.⁴⁸ Although the right to health includes the right to the underlying determinants of health—also known as the social determinants of health⁴⁹—this Article focuses specifically on the right to *health care* dimension of the right to health.

General Comment 14 further specifies that the right to health care has four essential elements: availability, accessibility, acceptability, and quality.⁵⁰ *Availability* means that health care facilities, goods, and services must be available in sufficient quantity in the country.⁵¹ This includes sufficient hospitals, clinics, trained health care professionals, and essential medicines as defined by the World Health Organization.⁵² *Accessibility* means that health facilities, goods, and services must be obtainable by everyone in the jurisdiction without discrimination, including economically accessible (affordable), physically accessible, and within a reasonable distance for all people.⁵³ *Accessibility* also includes the right to seek, receive, and impart health information.⁵⁴ *Acceptability* means that all health facilities, goods, and services must be: respectful of ethical codes of health

42 ICESCR, *supra* note 35; United Nations Treaty Collection, Chapter IV Human Rights, International Covenant on Economic, Social and Cultural Rights, https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en.

43 CEDAW, *supra* note 36, art. 12.

44 CRC, *supra* note 36, art. 24. Importantly, the Convention on the Rights of Children, which recognizes the right to health in article 24, has been ratified by 196 countries, indeed all countries but South Sudan and the USA. *See* United Nations Treaty Collection, Chapter IV Human Rights, Convention on the Rights of the Child, https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11&chapter=4&lang=en.

45 ICRMW, *supra* note 36, arts. 28, 43, 45.

46 CRPD, *supra* note 36, art. 25.

47 Comm. on Econ., Social and Cultural Rights, General Comment No. 14: The Right to the Highest Standard of Health, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter CESCR General Comment 14: Right to Health].

48 *Id.* ¶ 11.

49 *See, e.g.*, COMM’N ON THE SOCIAL DETERMINANTS OF HEALTH, CLOSING THE GAP IN A GENERATION: HEALTH EQUITY THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH (2008).

50 CESCR General Comment 14: Right to Health, *supra* note 47, ¶ 12.

51 *Id.* ¶ 12(a).

52 *Id.*

53 *Id.* ¶ 12(b).

54 *Id.* ¶ 12(b) (citing to the International Covenant on Civil and Political Rights art. 19.2).

professionals, designed to improve health, culturally appropriate, and sensitive to gender and life-cycle requirements.⁵⁵ *Quality* means that health care facilities, goods, and services must be scientifically sound, medically appropriate, and of good quality—including qualified health care personnel and scientifically approved medicines and medical equipment.⁵⁶ These four elements of the human right to health care are often shortened to the acronym “AAAQ.”

Additionally, the right to health care encompasses general human rights principles that apply across all human rights, including universality, equality and nondiscrimination,⁵⁷ transparency, participation,⁵⁸ and accountability.⁵⁹ The principle of *universality* means that the right to health applies to all humans, and cannot be limited to specific populations, such as citizens or males.⁶⁰ The principles of *equality and nondiscrimination* require states to ensure that there is no discrimination in access to health facilities, goods, and services on the grounds of “race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”⁶¹ To these grounds explicitly stated in the ICESCR, the CESCR has added physical or mental disability, health status (including HIV/AIDS status), and sexual orientation.⁶² In addition to the prohibition against discrimination, the government has obligations to both promote equality and to ensure that policies and programs do not have a disparate impact that furthers inequality.⁶³ The principle of *participation* means that people have the right to take part in the decision-making processes concerning policies, programs, and projects that may affect the

55 *Id.* ¶ 12(c).

56 *Id.* ¶ 12(d).

57 ICESCR, *supra* note 35, art. 2(2) (rights in the Covenant are guaranteed without discrimination); CESCR General Comment 14: Right to Health, *supra* note 47, ¶¶ 18–19 (applying ICESCR art. 2.2 to the right to health), ¶ 43 (government is obliged to ensure the right of access to health facilities, goods, and services as part of the minimum core of the right to health).

58 CESCR General Comment 14: Right to Health, *supra* note 47, ¶ 43(f) (national health strategy and plan of action must be devised and revised on the basis of participatory and transparent process), ¶ 54 (“the right of individuals and groups to participate in decision-making processes, which may affect their development, must be an integral component of any policy, programme or strategy developed to discharge government obligations under article 12”).

59 *Id.* ¶¶ 55–60 (outlining a framework for accountability, including, a national strategy and plan of action with benchmarks and indicators, against which civil society may hold the government accountable, in addition to effective judicial and other remedies for victims of violations of the right to health).

60 *See* UDHR, *supra* note 36, art. 1 (“All human beings are born free and equal in dignity and rights.”); U.N. Dev. Grp., *The Human Rights Based Approach to Development Cooperation: Towards a Common Understanding Among UN Agencies* (2003) [hereinafter U.N. Common Understanding], <http://hrbportal.org/the-human-rights-based-approach-to-development-cooperation-towards-a-common-understanding-among-un-agencies> (that human rights are universal means that “[a]ll people everywhere in the world are entitled to them.”).

61 ICESCR, *supra* note 35, art. 2(2).

62 CESCR General Comment 14: Right to Health, *supra* note 47, ¶ 18.

63 Comm. on Econ., Social and Cultural Rights, General Comment 20: Non-discrimination in Economic, Social and Cultural Rights, U.N. Doc E/C.12/GC/20, ¶¶ 8–9 (Jul. 2, 2009); CESCR General Comment 14: Right to Health, *supra* note 47, ¶ 19 (“For example, investments should not disproportionately favor curative health services which are often accessible only to a small privileged fraction of the population, rather than primary and preventative health care benefitting a far larger part of the population.”).

enjoyment of their human rights, in particular, their right to health.⁶⁴ *Transparency* in government is a necessary precondition for people to enjoy the right to participation because without being fully informed, people cannot meaningfully engage in decisionmaking.⁶⁵ The principle of *accountability* means that the government is answerable for respecting, protecting, and fulfilling their human rights obligations, and that people are entitled to redress for any violations of their human rights.⁶⁶ Transparency is also essential to hold governments accountable for their human rights obligations.⁶⁷

The right to health is also subject to human rights principles that are specific to economic and social rights, including progressive realization and maximum available resources.⁶⁸ These principles derive from article 2(1) of the ICESCR, which requires state parties to the Covenant to take steps, to the maximum of their available resources, to progressively realize all the rights in the ICESCR.⁶⁹ The CESCR has explained that “while the Covenant provides for progressive realization and acknowledges the constraints due to the limits of available resources, it also imposes various

64 Int’l Covenant on Civil and Political Rights, G.A. Res. 2200A (XXI), 21 U.N. GAOR Supp. (No. 16) at 52, U.N. Doc. A/6316 (1966), 999 U.N.T.S. 171, *entered into force* Mar. 23, 1976, art. 25 (every citizen shall have the right to take part in the conduct of public affairs); CESCR General Comment 14: Right to Health, *supra* note 47, ¶ 54 (“Promoting health must involve effective community action in setting priorities, making decisions, planning, implementing and evaluating strategies to achieve better health.”); U.N. Common Understanding, *supra* note 60 (“Every person and all peoples are entitled to active, free and meaningful participation in, contribution to, and enjoyment of civil, economic, social, cultural and political development in which human rights and fundamental freedoms can be realized.”).

65 See Office of the U.N. High Commissioner for Human Rights, Principles and Guidelines for a Human Rights Approach to poverty Reduction Strategies 15 (2006) [hereinafter OHCHR Principles and Guidelines] (“In practice, this means that when alternative policy options are being explored by experts, the implications of these options for the interests of various population groups must be made *transparent* and presented in an understandable manner to the general public, including the poor, so that they can have an opportunity to argue for the options that serve their interests best.”) (emphasis added).

66 CESCR General Comment 14: Right to Health, *supra* note 47, ¶ 59 (“Any person or group victim of the right to health should have access to effective judicial or other appropriate remedies at both the national and international levels.”); U.N. Common Understanding, *supra* note 62 (“States and other duty-bearers are answerable for the observance of human rights. In this regard, they have to comply with the legal norms and standards enshrined in human rights instruments. Where they fail to do so, aggrieved rights-holders are entitled to institute proceedings for appropriate redress before a competent court or other adjudicator in accordance with the rules and procedures provided by law.”); see generally HELEN POTTS, ACCOUNTABILITY AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH, <http://repository.essex.ac.uk/9717/1/accountability-right-highest-attainable-standard-health.pdf> (last visited Feb. 23, 2016).

67 See OHCHR Principles and Guidelines, *supra* note 65, at 17 (“In practice, this means that when alternative policy options are being explored by experts, the implications of these options for the interests of various population groups must be made transparent and presented in an understandable manner to the general public, including the poor, so that they can have an opportunity to argue for the options that serve their interests best.”).

68 CESCR General Comment 14: Right to Health, *supra* note 47, ¶¶ 30–31. These two principles derive from ICESCR art. 2(1), which states: “Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the *maximum of its available resources*, with a view to achieving *progressively the full realization of the rights* recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.” (emphasis added).

69 ICESCR, *supra* note 35, art. 2(1).

obligations that are of immediate effect.”⁷⁰ One of the immediate obligations is that governments must guarantee nondiscrimination in the exercise of rights.⁷¹ Another is the immediate obligation “to take steps” that are “deliberate, concrete and targeted as clearly as possible towards meeting the obligations recognized in the Covenant.”⁷² In terms of using maximum available resources to realize the right to health care, the government has an array of strategies at its disposal including, among others: revenue raising through taxes and commercial activities, improving efficiency in government operations, ensuring budget allocations are directed to the realization of human rights rather than other endeavors, monitoring expenditures to ensure that allocations are spent efficiently and as intended, and preventing corruption and other abuse of government funds.⁷³ In sum, the right to health care encompasses a bundle of rights—including entitlements and freedoms—that give people a fairer chance of living a healthy life.⁷⁴

Although the right to health is recognized in many international human rights treaties and in the majority of national constitutions around the world,⁷⁵ the United States has not ratified the ICESCR, which includes the most broadly applicable provision on the right to health. Further, the U.S. Constitution does not include a right to health generally or a right to health care in particular. Nonetheless, the U.S. government has some obligations to recognize a right to health. First, as a signatory to the ICESCR, the U.S. government must “refrain from acts which would defeat the object and purpose” of the treaty.⁷⁶ Second, the U.S. government has human rights obligations, including economic and social rights, under the UN Charter, the Universal Declaration of Human Rights, and international customary law.⁷⁷ Every four years, the U.S. government must report to the UN

70 Comm. on Econ., Social and Cultural Rights, General Comment 3: The Nature of State Parties Obligations, U.N. Doc. E/1991/23 (1990), reprinted in *Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies*, U.N. Doc. HRI/GEN/1/Rev.6 at 14, ¶ 1 (2003).

71 *Id.* ¶ 1.

72 *Id.* ¶ 2.

73 See MAGDALENA SEPÚLVEDA CARMONA, REPORT OF THE SPECIAL RAPPORTEUR ON EXTREME POVERTY AND HUMAN RIGHTS (May 22, 2014) (addressing revenue raising to comply with obligation to use maximum available resources to achieve realization of economic, social, and cultural rights); Sigrun Skogly, *The Requirement of Using ‘Maximum Available Resources’ for Human Rights Realisation: A Question of Quality as Well as Quantity?*, 12:3 HUM. RTS. L. REV. 393 (2012); see also Ann Blyberg, *The Case of the Mislaid Allocation: Economic and Social Rights and Budget Work*, 6 SUR INT’L J. ON HUM. RTS. 123 (2009); RADHIKA BALAKRISHNA ET AL., CENTER FOR WOMEN’S GLOBAL LEADERSHIP, RUTGERS UNIVERSITY, MAXIMUM AVAILABLE RESOURCES: ANALYTICAL REPORT (2011).

74 CESCR General Comment 14: Right to Health, *supra* note 47, ¶ 7 (explaining the freedoms and entitlements encompassed in the right to health).

75 See, e.g., Eleanor Kinney and Brian Alexander Clark, *Provisions of Health and Health Care in the Constitutions of the Countries of the World*, 37 CORNELL INT’L L.J. 285, 287 (2004) (67.5 percent of national constitutions in the world have provisions on health or health care); OHCHR, THE RIGHT TO HEALTH, FACT SHEET NO. 31, at 10, <http://www.ohchr.org/Documents/Publications/Factsheet31.pdf> (at least 115 countries recognize the right to health or the right to health care in their constitutions).

76 Vienna Convention on the Law of Treaties, 1155 U.N.T.S. 331, art. 18 (1969).

77 Office of the U.N. High Commissioner for Human Rights, Universal Periodic Review, Basic Facts, <http://www.ohchr.org/EN/HRBodies/UPR/Pages/BasicFacts.aspx> (last visited Feb. 23, 2016).

Human Rights Council for the Universal Periodic Review, on its progress in implementing these rights, including the right to health care set out in the Universal Declaration of Human Rights.⁷⁸ In its 2010 report to the Human Rights Council, the U.S. government acknowledged its obligations for the right to health care by devoting five paragraphs to the PPACA, maintaining that the Act would expand health insurance to thirty-two million people in the country.⁷⁹ Moreover, in response to Cuba's recommendation that the U.S. government "[e]nsure the rights to food and health of all who live in its territory,"⁸⁰ the U.S. government stated:

[W]e are a non-party to the International Covenant on Economic, Social and Cultural Rights, and accordingly we understand the references to the rights to food and health as references to rights in other human rights instruments that we have accepted. We also understand that these rights are to be realized progressively.⁸¹

As such, the U.S. government recognized its obligations for the right to progressive realization of the right to health, including the right to health care.⁸² In this light, the next Section analyzes the PPACA under the framework of the international human right to health care.

78 *Id.*; Sarah H. Paoletti, *Using the Universal Periodic Review to Advance Human Rights: What Happens in Geneva Must Not Stay in Geneva*, 45 CLEARINGHOUSE REV. J. OF POVERTY L. & POL'Y 268, 269 (2011).

79 Human Rights Council, Report of the Working Group on the Universal Periodic Review: United States of America, U.N. Doc A/HRC/WG.6/9/USA/1, ¶¶ 69-73 (Aug. 23, 2010). The U.S. government also devoted two paragraphs to health care in its 2015 UPR report. See Human Rights Council, Report of the Working Group on the Universal Periodic Review: United States of America, U.N. Doc A/HRC/WG.6/22/USA/1 (Feb. 13, 2015), ¶¶ 100-01.

80 Human Rights Council, Report of the Working Group on the Universal Periodic Review: United States of America, U.N. Doc A/HRC/16/11 (Jan. 4, 2011), ¶ 92.195.

81 U.S. DEP'T OF STATE, U.S. RESPONSE TO UN HUMAN RIGHTS COUNCIL WORKING GROUP REPORT ¶ 19 (Mar. 10, 2011), <http://www.state.gov/j/drl/upr/archive/157986.htm>.

82 The U.S. government has also recognized its obligations for economic and social rights arising from the UN Charter and the Universal Declaration of Human Rights by inviting several Special Procedures, including the Special Rapporteur on the Right to Education, the Special Rapporteur on the Right to Housing, the Special Rapporteur on the Right to Water, and the Independent Expert on Human Rights and Extreme Poverty, on missions to the U.S. to investigate the implementation of these rights. See Katarina Tomasevski (Special Rapporteur on the Right to Education), *Annual Rep. of the Special Rapporteur on the Right to Education*, U.N. Doc. E/CN.4/2002/60/Add.1 (Jan. 17, 2002); Arjun Sengupta (Independent Expert on Human Rights and Extreme Poverty), *Human Rights and Extreme Poverty*, U.N. Doc. E/CN.4/2006/43/Add.1 (Mar. 27, 2006); Raquel Rolnick (Special Rapporteur on the Right to Adequate Housing), *Rep. of the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living, and on the right to non-discrimination in this context*, U.N. Doc. A/HRC/13/20/Add.4 (Feb. 12, 2010); Catarina de Albuquerque (Special Rapporteur on the Human Right to Safe Drinking Water and Sanitation), *Rep. of the Special Rapporteur on the Human Right to Safe Drinking Water and Sanitation*, U.N. Doc. A/HRC/18/33/Add.4 (Aug. 2, 2011).

III. THE RIGHT TO HEALTH CARE AT THE FEDERAL LEVEL

A. AN INTRODUCTION TO THE PPACA

The U.S. Constitution does not recognize a right to health care. Nor does the PPACA, which was enacted in 2010 and modeled on health care reforms in Massachusetts that were implemented in 2006.⁸³ Both the Massachusetts and the federal reforms are based on an individual mandate that requires all residents who are not covered by a public health program, such as Medicare, Medicaid, or the Veterans' Health Administration, to enroll in private health insurance plans.⁸⁴ According to policymakers, the individual mandate is critical to ensure that younger and healthier people purchase health insurance, when they might not otherwise, to subsidize older and less healthy people, thus making health insurance affordable for all.⁸⁵ Without the inclusion of an individual mandate, policymakers worried that healthy people would put off purchasing insurance until they needed serious medical care from illness or injury; in turn, this delay would increase the cost of health insurance premiums overall because the insurance risk pool would be disproportionately less healthy, thus creating an "insurance death spiral."⁸⁶ The individual mandate also helped win the political support of the private insurance industry lobby that might not have supported the health reforms without the promise of millions of new customers.⁸⁷

Both the Massachusetts health law and the PPACA combine the individual mandate with the creation of health insurance exchanges that enable individuals and families to purchase health insurance in a transparent public marketplace where they can compare prices and benefits.⁸⁸ The architects of the PPACA envisioned each state establishing its own exchange, but also made provisions for the federal government to establish a federal exchange if states were unable or unwilling to establish their own exchanges.⁸⁹ In late 2013, the state and federal exchanges

⁸³ See generally PPACA, *supra* note 1; An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts. ch.58 [hereinafter An Act], <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/ChapterI76J>.

⁸⁴ An Act § 5000A(a)-(b)(1); Requirement to Maintain Minimum Essential Coverage, MASS. GEN. LAWS ch. 111M §2,

<https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXVI/ChapterI11M/Section2>; KAISER FAMILY FOUND., SUMMARY OF THE NEW HEALTH REFORM LAW 4 (2013) [hereinafter SUMMARY OF THE AFFORDABLE CARE ACT], <http://www.kff.org/healthreform/upload/8061.pdf>.

⁸⁵ Michael Lee, Jr., *Trends in the Law: The Patient Protection and Affordable Care Act*, 11 YALE J. HEALTH POL'Y L. & ETHICS 1, 3 (2011).

⁸⁶ Ezra Klein, *The Importance of the Individual Mandate*, WASH. POST, (Dec. 16, 2009, 3:32 PM), http://voices.washingtonpost.com/ezra-klein/2009/12/draft_1.html.

⁸⁷ Lisa Girion, *Private Insurance Companies Push 'Individual Mandate'*, L.A. TIMES (June 7, 2009), <http://articles.latimes.com/2009/jun/07/business/fi-healthcare7>.

⁸⁸ SUMMARY OF THE AFFORDABLE CARE ACT, *supra* note 84, at 2-4; CAROL PRYOR & ANDREW COHEN, KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM, CONSUMERS' EXPERIENCE IN MASSACHUSETTS: LESSONS FOR NATIONAL REFORM 4 (2009), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/7976.pdf>.

⁸⁹ Margot Sanger-Katz, *Obamacare Ruling May Have Just Killed State-Based Exchanges*, N.Y. TIMES (June 26, 2015), <http://www.nytimes.com/2015/06/26/upshot/obamacare-ruling-may-have-just->

became operational with enrollment in health insurance plans beginning January 2014.⁹⁰ The health insurance plans sold in the state and federal health insurance exchanges must contain a comprehensive set of medical services including doctor visits, hospital admissions, and mental health and substance abuse treatment.⁹¹ The PPACA prohibits insurance companies from placing annual or lifetime caps on essential health benefits and sets yearly caps on deductibles for individuals and families.⁹²

The health care exchanges enable individuals and small businesses to comparison shop for health insurance plans. Health insurers participating in the exchanges must offer four coverage tiers—bronze, silver, gold, and platinum—and a catastrophic plan for young adults.⁹³ The plans must accept everyone regardless of age, health status, and pre-existing conditions.⁹⁴ The plans are prohibited from engaging in gender rating, whereby women are charged more for their health insurance than men, but are allowed to vary ratings depending on age, geographic area, family composition, and tobacco use.⁹⁵

The exchanges also determine eligibility for tax credit premium subsidies. The PPACA provides premium subsidies for individuals and families with incomes between 133-400 percent of the federal poverty line to enable them to purchase health insurance on the exchanges. The health care insurance exchanges, via their websites, determine eligibility for these subsidies and apply them to the plans that people chose to purchase.⁹⁶

As originally enacted, the PPACA also significantly expanded access to Medicaid. The legislation expanded Medicaid to all individuals under sixty-five with incomes up to 133 percent of the federal poverty line, thus ensuring that everyone below the eligibility level for the subsidy was eligible for Medicaid. The legislation conditioned each state's federal Medicaid funding on the maintenance of its eligibility levels and enrollment procedures that were in place when the PPACA was passed; this conditional funding was meant to prevent states from scaling back the program.⁹⁷ The federal government fully funds the expansion through

killed-state-based-exchanges.html?_r=0; PPACA, *supra* note 1, §§18031(b)(1)(A), 18041(a)(1), (b)-(c)(1). The PPACA originally stipulated that States either create their own exchange or default to a federal exchange. However, observers have noted that a continuum of exchange options have emerged giving states a variety of options including operating exchanges in partnership with other states and divvying up responsibilities between the state and the federal government whereby the state runs the marketplace management, but the federal government operates the exchange. See Kevin Lucia et. al., *Evolving Dynamics of Health Insurance Exchange Implementation*, THE COMMONWEALTH FUND BLOG (June 19, 2013), <http://www.commonwealthfund.org/publications/blog/2013/jun/evolving-dynamics-of-exchange-implementation>.

⁹⁰ *Health Care Reform Implementation Timeline*, KAISER FAMILY FOUND. (Jan. 26, 2016), <http://healthreform.kff.org/timeline.aspx>.

⁹¹ PPACA, *supra* note 1, §§ 18031(b)(1)(A), 18041(a)(1), (b)-(c)(1).

⁹² Pratt, *supra* note 2, at 524-26; PPACA, *supra* note 1, § 1302(c)(1)(B)(i)-(ii).

⁹³ Scott Harrington, *U.S. Health-Care Reform: The Patient Protection and Affordable Care Act*, 77 J. RISK & INS. 703, 704 (2010).

⁹⁴ PPACA, *supra* note 1, §§ 2704, 2705.

⁹⁵ *Id.* §§ 1557, 2701.

⁹⁶ *Id.* § 36(B)(a)-(2)(A); Pratt, *supra* note 4, at 515-16.

⁹⁷ *Children's Health*, *supra* note 99.

2016. After 2016, federal aid will be gradually reduced to 90 percent of total cost by 2020 for all subsequent years.⁹⁸

The PPACA extends the Children's Health Insurance Program ("CHIP") to 2019, although funding for the program has only been extended through 2017 at this point.⁹⁹ Beginning in fiscal year 2016, states will receive additional federal funding for their CHIP programs.¹⁰⁰

Although the original legislation expanded Medicaid to all individuals below 133 percent of the federal poverty line, the Medicaid expansion soon suffered a significant setback. In 2012, the U.S. Supreme Court ruled that the Medicaid expansion was optional. States could refuse the additional federal dollars to provide health insurance coverage to all people below 133 percent of the poverty line without losing their pre-PPACA federal Medicaid funding.¹⁰¹ In the wake of this decision, twenty-four states chose not to expand Medicaid, leaving a projected 6.7 million uninsured.¹⁰² However, in the years following that decision, a few states have chosen to expand Medicaid after all. Currently, thirty-one of the fifty states have expanded Medicaid.¹⁰³

B. ANALYSIS OF THE PPACA UNDER THE RIGHT TO HEALTH CARE

The PPACA has had mixed results. Although the legislation improved access to health care insurance in several states, it is also likely to have increased the number of underinsured people. Further, the PPACA has created setbacks for at least one state that already had made significant progress toward universal health care.¹⁰⁴ Crucially, the PPACA does not ensure that all individuals living in the United States receive health care as a basic human right and therefore does not meet international human rights legal standards.

98 GEORGETOWN UNIV. HEALTH INST., SUMMARY OF MEDICAID, CHIP AND LOW-INCOME PROVISIONS IN HEALTH CARE REFORM 2 (Apr. 2010), <http://ccf.georgetown.edu/wp-content/uploads/2012/03/Health-reform-summary.pdf>.

99 *Children's Health Insurance Program Overview*, NAT. CONFERENCE OF STATE LEGISLATURES (April 17, 2015), <http://www.ncsl.org/research/health/childrens-health-insurance-program-overview.aspx>; Medicare Access and CHIP Reauthorization Act of 2015, Pub. L. No. 114-10, § 301, 129 Stat. 87 (2015).

100 See sources cited *supra* note 99.

101 Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2015).

102 STAN DORN ET AL., ROBERT WOOD JOHNSON FOUND., WHAT IS THE RESULT OF STATES NOT EXPANDING MEDICAID? 1 (2014),

http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf414946.

103 *A 50 State Look at Medicaid Expansion*, FAMILIES USA (July 2015), <http://familiesusa.org/product/50-state-look-medicare-expansion>.

104 A report on the impact of the 2006 Massachusetts individual mandate and health care exchange, which was the model for the PPACA, indicates that underinsurance rose rapidly in the four years after the reform. BENJAMIN DAY & RACHEL NARDIN, MASS-CARE & MASS. PHYSICIANS FOR A NAT. HEALTH PROGRAM, THE MASSACHUSETTS MODEL OF HEALTH REFORM IN PRACTICE 15 (2011), <http://masscare.org/wp-content/uploads/2011/11/masshealthreforminpracticefinal.pdf>; see *infra* Part IV.C(1) on the setbacks that the PPACA created for Vermont in universalizing health care.

1. Availability of Health Care

The concept of *availability* means that the government must ensure that health care goods, facilities, and services (including clinics, hospitals, medical personnel, and essential medicines) are available in sufficient quantity.¹⁰⁵ Two positive outcomes of the expansion of health care availability wrought by the PPACA are the increased funding for community health centers and the increased reimbursement rates for physicians treating Medicaid patients. However, both these gains have proven to be vulnerable to political pressures relating to budget deficits; and politicians have already begun to reverse some of the positive gains of the PPACA.

a. Expansion of Community Health Centers

Community health centers provide essential primary health care to under-served populations, including people without health insurance or those on a publicly-funded program.¹⁰⁶ The PPACA, as enacted, provided an additional \$11 billion in new funding for community health centers, \$9.5 billion of which was allocated for new health centers.¹⁰⁷ The funding was projected to double the number of patients seen by community health centers to approximately forty million by 2015.¹⁰⁸

After several states declined to expand Medicaid, the community health centers took on an even greater role in ensuring that low-income and uninsured people had access to health care. Almost half of the states choosing to forgo the Medicaid expansion are Southern states with very high poverty and uninsured rates.¹⁰⁹ The decision to forgo the Medicaid expansion in those states has had a disproportionate impact on African American residents, who represent one-quarter of patients in community health centers in non-expansion states.¹¹⁰ Community health centers are proving to be a critical safety net for low-income people who cannot afford health insurance in the non-expansion states.

Unfortunately, in 2011, Congress cut the funding for community health centers by \$600 million annually, with a total loss of \$3 billion in funding over five years.¹¹¹ These cuts were part of the sequestration deal reached between Congress and President Obama in 2011 to keep the federal

105 CESCR General Comment 14, *supra* note 47, ¶ 12(a).

106 NAT'L ASS'N OF CMTY. HEALTH CTRS., EXPANDING HEALTH CENTERS UNDER HEALTH CARE REFORM: DOUBLING PATIENT CAPACITY AND BRINGING DOWN COST (2010), http://www.nachc.com/client/HCR_New_Patients_Final.pdf.

107 *Id.*

108 *Id.*

109 PETER SHIN ET AL., KAISER FOUND., COMMUNITY HEALTH CENTERS: A 2013 PROFILE AND PROSPECTS AS ACA IMPLEMENTATION PROCEEDS 2 (2013), <http://files.kff.org/attachment/issue-brief-community-health-centers-a-2013-profile-and-prospects-as-aca-implementation-proceeds>.

110 *Id.* at 2.

111 NAT'L ASS'N OF CMTY. HEALTH CTRS., COMMUNITY HEALTH CENTERS: PAST, PRESENT AND FUTURE: BUILDING ON 50 YEARS OF SUCCESS 9 (2015), http://nachc.com/client/PI_50th.pdf.

government operating.¹¹² As a result of these budget cuts, community health centers treated an estimated five million fewer patients each year than expected. Moreover, the funding support allocated under the PPACA is set to run out in 2015 and, if not renewed, approximately 9.8 million patients will lose their access to health care via community health centers by 2020.¹¹³ In sum, while the increased funding for community health centers in the PPACA expanded the availability of health care to millions who did not previously have access, leaving funding up to the vagaries of the political process has undermined the ability of these community health centers to provide critical health care delivery, and reduced the number of people they were expected to serve.

b. Increased Medicaid Reimbursement Rates

Another positive aspect of the PPACA in terms of expanding availability of health care was a provision to increase payments to physicians and providers treating Medicaid patients. Prior to the passage of the PPACA, Medicaid reimbursed physicians at a significantly lower rate than private insurers. As a result, many primary care physicians and specialists either refused to take patients with Medicaid at all, or capped the number of Medicaid patients in their practice.¹¹⁴ In 2011, almost one-third of primary care physicians were reluctant to add new Medicaid patients to their practices.¹¹⁵ As a result, people eligible for Medicaid likely faced difficulties accessing care despite having health insurance.

The PPACA addressed this issue by mandating a two-year increase in Medicaid reimbursement rates in order to raise them to the same level as the Medicare reimbursement rates.¹¹⁶ Medicare, on average, reimburses physicians at approximately 80 percent of what private insurers reimburse.¹¹⁷ In contrast, prior to the passage of the PPACA, Medicaid reimbursed physicians only approximately 56 percent of what private insurers reimbursed.¹¹⁸ Raising the Medicaid rates to Medicare levels was a significant step and likely made physicians more willing to treat patients

¹¹² *Id.*

¹¹³ *Id.* at 10; Kimberly Leonard, *Funding Cliff Threatens Community Health Centers*, US NEWS AND WORLD REPORT, (March 17, 2015, 6:26 PM), <http://www.usnews.com/news/articles/2015/03/17/funding-cliff-threatens-community-health-centers>.

¹¹⁴ Sandra Decker, *Nearly One-Third of Physicians do not Accept New Medicaid Patients but Incentives May Help*, ORTHOPEDICS TODAY (Oct. 2012), <http://www.healio.com/orthopedics/business-of-orthopedics/news/print/orthopedics-today/%7Ba38ecb7f-a822-42b7-a79f-3174b07b0aa9%7D/nearly-one-third-of-physicians-do-not-accept-new-medicare-patients-but-incentives-may-help>.

¹¹⁵ *Id.*

¹¹⁶ STEPHEN ZUCKERMAN ET AL., URBAN INST., *REVERSING THE MEDICAID FEE BUMP: HOW MUCH COULD MEDICAID PHYSICIAN FEES FOR PRIMARY CARE FALL IN 2015?* (2014), <http://www.urban.org/research/publication/reversing-medicare-fee-bump-how-much-could-medicare-physician-fees-primary-care-fall-2015>.

¹¹⁷ Merrill Matthews, *Doctors Face a Huge Medicare and Medicaid Pay Cut in 2015*, FORBES (Jan. 5, 2015, 9:50 AM), <http://www.forbes.com/sites/merrillmatthews/2015/01/05/doctors-face-a-huge-medicare-and-medicare-pay-cut-in-2015/>.

¹¹⁸ *Id.*

with Medicaid.¹¹⁹ Unfortunately, the higher Medicaid reimbursement rates are set to expire in 2015; and while a number of states have committed to keeping the Medicaid reimbursement rates at current levels through the use of state funds, many others have decided not to continue the increase.¹²⁰ A recent study estimates that in some cases, physicians will see reimbursement rates reduced by an average of 42 percent in 2015 and beyond.¹²¹ It is too early to know the impact that the falling reimbursement rates will have on Medicaid recipients' access to care, but given that previous studies have found a correlation between low Medicaid reimbursement rates and providers' reluctance to treat Medicaid patients, it is likely that the rate reduction will impede Medicaid patients' access to care.

It is also important to note that Congress had the opportunity to address this issue before the higher reimbursement rates were discontinued. In April 2015, Congress passed legislation with strong bipartisan support that prevented a Medicare reimbursement rate decrease of approximately 20 percent (half of the estimated reduction of Medicaid reimbursement rates) and extended funding for the Children's Health Insurance Program.¹²² Although President Obama's 2016 budget proposal included a one-year extension to the Medicaid reimbursement increase, the one-year extension was not included in the legislation that enacted the Medicare reimbursement and the CHIP extension.¹²³

While the PPACA increased the availability of health care in the United States when first implemented, the community health center funding cuts and the drop in reimbursement rates for physicians treating Medicaid patients have already reversed some of these gains. Scholars have repeatedly noted that social programs that provide universal benefits (i.e., Social Security and Medicare) tend to be more popular than programs that are perceived to be targeted solely at low-income people (i.e., Medicaid).¹²⁴ So long as the American public views community health centers and Medicaid as programs for poor people that are paid for by taxpayers, the programs will be vulnerable to budget cuts in the future. Additional cuts to these programs could further reduce the availability of health care for low-income people in the United States and undermine some of the progress made under the PPACA.

¹¹⁹ *Id.*

¹²⁰ LAURA SNYDER ET AL., KAISER FAMILY FOUND., THE ACA PRIMARY CARE INCREASE: STATE PLANS FOR SFY 2015 (2015), <http://kff.org/medicaid/perspective/the-aca-primary-care-increase-state-plans-for-sfy-2015/>.

¹²¹ ZUCKERMAN, *supra* note 116.

¹²² Mary Agnes Carey, *FAQ: Congress Passes a Bill to Fix Medicare's Doctor Payments. What's In It?*, KAISER HEALTH NEWS (Apr. 15, 2015), <http://khn.org/news/faq-could-congress-be-ready-to-fix-medicare-pay-for-doctors-2/>.

¹²³ Jason Millman, *Obamacare Paradox: Medicaid is Expanding but Doctors are Facing a Huge Pay Cut*, WASH. POST (Dec. 10, 2014), <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/12/10/obamacare-paradox-medicaid-is-expanding-but-doctors-are-facing-a-huge-pay-cut/>.

¹²⁴ David Orentlicher, *Medicaid at 50: No Longer Limited to the "Deserving" Poor?* 15 YALE J. HEALTH POL'Y L., & ETHICS 185, 193 (2015).

2. Accessibility of Health Care

The human right to health care requires that health facilities, goods, and services be *accessible* to everyone without discrimination.¹²⁵ They must also be economically accessible and equitable, in other words, affordable for everyone.¹²⁶ The PPACA has succeeded in expanding health insurance coverage to millions of U.S. residents, and it requires this insurance to cover a comprehensive set of benefits, including preventative care and mental health services. This is no small achievement. Access to health *insurance* is not the same as access to health *care* but health insurance coverage is strongly correlated with better health care outcomes.¹²⁷ Therefore, by expanding access to health insurance, the PPACA expands access to health care.

Unfortunately, the PPACA does not do enough to ensure that access to health care is equitable and affordable. The PPACA actually enshrines health care inequality by creating health insurance tiers and by providing more generous tax breaks for employer-sponsored health insurance than those given on the exchange. Even the PPACA's definition of health insurance "affordability" preserves inequality in the American health care system. Despite its efforts to expand access to health insurance and thus health care, the PPACA still props up a system wherein wealthy people have access to quality care for a smaller fraction of their income than people with moderate or low incomes. Moreover, access to health *insurance* does not necessarily translate into access to health *care*. Many people who have purchased health insurance policies find themselves unable to access health care due to the cost sharing allowed by the PPACA.

a. Health Insurance Expansion

In 2010, approximately forty-nine million U.S. residents lacked health insurance.¹²⁸ One of the primary goals of the PPACA was to expand insurance coverage to the uninsured; analysts predicted that the reform would increase coverage to approximately thirty-two million people when fully implemented.¹²⁹ One way the PPACA expands health insurance coverage is by requiring health plans to allow children up to age twenty-six—rather than age eighteen—to remain on their parents' employer-

¹²⁵ CESCR General Comment 14: Right to Health, *supra* note 47, ¶ 12(b).

¹²⁶ *Id.* (Accessibility also means that health care facilities, goods, and services must be within a safe and reasonable distance of the homes and workplaces of all sections of the population. Finally, health information must be accessible—including the right to seek and impart information and ideas. We do not address these additional aspects of "accessibility" in this article).

¹²⁷ JILL BERNSTEIN ET AL., MATHEMATICA, HOW DOES INSURANCE COVERAGE IMPROVE HEALTH OUTCOMES? 1-3 (Apr. 2010), http://www.mathematica-mpr.com/~media/publications/PDFs/health/reformhealthcare_ib1.pdf.

¹²⁸ Alicia Ely Yamin & Jean Connolly Carmalt, *The United States: Right to Health Obligations in the Context of Disparity and Reform*, in ADVANCING THE HUMAN RIGHT TO HEALTH 232 (Joseph M. Zuniga et al. eds., 2013).

¹²⁹ Jean Connolly Carmalt, et al., *Entrenched Inequity: Health Care in the United States*, in HUMAN RIGHTS IN THE UNITED STATES: BEYOND EXCEPTIONALISM 154 (Shereen Hertel & Kathryn Libal eds., 2011).

sponsored group plans.¹³⁰ According to the Department of Health and Human Services, within the first year of enactment of this provision, an additional 2.5 million young people had enrolled in insurance.¹³¹

The expansion of Medicaid to all people at or below 138 percent of the poverty level also increased coverage.¹³² Prior to the PPACA, Medicaid eligibility was reserved for people below the poverty level who fit within a specific category including children, parents, pregnant women, or those receiving Supplemental Security Income (SSI) assistance.¹³³ Generally speaking, childless adults were not eligible for Medicaid even if their income was below the federal poverty level, unless their state had sought a waiver from the federal government.¹³⁴ Additionally, states had broad discretion in determining Medicaid eligibility. Some states chose to cover children and families with incomes up to 250 percent of the federal poverty line (\$46,325 for a family of three in 2011) while other states chose to cap eligibility at 138 percent of the federal poverty level.¹³⁵ In some states, eligibility for parents of dependent children was capped at less than 50 percent of the federal poverty level.¹³⁶ As a result of these low caps, millions of people in those states were left without insurance and were forced to access health care through the emergency room or through free health clinics.¹³⁷

By expanding Medicaid eligibility to U.S. residents with incomes up to 138 percent of the federal poverty level, the PPACA had the potential to significantly improve health care access and outcomes for millions. However, in 2012, the U.S. Supreme Court ruled that states could opt out of the Medicaid expansion.¹³⁸ As a result of this ruling, twenty-two states have opted out of the Medicaid expansion; this means that people who should have been eligible for Medicaid under the PPACA are not eligible.¹³⁹ The PPACA, as designed, envisioned that low-income adults would receive health insurance through Medicaid. Therefore, it did not provide for people

¹³⁰ PPACA, *supra* note 1, at § 300gg.

¹³¹ AMERICAN COLL. OF SURGEONS, *Affordable Care Act Provision for Young Adults Leaves Racial Disparities Intact Among Trauma Patients*, NEWSWISE (Apr. 9, 2015), <http://newswise.com/articles/affordable-care-act-provision-for-young-adults-leaves-racial-disparities-intact-among-trauma-patients>.

¹³² RACHEL GARFIELD ET. AL., KAISER FAMILY FOUND., COMMISSION ON MEDICAID AND THE UNINSURED, *THE COVERAGE GAP: UNINSURED POOR ADULTS IN STATES THAT DO NOT EXPAND MEDICAID 1* (2015), <http://files.kff.org/attachment/issue-brief-the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicare-an-update>. Kaiser Health News uses the figure of 138 percent rather than 133 percent above the federal poverty level as the cap for the Medicaid expansion. This is due to the fact that while the PPACA caps income eligibility at 133 percent above poverty level, it also disregards a fixed portion of income (that varies with family size) in calculating income level. This has the effect of raising the income eligibility to 138 percent. See Phil Galewitz, *KHN Changes How it Describes Medicaid Eligibility Under Health Law*, KAISER HEALTH NEWS (Dec. 5, 2012), <http://khn.org/news/khn-changes-how-it-describes-medicare-eligibility-level-under-health-law/>.

¹³³ Parento & Gostin, *supra* note 21, at 492.

¹³⁴ *Id.* at 493-94.

¹³⁵ *Id.* at 493.

¹³⁶ *Id.* at 494.

¹³⁷ *Id.* at 495.

¹³⁸ Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2575 (2012).

¹³⁹ GARFIELD, *supra* note 132, at 1.

living at or below 138 percent of the federal poverty level to be eligible for the advanced premium tax credits to enable them to purchase affordable health insurance on the exchange.¹⁴⁰ As a result, approximately four million Americans have fallen into a “coverage gap,” making too little to qualify for the tax credits to purchase health insurance on the exchange but too much to qualify for Medicaid because their states opted out of the expansion.¹⁴¹ The majority of people in the coverage gap are working either full or part-time at low-paying jobs and typically do not have access to employer-sponsored health insurance plans.¹⁴² It is unlikely that the people in the coverage gap would be able to afford health insurance on the health care exchange without assistance from the tax subsidies. For example, the average cost of a health plan for a forty year-old single individual (\$213 for bronze and \$276 for silver) amounts to between one-quarter and one-half of the average monthly income of those in the coverage gap.¹⁴³ Therefore, it is likely that the people who find themselves in this coverage gap will simply do without health insurance and, as a result, often do without health care.

b. *Affordability and Equity of the Health Insurance Exchanges*

The second way that the PPACA expanded access to health insurance was through the health insurance market places that individuals and small businesses use to purchase health insurance. As discussed previously, the plans on the state and federal exchanges are divided into tiers: bronze, silver, gold, and platinum. The PPACA mandates that all plans at every tier cover a basic set of preventive services without co-pays, deductibles, or other kinds of cost-sharing.¹⁴⁴ Patients at every tier level are subject to cost-sharing in the form of deductibles, co-payments, and co-insurance for other services.¹⁴⁵ The tier of health insurance purchased determines the level of cost sharing. Bronze plans are required to cover 60 percent of health care costs on average, leaving the patient to pay for 40 percent of costs; silver plans cover 70 percent, leaving 30 percent of the costs to the patient, and so on.¹⁴⁶ Table 2 sets out these elements of the four tiers.

140 *Id.*

141 *Id.* at 4.

142 *Id.*

143 *Id.* at 4–5.

144 KAISER FAMILY FOUND., PREVENTATIVE SERVICES COVERED BY PRIVATE HEALTH PLANS UNDER THE AFFORDABLE CARE ACT 1 (2015), <http://kff.org/health-reform/fact-sheet/preventive-services-covered-by-private-health-plans/>.

145 *Id.*

146 KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: WHAT THE ACTUARIAL VALUES IN THE AFFORDABLE CARE ACT MEAN 2 (2011), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8177.pdf>.

Table 2: Health Care Plans on State and Federal Exchanges – Actuarial Values and Cost-Sharing		
<i>Plan Tier</i>	<i>Actuarial Value</i>	<i>Patient Cost-Sharing</i>
Bronze	60%	40%
Silver	70%	30%
Gold	80%	20%
Platinum	90%	10%

While gold and platinum plans have lower out-of-pocket costs, they have much higher monthly premiums than the bronze and silver plans. Therefore, people purchasing insurance on the health care exchanges must predict how much health care they expect to use over the year and decide whether it makes sense to purchase a plan with lower premiums, but higher out-of-pocket costs, or a plan with higher premiums and lower out-of-pocket costs.

Regardless of what tier of plan people choose, the PPACA mandates that the maximum out-of-pocket cost for an individual in 2015 is \$6000 and for a family is \$13,200.¹⁴⁷

To make health insurance more affordable, the PPACA established an advanced premium tax credit that provides subsidies to purchase health insurance to people with incomes below 400 percent of the federal poverty level (FPL.) In 2015, 400 percent of the FPL was \$47,080 for an individual and \$97,000 for a family of four.¹⁴⁸ The advanced premium tax credits may be used to purchase a health insurance plan in any of the four tiers.

To be eligible for the advanced premium tax credits, people must have incomes below 400 percent of the federal poverty line and must not receive “affordable” employer-sponsored health insurance. The PPACA defines an affordable employer-sponsored plan as one that is no more than 9.5 percent of the employee’s modified adjusted gross income (MAGI).¹⁴⁹ If the employer-sponsored plan would cost more than 9.5 percent of the employee’s MAGI, the person can shop for health insurance on the exchange and is eligible for the advanced premium tax credits. If an employer offers family coverage, family members cannot purchase health insurance on the exchange, nor can they receive the premium tax credits, unless the cost of coverage is over 9.5 percent of the employee’s MAGI.¹⁵⁰ However, the affordability calculation for family plans is based on the cost of the self-only plan, not the often significantly higher cost of employer-

¹⁴⁷ *Glossary: Out-of-pocket maximum/limit*, HEALTHCARE.GOV, <https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/> (last visited Feb. 23, 2016).

¹⁴⁸ *Federal Poverty Guidelines*, FAMILIES USA (Feb. 2015), <http://familiesusa.org/product/federal-poverty-guidelines>.

¹⁴⁹ *What is Affordable Coverage Under Obamacare?*, OBAMACARE FACTS, <http://obamacarefacts.com/affordable-employer-sponsored-coverage/> (last visited Feb. 23, 2016).

¹⁵⁰ Tricia Brooks, *The Family Glitch*, HEALTH AFFAIRS (2014), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=129.

sponsored family coverage. Provided that the cost of the self-only employer-sponsored health insurance plan is less than 9.5 percent of the employee's MAGI, the family is ineligible for premium assistance.¹⁵¹

For example, according to Tricia Brooks, Research Assistant Professor at the Georgetown University Health Policy Institute, the average annual cost of an employer-sponsored self-only plan in 2013 was \$999 per year, whereas the average cost of family employer-sponsored plan was \$4,565.¹⁵² For a family with an income of \$33,000 per year (140 percent of the federal poverty line), the cost of the average employer-sponsored health plan would be 13.8 percent of their household income, which is well above the affordability threshold of 9.5 percent.¹⁵³ In contrast, were they eligible to purchase health insurance on the exchange they would receive both premium and cost-sharing subsidies and would pay approximately 3.4 percent of their annual income for a silver plan.¹⁵⁴ This anomaly is what is known as the "family glitch," whereby families cannot afford the cost of employer-sponsored coverage but are not eligible to purchase health insurance on the exchange or take advantage of the subsidies. In these cases, families may be eligible for an exemption from the mandate to purchase health insurance, but then they remain uninsured.¹⁵⁵ An estimated two million people fall into this category, and while the children may be eligible to get health insurance through Medicaid or CHIP, adult family members may not be able to find affordable health insurance.¹⁵⁶

Assuming people are able to find and purchase affordable health insurance through their employer or the health exchanges, they still may have difficulties affording access to health care due to the cost-sharing allowed by the PPACA. Although a basic set of services are not subject to cost-sharing, other services will require patients to pay deductibles and co-payments amounting to as much as \$6600 a year for an individual, or \$13,200 for a family.¹⁵⁷ To address this problem, the PPACA also created cost-sharing subsidies to assist people with deductibles, co-pays, and other out-of pocket costs. However, these cost-sharing subsidies are only available to people with incomes below 250 percent of the federal poverty level (\$59,625 for a family of four in 2015).¹⁵⁸ People over that threshold must pay the full amount of the cost-sharing allowed by the PPACA. In

¹⁵¹ *Id.*

¹⁵² *Id.*

¹⁵³ *Id.*

¹⁵⁴ *Id.*

¹⁵⁵ *Id.* (The PPACA calculates affordability for the purpose of the affordability exemption differently. If self-only health insurance or family insurance coverage costs more than 8 percent of the MAGI, they are exempt from the penalty for not having health insurance); See *What is Affordable Coverage Under Obamacare?*, *supra* note 149.

¹⁵⁶ *A Glitch in Health Care Reform*, N.Y. TIMES (Aug. 25, 2012), http://www.nytimes.com/2012/08/26/opinion/sunday/a-glitch-in-health-care-reform.html?_r=0.

¹⁵⁷ KAISER FAMILY FOUND., FOCUS ON HEALTH REFORM: EXPLAINING HEALTH CARE REFORM: QUESTIONS ABOUT HEALTH INSURANCE SUBSIDIES 2 (Oct. 27, 2014), <http://kff.org/health-reform/issue-brief/explaining-health-care-reform-questions-about-health/>.

¹⁵⁸ *Id.*

some cases, the premiums and cost-sharing allowed by the PPACA could account for almost 20 percent of pre-tax income.¹⁵⁹

There is very little data on whether the cost sharing mandated by the PPACA will discourage people from utilizing health care, but there are anecdotal reports that people have forgone necessary health care due to concerns about the cost.¹⁶⁰ Moreover, in studies examining the impact that premiums and cost-sharing would have if imposed on Medicaid recipients, researchers found that these kinds of fees would pose a significant barrier to accessing health care.¹⁶¹ Studies have found that cost-sharing not only reduces utilization of less-essential services, but reduces utilization of essential services as well, which in turn leads to poorer and more expensive health outcomes in the long run.¹⁶² Extrapolating from these previous studies, it is likely that many people will forgo care despite having health insurance because they cannot afford the out-of-pocket costs, and in many cases forgoing that care will lead to worse health outcomes and higher health care costs later.

3. Acceptability of Health Care

The concept of *acceptability* means that all health facilities, goods, and services must be respectful of ethical codes of health professionals, designed to improve health, culturally appropriate, and sensitive to gender and life-cycle requirements.¹⁶³ The PPACA takes several measures to improve the acceptability of health care for people living in the United States. First, the legislation requires that insurance plans provide information regarding plans, benefits, coverage, and the appeals process in a “culturally and linguistically appropriate manner.”¹⁶⁴ Prior to the passage of the PPACA, insurance companies were only required to provide summary plan descriptions in a culturally and linguistically appropriate manner if 10 percent of plan participants were literate only in the same non-English language.¹⁶⁵ The PPACA expands that requirement to include more plan documents, and shifts the standard to include every county where 10 percent of the population is only literate in the same non-English language.¹⁶⁶ The Department of Health and Human Services publishes an

¹⁵⁹ Ryan Sugden, *Sick and (Still) Broke: Why the Affordable Care Act Won't End Medical Bankruptcy*, 38 WASH. U. J.L. & POL'Y 441, 468 (2012).

¹⁶⁰ Abby Goodnough & Robert Pear, *Unable to Meet the Deductible or the Doctor*, N.Y. TIMES (Oct. 17, 2014), <http://www.nytimes.com/2014/10/18/us/unable-to-meet-the-deductible-or-the-doctor.html>.

¹⁶¹ LAURA SNYDER & ROBIN RUDOWITZ, KAISER COMM'N ON MEDICAID AND THE UNINSURED, KAISER FAMILY FOUND., PREMIUMS AND COST SHARING IN MEDICAID: A REVIEW OF RESEARCH FINDINGS 6 (Feb. 2013), <https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8417-premiums-and-cost-sharing-in-medicaid.pdf>.

¹⁶² *Id.* at 6–7.

¹⁶³ CESC General Comment 14, *supra* note 47, ¶ 12(c).

¹⁶⁴ 45 C.F.R. § 147.136 (e) (2010).

¹⁶⁵ Lisa Klinger, *County Data Released for “Culturally and Linguistically Appropriate” Services*, LEAVITT GROUP (Aug. 8, 2013), <https://news.leavitt.com/health-care-reform/2013-county-data-released-for-culturally-and-linguistically-appropriate-services/>.

¹⁶⁶ *Id.*

annual list of counties that meet the test.¹⁶⁷ To be considered culturally and linguistically appropriate, insurance plans must provide oral language services in the non-English language and provide written documents in the non-English language upon request. Every relevant plan document must include a written notice in the relevant non-English language that describes how consumers can access plan documents in another language.¹⁶⁸

In addition to making insurance plan information more accessible, the PPACA also expands health care provided by community health workers. Community health workers typically come from, or have very close ties to, the communities in which they serve and can help to ensure that the health care services provided are culturally appropriate.¹⁶⁹ Because community health workers have close cultural and linguistic ties to the people with whom they work, they are able to build trust and credibility in the community, which can have a significant impact on the health of the community as a whole.¹⁷⁰ Numerous studies have shown that community health workers can have a significant impact on improving health outcomes for low-income and minority groups, particularly in the areas of managing and preventing chronic illnesses.¹⁷¹ To support these efforts, the PPACA authorizes grant funding to entities that utilize community health workers in a variety of capacities including home visitation for prenatal and maternal care, promoting healthy behaviors, conducting outreach regarding prevalent health problems in underserved communities, and more.¹⁷²

These two examples indicate that the PPACA has improved the U.S. healthcare system through the lens of acceptability by taking steps to ensure that health insurance information is provided in a culturally and linguistically appropriate manner and by encouraging the utilization of community health workers to advance health in underserved and vulnerable communities. Moreover, the PPACA expansion of health insurance, which results in fewer uninsured people relying on emergency room care, also makes health care more acceptable as evidence shows there is a heightened cultural miscommunication in this setting.¹⁷³ Finally, the PPACA provides for scholarship and loan repayment initiatives to encourage minorities, who are underrepresented in the field, to enter health professions. An increase of minority health workers will make health care more culturally acceptable in these communities and begin to address the gross disparities in health outcomes for minorities as a result.¹⁷⁴

¹⁶⁷ *Id.*

¹⁶⁸ *Id.*

¹⁶⁹ Nadia Islam, et al., *Integrating Community Health Workers Within Patient Protection and Affordable Care Act Implementation*, 21 J. PUB. HEALTH MGMT. & PRAC. 42, 43 (2015).

¹⁷⁰ *Id.*

¹⁷¹ *Id.*

¹⁷² *Id.*

¹⁷³ Yamin & Carmalt, *supra* note 128, at 235.

¹⁷⁴ Carmalt et al., *supra* note 129, at 167.

4. *Quality of Health Care*

The final element of the AAAQ is *Quality*. *Quality* means that health care facilities, goods, and services must be scientifically sound, medically appropriate, and of good quality. This includes qualified health care personnel and scientifically approved medicines and medical equipment.¹⁷⁵ Provisions in the PPACA aim to improve health care quality through the use of Accountable Care Organizations (“ACOs”).¹⁷⁶ ACOs are an extension of the patient-centered medical home model that began to take hold in the 1990s.¹⁷⁷ A patient-centered medical home is one in which a physician coordinates a health care team to provide high-quality, coordinated health care to patients.¹⁷⁸ Patient-centered medical homes were an effort to address fragmented health care delivery that often resulted in costly, poor-quality health care and poor health outcomes for patients.¹⁷⁹ Studies have shown that the medical home model has been successful in improving health care quality.¹⁸⁰ ACOs expand the patient-centered medical home model to create better-coordinated care across the health care continuum from primary care providers, to hospitals and specialists.¹⁸¹ The PPACA encourages the creation and expansion of ACOs by restructuring payment policies and authorizing pilot programs.¹⁸² Early evidence indicates that ACOs are improving the quality of care. California, for example, has more ACOs than any other state in the United States and studies indicate significant health-care-quality improvements under the ACO expansion.¹⁸³ The creation and expansion of ACOs is an important step towards improving health care quality in the United States.

C. ANALYSIS OF THE PPACA UNDER HUMAN RIGHTS PRINCIPLES

1. *Universality*

Universality is fundamental to human rights. All human beings have a right to health care. The PPACA does not create a universal health care system, however, or even ensure universal health insurance coverage to all U.S. residents. In fact, the PPACA, as designed, assumed that certain segments of the population would either be unable to afford insurance or otherwise be ineligible. The law includes an exemption from the individual

¹⁷⁵ CESCR General Comment 14: Right to Health, *supra* note 47, ¶ 12(d).

¹⁷⁶ PPACA, *supra* note 1, §§ 2706, 3022.

¹⁷⁷ David Longworth, *Accountable Care Organizations, the Patient-Centered Medical Home and Health Care Reform: What does it all Mean?*, 78 CLEVELAND CLINIC J. MED. 571, 576 (2011).

¹⁷⁸ *Id.*

¹⁷⁹ *Id.*

¹⁸⁰ *Id.*

¹⁸¹ *Id.*

¹⁸² *The Medical Home Model of Care*, NAT’L CONFERENCE OF STATE LEGISLATURES, <http://www.ncsl.org/research/health/the-medical-home-model-of-care.aspx> (last updated Sept. 2012).

¹⁸³ Stephen Shortell & Richard Scheffler, *Accountable Care Organizations Taking Hold and Improving Health Care in California*, HEALTH AFFAIRS BLOG (June 2, 2015), <http://healthaffairs.org/blog/2015/06/02/accountable-care-organizations-taking-hold-and-improving-health-care-in-california/>.

mandate for people who are unable to find “affordable” health care.¹⁸⁴ The exemption ensures that people without access to affordable health insurance are not fined, but this is cold comfort for those in need of health care who cannot afford it.

In addition, the PPACA, by design, discriminates against new legal permanent residents and other noncitizens present under nonimmigrant visas, and it excludes altogether undocumented immigrants from coverage.¹⁸⁵ Some of the legal restrictions in the PPACA are rooted in the 1996 welfare reform law that placed a five-year bar on legal permanent residents’ eligibility to receive Medicaid benefits and a seven-year bar for refugees and asylum seekers.¹⁸⁶ The PPACA left those bars unchanged but made newly arrived legal permanent residents and refugees subject to the individual mandate requirement.¹⁸⁷ As a result, individuals who would otherwise be eligible for Medicaid must instead purchase health insurance on the exchanges. Legal permanent residents are eligible for premium subsidies, including those below 138 percent of the poverty level who, but for their immigration status, would be eligible for Medicaid.¹⁸⁸ However, legal permanent residents and refugees, who would otherwise qualify for Medicaid, will shoulder a significant financial burden despite the premium subsidies they may receive when purchasing health insurance on the exchange.¹⁸⁹ Similarly, non-immigrants (i.e., people with non-immigrant status student or work visas) can purchase health insurance on the exchange and may be eligible for subsidies but are permanently barred from Medicaid.¹⁹⁰

While legal permanent residents, refugees, and asylum seekers can eventually receive Medicaid, undocumented immigrants are permanently barred from the Medicaid and CHIP programs. Moreover, they are not eligible for premium subsidies and are even barred from purchasing health insurance without the use of subsidies via the exchange.¹⁹¹ In contrast to permanent residents and non-immigrants, for whom the PPACA simply did not change pre-existing law, undocumented immigrants were explicitly excluded from coverage.¹⁹² As a result, approximately eleven million people living and working in the United States are excluded from the health care system that the PPACA established. Although it is possible that some insurance companies will sell policies outside of the exchanges to undocumented immigrants, these policies are likely to be prohibitively expensive.

184 PPACA, *supra* note 1, § 1501; 26 U.S.C. § 5000A(e)(1)(A)-(B) (Supp. IV 2010).

185 Andrapalliyal, *supra* note 2, at 63-64.

186 *Id.*

187 *Id.*

188 US DEP’T OF HEALTH AND HUMAN SERVS., THE AFFORDABLE CARE ACT: COVERAGE IMPLICATIONS AND ISSUES FOR IMMIGRANT FAMILIES (Apr. 30, 2012), <http://aspe.hhs.gov/hsp/11/ImmigrantAccess/Coverage/ib.shtml>.

189 Andrapalliyal, *supra* note 2, at 64.

190 *Id.* at 65.

191 *Id.* at 66.

192 *Id.*

Moreover, the PPACA cut existing funding for the Emergency Medicaid program.¹⁹³ This program provides funding for emergency health care and is available to undocumented immigrants and legal permanent residents.¹⁹⁴ Because the PPACA excludes undocumented immigrants from publicly-subsidized programs and from purchasing health care coverage on the exchanges, the PPACA's budget cuts to the emergency Medicaid program and community health centers discussed previously, disproportionately impact undocumented immigrants.¹⁹⁵

On top of the threat to the lives of undocumented immigrants who require medical attention and are unable to receive it, the failure to cover undocumented immigrants in health care reform has a staggering financial cost. Undocumented immigrants—who often neither have access to affordable health insurance nor the money to pay the cost of emergency room bills—generate the majority of the \$5 billion in annual uncompensated emergency health care costs. The right to health care is afforded to all by virtue of being human, not by virtue of being an American citizen or legal permanent resident. The exclusion of undocumented immigrants from most of the protections of the health care reform legislation means that the PPACA has failed to provide universal health care.

2. *Equality and Non-Discrimination*

The rights to equality and non-discrimination are core principles of international human rights law. One positive aspect of the PPACA is that it prohibits insurance companies from discriminating against patients with pre-existing conditions.¹⁹⁶ Beginning in 2010, insurance companies were no longer able to discriminate against children with pre-existing health conditions, and in 2014, this protection extended to adults as well.¹⁹⁷ This is a core provision of the PPACA that complements the individual mandate; everyone is required to purchase health insurance and everyone who is a legal resident is eligible to purchase health care insurance.

The PPACA has also addressed discriminatory practices against women. Prior to the passage of the PPACA, women were less likely than men to be insured through their employers; thus, the creation of the insurance marketplaces had a positive impact on expanding insurance access for women.¹⁹⁸ Indeed, in the first open enrollment period, 54 percent of the people signing up for health insurance were women.¹⁹⁹ Since the implementation of the PPACA, the overall rate of uninsurance among

¹⁹³ *Id.* at 63.

¹⁹⁴ *Id.*

¹⁹⁵ Andrapalliyal, *supra* note 2, at 64, 66.

¹⁹⁶ Lee, *supra* note 85, at 2; Pratt, *supra* note 2, at 527.

¹⁹⁷ PPACA, *supra* note 1, §§ 300gg-3, 300gg-4.

¹⁹⁸ Rachel Hansen & Rebecca Newman, *Health Care: Access After Health Care Reform*, 16 GEO. J. GENDER & L. 191, 214 (2015).

¹⁹⁹ *Id.*

women residing in the U.S. has declined by 5 percent in contrast to 4.7 percent for men.²⁰⁰

The legislation also prohibits insurance companies from charging higher premiums for women, a common practice prior to the passage of the PPACA, and requires that insurance companies provide access to obstetric and gynecological care and to cover maternity care for all plans purchased on the exchanges.²⁰¹ Finally, the PPACA requires insurance companies to eliminate cost-sharing from certain categories of preventive care, including all FDA-approved contraceptives.²⁰² As a result of these requirements, women should have significantly greater access to health care, and to reproductive health care in particular, than they did prior to the passage of the PPACA. However, the Department of Health and Human Services, the Department of Labor, and the Treasury have issued rules and regulations that carve out a significant loophole to the contraception mandate.²⁰³ Churches and organizations defined as religious employers are entirely exempt from the requirement that they provide insurance coverage for contraception.²⁰⁴ Nonprofit organizations are subject to the mandate but can receive an “accommodation” under which they are still required to provide insurance plans that cover contraception without cost-sharing, but do not have to pay for the portion of the insurance premiums that go to contraceptives.²⁰⁵

The exemption and accommodation were created to respond to religious groups who objected to all forms of contraception or to forms of contraception that they believe to be abortifacients.²⁰⁶ Originally, the exemption and the carve-out were for churches and religious organizations. However, the Supreme Court held in *Burwell v. Hobby Lobby* that closely-held corporations whose owners objected to contraception could opt out of the contraception mandate as well.²⁰⁷ In July 2015, the Obama Administration announced that the birth control accommodation would be available to women who worked for private companies whose employers objected to birth control, in addition to employees of churches and religious organizations.²⁰⁸ Employers at churches, religious organizations, and closely held corporations can request the accommodation by notifying the federal Department of Health and Human Services that they object to

200 *Id.*

201 *Id.* at 214.

202 *Id.*

203 Maria Iliadis, *An Easy Pill to Swallow: While the Supreme Court Found that For-Profit, Secular Companies Can Exercise Religion Within the Meaning of the Religious Freedom Restoration Act, the Mandate Should Have Prevailed With Respect to those Entities Because it Advances the Government's Compelling Interest in Public Health and is the Least Restrictive Means of Doing So*, 44 U. BALT. L. REV. 341, 346 (2015).

204 *Id.*

205 *Id.* at 347.

206 *Id.* at 345.

207 *Burwell v. Hobby Lobby Stores, Inc.* 134 S. Ct. 2751, 2759-60 (2014).

208 Kimberly Leonard, *After Hobby Lobby, A Way to Cover Birth Control*, US NEWS & WORLD REP. (July 10, 2015), <http://www.usnews.com/news/articles/2015/07/10/after-hobby-lobby-ruling-hhs-announces-birth-control-workaround>.

providing birth control coverage.²⁰⁹ The Department of Health and Human Services then notifies insurers, who are required to pay for the costs of contraceptives with no additional cost to the employer or enrollees.²¹⁰ As a result, women should be able to receive birth control without cost-sharing regardless of the religious beliefs of their employers.

Even women whose employers do not object to contraception have had difficulties receiving the broad array of reproductive health services mandated by the PPACA.²¹¹ Researchers at the National Women's Law Center, for example, conducted a comprehensive study of women's health care coverage in fifteen states; the study found extensive violations by insurers relating to maternity care, birth control, breastfeeding supports, and more.²¹² For example, researchers found that insurers in some states imposed limits on the number of prenatal visits covered, required co-pays for some or all forms of contraception, and excluded genetic testing for women at high risk of developing ovarian or breast cancer.²¹³

More oversight by state and federal agencies is clearly required to ensure that women receive the full benefits they are entitled to under the PPACA. In fact, in response to the report issued by the National Women's Law Center, in May of 2015 the Department of Health and Human Services tightened the rules to make clear that insurers must offer the full spectrum of reproductive health services that women require.²¹⁴

Even if the law is applied correctly, the PPACA still discriminates against women due to its failure to provide full coverage for abortions. First, the PPACA incorporates the Hyde Amendment, which limits the use of federal funds for abortions to cases in which the pregnancy is the result of rape, or incest, or poses a danger to the life of the woman.²¹⁵ Second, abortions are not considered an essential benefit and insurance companies may choose not to cover them.²¹⁶ Third, states can choose to restrict access to abortion in the plans sold in the state, both on and off the exchanges. Currently, twenty-five states have enacted laws prohibiting private insurance companies from providing abortion coverage in policies sold on their state administered exchanges in some or all cases.²¹⁷ Ten states restrict coverage for abortion on all plans offered within their respective

209 *Id.*

210 Iliadis, *supra* note 203, at 346.

211 NAT'L WOMEN'S LAW CTR., STATE OF WOMEN'S COVERAGE: HEALTH PLAN VIOLATIONS OF THE AFFORDABLE CARE ACT 3 (2015), <http://www.nwlc.org/sites/default/files/pdfs/stateofcoverage2015final.pdf>.

212 *Id.* at 1.

213 *Id.* at 6, 11, 13.

214 Louise Radnofsky, *HHS Tightens Rules on Insurers Coverage of Contraception*, WALL ST. J. (May 11, 2015), <http://www.wsj.com/articles/hhs-tightens-rules-on-insurers-coverage-of-contraception-1431369349>.

215 KAISER FAMILY FOUND., ACCESS TO ABORTION COVERAGE AND HEALTH REFORM 2 (2010), <http://www.kff.org/healthreform/upload/8021.pdf>.

216 *Id.* at 3.

217 *Id.*; STATE OF WOMEN'S COVERAGE, *supra* note 211, at 15.

states.²¹⁸ Five states permit insurers to provide abortion coverage, but only if women purchase a supplemental policy rider.²¹⁹

To ensure that no federal dollars are spent on abortions, the PPACA establishes a burdensome administrative procedure for states that allow private insurance companies to sell insurance plans covering abortions on the exchanges.²²⁰ Each plan that receives federal subsidies and provides abortion coverage is required to collect two premium payments from all enrollees: one for the value of the abortion benefit, and one for all other services.²²¹ The full impact of these restrictions is not yet known, but it is likely that the regulations requiring the separation of premium payments, or the creation of supplemental rider policies, will be so burdensome that they will encourage insurers to simply drop abortion coverage.²²²

As these examples demonstrate, the PPACA fails to ensure access to health care goods, services, and facilities in a non-discriminatory manner. Women in the United States are currently being denied access to safe, effective, and medically necessary care due to the religious and moral objections of other U.S. residents. By allowing women's health care to be subjected to the whims of religious conservatives, the PPACA fails to ensure health care as a human right for all.

3. *Transparency and Accountability*

Accountability is a key component of the right to health care. Accountability requires monitoring and reporting on implementation and impacts, and there must be effective legal and administrative remedies at the state, federal, and international level to address health system failures.²²³ Additionally, transparency is necessary for people to be informed about health insurance, health care, and health impacts, and thereby to be able to hold their governments accountable for progressively realizing the right to health care. One of the key functions of the health insurance exchanges is to provide people with a transparent marketplace where they can compare insurance plans and shop for the plan that best meets their needs. The PPACA also creates and provides funding for "navigator" positions tasked with helping people understand the process, apply for health insurance, and access the subsidies if they are eligible.²²⁴ These features have provided a measure of transparency to consumers.

218 GUTTMACHER INST., RESTRICTING INSURANCE COVERAGE OF ABORTION 1 (Feb. 1, 2016), http://www.guttmacher.org/statecenter/spibs/spib_RICA.pdf.

219 NAT'L WOMEN'S LAW CTR., SUPPLEMENTAL INSURANCE COVERAGE OF ABORTION ONLY FURTHER ENCOURAGES THE END OF ALL PRIVATE INSURANCE COVERAGE OF ABORTION 1 (2013), http://www.nwlc.org/sites/default/files/pdfs/supp_ins_covg_abortion_factsheet_12-6-13.pdf.

220 PPACA, *supra* note 1, §1303(2)(A)-(B).

221 ACCESS TO ABORTION COVERAGE, *supra* note 217, at 3.

222 Susan A. Cohen, *Insurance Coverage of Abortion: The Battle to Date and the Battle to Come*, GUTTMACHER POL'Y. REV., Oct. 11, 2010, <https://www.guttmacher.org/about/gpr/2010/10/insurance-coverage-abortion-battle-date-and-battle-come>.

223 CESCR General Comment 14: Right to Health, *supra* note 47, ¶ 59.

224 PPACA, *supra* note 1, §18031(i).

The PPACA, however, requires consumers to provide information they may not know or be able to provide; furthermore, it is not transparent about the consequences for consumers who provide inaccurate or incomplete information about employment and income. For example, the PPACA provides advanced premium tax credits to millions of people below 400 percent of the poverty level to enable them to purchase private health insurance on the exchange.²²⁵ The tax credits are given in advance but are based on annual income for the next year.²²⁶ Therefore, people must predict their annual income during the open enrollment period (November through January) for the following year of coverage (January through December).²²⁷ The following April—over a year after enrolling for coverage—consumers must reconcile their income for the previous year with the tax credits they received. If they overestimated their income, consumers will have overpaid their premiums for the previous year (money that could have gone to other necessities) and will receive the overpayments in the form of a tax refund. If consumers underestimated their income at tax filing time, they will discover that they have to pay back hundreds or thousands of dollars in premium subsidies for which they were not entitled. Ultimately, most consumers will either receive a smaller tax refund or will owe taxes at the end of the year.²²⁸

This system is problematic because it can be quite difficult for some people to predict their income in advance. People who underestimate their annual income will be required to pay back some or all of the money they received in premium subsidies when they file their taxes, when it is likely that they no longer have that money.²²⁹ The PPACA sets a sliding scale cap on the total amount of the “claw back” for people below 400 percent of the poverty level. However, people whose incomes are even slightly over the 400 percent threshold must pay back the full amount of the premium subsidies they received, which in many cases will amount to thousands of dollars.²³⁰ The claw back provision will affect hundreds of thousands, if not millions of people; in many cases, people are simply unaware that the subsidies are based on projected annual, rather than current, income. According to tax preparation service H&R Block, 52 percent of their customers underestimated their income in 2014 and owed the IRS an average of \$530.²³¹ Another study, based on California as a model,

225 PPACA, *supra* note 1, §36(b)(a)-(f).

226 PPACA, *supra* note 1, §36(b)(a)-(f).

227 2016 Open Enrollment, HEALTHCARE.GOV, <https://www.healthcare.gov/marketplace-deadlines/2016/> (last visited Feb. 23, 2016).

228 KAISER FAMILY FOUND., EXPLAINING THE 2015 OPEN ENROLLMENT PERIOD (Nov. 6, 2014), <http://kff.org/health-reform/issue-brief/explaining-the-2015-open-enrollment-period/>.

229 KEN JACOBS ET. AL., CALIFORNIA PROGRAM ON ACCESS TO CARE, MINIMIZING FAMILIES' HEALTH CARE SUBSIDY REPAYMENTS DUE TO INCOME VOLATILITY 1 (2012), <http://healthpolicy.ucla.edu/programs/health-economics/projects/calsim/documents/subsidyrepaymentcpac1.pdf>.

230 Open Enrollment, *supra* note 227.

231 Anna Gorman, *For Many Middle-Class Taxpayers on Obamacare, It's Payback Time*, KAISER HEALTH NEWS (Feb. 26, 2015), <http://khn.org/news/for-many-middle-class-taxpayers-on-obamacare-its-payback-time/>.

estimated that approximately 23 percent of consumers eligible for subsidies would have to pay back at least some of the subsidies received, and 9 percent would have to pay back the entire amount.²³²

Critics of the claw back provision argue that people are unable to accurately predict their income, or are simply unaware that the subsidy will have to be reconciled with their annual income tax filing.²³³ Even in cases in which people promptly report mid-year income or family size changes, and their subsidy is subsequently adjusted or cut, they may still be liable for the previous months' subsidies.²³⁴ The PPACA fails the transparency element because the advanced premium tax credits, which are a pillar of the law, put the onus on ordinary people to navigate the complex U.S. tax code and accurately predict their MAGI to receive only the proper amount of subsidy. Additionally, the government has not been transparent about the implications of incorrectly predicting income, which caused many taxpayers to be completely surprised upon filing their tax returns in 2015.²³⁵

Perhaps most importantly, the PPACA creates an amazingly complex system in which the majority of U.S. residents are confronted by multiple private insurers offering a tiered array of health care benefit packages that are constantly in flux. Consequently, it is impossible for most ordinary people to discern what health care benefits they are entitled to, and even if they succeed, the packages change soon after, indeed on an annual basis. In this way, the PPACA does not establish a transparent and effective system through which U.S. residents can hold the government accountable for ensuring the right to health care for the majority of residents who have private health insurance.

According to Professor Audrey Chapman of the University of Connecticut School of Medicine, true accountability is more difficult to achieve in health systems that rely on private health care providers.²³⁶ After all, human rights primarily impose obligations on states, not on private actors.²³⁷ While governments ought to be responsible for ensuring that private actors comport with human rights principles in insuring and delivering health care, in practice it may be difficult for them to do so.²³⁸ Accountability is particularly problematic when there is a wide array of private actors, as is the case in the United States.²³⁹

232 *Id.*

233 *Id.*

234 *Id.*

235 *Id.*

236 Audrey Chapman, *The Impact of Reliance on Private Sector Health Services on the Right to Health*, 16 *HEALTH & HUM. RTS. J.* 122, 128 (2014).

237 *Id.*

238 *Id.*

239 *Id.*

The PPACA expands the right to appeal adverse benefit determinations, which helps patients hold private insurers accountable.²⁴⁰ Under the PPACA, patients may first utilize an internal appeals process to get the insurers to reverse a denial of coverage, and insurers must maintain meaningful internal appeals processes for patients.²⁴¹ Insurers must disclose the information they reviewed, disclose the rationale they used to reach an adverse benefit determination, and give patients time to respond.²⁴² After exhausting the internal appeals process, patients can turn to an external appeals process overseen by an impartial third party. As a last resort, they can turn to litigation.²⁴³

Prior to the enactment of the PPACA, patients in general had significantly fewer appeal rights at the state and federal level, and those in self-funded ERISA plans had no right to external review at all.²⁴⁴ Therefore, these provisions provide a welcome expansion of the appeal rights patients have vis-à-vis insurance companies.²⁴⁵ However, in order to exercise their rights, patients must understand the often obscure reasons their benefits were denied, the grounds they have to appeal, and the appeals process itself.²⁴⁶ Insurance companies who know and understand all aspects of the policy provisions and are experienced in the appeals process likely still have a significant advantage over patients who are often engaging in the process for the first time.²⁴⁷ For these reasons, while the PPACA expands patient's options to hold private insurers accountable in theory, effective accountability is likely still elusive.

Finally, the United States Constitution does not recognize a right to health care and has not ratified the ICESCR recognizing a right to health. Therefore, the U.S. and the PPACA largely fail to provide avenues to ensure that U.S. residents enjoy a system of accountability that meets international standards for ensuring the human right to health care.

4. Participation

The right to health care requires that people have a voice in decisionmaking related to health care at the state, local, international, and community level.²⁴⁸ Transparency is again a key aspect of the principle of participation because without transparent information on the health care system and proposed policies, people cannot effectively participate in decisionmaking.²⁴⁹

240 Juliette Forstenzer Espinoza, *Strengthening Appeals Rights for Privately Insured Patients: The Impact of the Patient Protection and Affordable Care Act*, 127 PUB. HEALTH REP. 460 (2012), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3366385/pdf/phr127000460a.pdf>.

241 PPACA, *supra* note 1, §2719.

242 Espinoza, *supra* note 240, at 460–61.

243 *Id.*

244 *Id.*

245 *Id.* at 461.

246 *Id.* at 460–61.

247 *Id.*

248 CESCR General Comment 14: Right to Health, *supra* note 47, ¶ 54.

249 *Id.*

The drafting and implementation of the PPACA has not provided avenues and opportunities for people to effectively participate in the process of health care reform. Although elected officials are, in theory, representatives of the people and should be responsive to their concerns; in practice, elected officials are often more responsive to entrenched power and money interests. Recent studies have shown that average voters have very little influence in public policy in all spheres.²⁵⁰

In the context of health care reform, the elected officials tasked with drafting and passing the PPACA were heavily influenced by well-financed lobbyists for the insurance and pharmaceutical industries, trade groups for medical professionals, and others.²⁵¹ These groups set much of the agenda and the parameters for the shape that health care reform would take.²⁵² For example, although a CBS poll taken in 2009, around the time the PPACA was drafted, showed 59 percent of U.S. residents supported government sponsored health insurance, the architects of health care reform never considered a single-payer health care system to be a viable option.²⁵³ Although a few single-payer plans were proposed, only one subcommittee hearing was held on single-payer plans and none of the proposals came up for a vote.²⁵⁴ Peter Harbage, a Health Care Fellow at the Center for American Progress, a Washington think tank, admitted that it was not that single-payer health care was taken off the table, “[i]t just never really was put on the table. It was never discussed as fully as some of these other ideas we see being discussed now.”²⁵⁵ Similarly, the public option—a government run plan that people could choose instead of private plans on the exchange—was supported by 77 percent of the population but was ultimately stripped from the bill.²⁵⁶

In contrast, pharmaceutical and insurance lobbyists and other medical trade groups had a disproportionate influence over the process. These groups first waged a well-financed public relations and lobbying campaign to ensure health care reform efforts failed and, at the same time, campaigned to ensure that whatever legislation did pass was ultimately favorable to their industry.²⁵⁷ For example, during the lead-up to the PPACA, the pharmaceutical industry increased its annual lobbying budget

250 Martin Gilens & Benjamin I. Page, *Testing Theories of American Politics: Elites, Interests Groups, and Average Citizens*, 12 PERSP. ON POL. 564 (2014).

251 Robert Steinbrook, *Lobbying, Campaign Contributions, and Health Care Reform*, 10.1056 NEW ENG. J. MED. e52(1)-e52(2) (2009).

252 *Id.* at e52(3).

253 Yamin & Carmalt, *supra* note 128, at 234; CBS NEWS & N.Y. TIMES, *American Public Opinion: Today vs. 30 Years Ago*, CBS NEWS (Feb. 1, 2009), http://www.cbsnews.com/htdocs/pdf/SunMo_poll_0209.pdf.

254 Yamin & Carmalt, *supra* note 128, at 233.

255 Scott Horsely, *Single Payer: The Health Care Plan Not on the Table*, NAT'L PUB. RADIO (July 24, 2009), <http://www.npr.org/templates/story/story.php?storyId=106969104>.

256 See Jordan Fabian, *Pelosi: Public Option Will Not Be in Health Bill Despite Liberal Efforts To Revive It*, THE HILL (March 12, 2010), <http://thehill.com/blogs/blog-briefing-room/news/86447-pelosi-public-option-will-not-be-in-health-bill>.

257 John Maher, *The Corporate Profit Motive and Questionable Public Relations Practices During the Lead-Up to the Affordable Care Act*, 25 J.L. & HEALTH 1, 16-17 (2012).

by 15 percent to over \$185 million to ensure that drug price controls were not incorporated into the legislation.²⁵⁸ Their lobbying efforts appear to have paid off. According to recent forecasts, the pharmaceutical industry's profits will increase by approximately 33 percent from \$359 to \$476 billion by 2020 largely due to the passage of the PPACA.²⁵⁹ Additionally, the American Health Insurance Plans lobbying group spent \$173 million to ensure that an individual mandate requiring people to purchase private health insurance was included and that the public option was excluded from the final legislation.²⁶⁰

In addition to these direct lobbying efforts, the insurance industry, the U.S. Chamber of Commerce, and others, spent hundreds of millions of dollars on a public relations campaign to defeat health care reform efforts.²⁶¹ The public relations campaign relied on lies and distortions about "death panels" and "government takeovers" of health care to scare people into opposing health care reform.²⁶² These efforts left the U.S. public confused about the issues and undermined one of the main avenues of participation available to many Americans: the "town hall meetings" of 2009.

In the summer of 2009, members of Congress returned to their states and districts and held a series of town hall meetings, which could have provided an opportunity for people to participate in the health care reform efforts; however, these events were often dominated by "grassroots groups" financed by the U.S. Chamber of Commerce and other anti-health care reform groups, spreading lies and distortions about health care proposals.²⁶³ Although these groups' actions were often portrayed as spontaneous acts by concerned citizens, the groups were financed and staffed by health care reform opponents.²⁶⁴ Politicians, policymakers, and lobbyists repeated these lies and distortions, which were often uncritically reported by the media as fact.²⁶⁵ The result of these efforts was to leave the U.S. public confused about the substance of the health care proposals, thus

258 Paul D. Jorgensen, *Pharmaceuticals, Political Money and Public Policy: A Theoretical and Empirical Agenda*, 41 J. OF LAW, MED AND ETHICS, 561, 563-64 (2012).

259 Bruce Japsen, *Obamacare Will Bring Drug Industry \$35 Billion In Profits*, FORBES (May 25, 2013), <http://www.forbes.com/sites/brucejapsen/2013/05/25/obamacare-will-bring-drug-industry-35-billion-in-profits/>.

260 Igor Volsky, *Health Insurers Spent \$173 million to Defeat Public Option, Affordability Measures*, THINK PROGRESS (Aug. 3, 2009), <http://thinkprogress.org/health/2009/08/03/170893/august-ahip/>.

261 Rick Ungar, *Busted! Health Insurers Secretly Spent Huge to Defeat Health Care Reform While Pretending to Support Obamacare*, FORBES (June 25, 2012), <http://www.forbes.com/sites/rickungar/2012/06/25/busted-health-insurers-secretly-spent-huge-to-defeat-health-care-reform-while-pretending-to-support-obamacare/#77a53016c73b>.

262 Jim Rutenberg & Jackie Calmes, *False Death Panel Rumor Has Some Familiar Roots*, N.Y. TIMES (August 13, 2009), <http://www.nytimes.com/2009/08/14/health/policy/14panel.html>.

263 *Id.*

264 Maher, *supra* note 257, at 27-28.

265 Matthew Schafer et. al., *Sarah Palin's 2009 "Death Panel" Claims: How the Media Handled Them, and Why that Matters*, NEIMANLAB (May 26, 2011), <http://www.neimanlab.org/2011/05/sarah-palins-2009-death-panel-claims-how-the-media-handled-them-and-why-that-matters/>.

making it very difficult for them to participate, even in a small way, in the political efforts to change the health care system. For example, polls show that 30-41 percent of U.S. residents polled believed the “death panels” rumor.²⁶⁶ Because the media, government, and vested interests either promoted lies and distortions or failed to correct them, many U.S. residents were left confused, scared, and with no opportunity to participate meaningfully in reforming a system that has a profound impact on their lives.

5. *Progressive Realization and Maximum Available Resources*

The right to health is subject to progressive realization, meaning that governments do not have to fully implement all aspects of the right to health immediately. Governments instead must take “deliberate, concrete and targeted steps” to achieve the full realization of the right to health as soon as possible.²⁶⁷ The corollary of progressive realization is that there is a presumption against any “retrogressive measures.”²⁶⁸ Moreover, governments must use the maximum of available resources to achieve the right to health.²⁶⁹

In many ways, the PPACA takes steps to progressively realize the right to health by expanding access to health insurance and health care and by establishing important consumer protection measures that end many of the worst kinds of insurance practices. Indeed, despite the fact that the United States has not ratified the key international human rights treaties that enshrine the right to health and does not recognize a right to health in its national constitution, the Obama administration recently recognized obligations for the right to health that arise for all members of the UN. In the 2011 Universal Periodic Report submitted to the United Nations Human Rights Council, the U.S. noted that the PPACA makes “significant progress by enacting major legislation that expands access to health care for our citizens.”²⁷⁰

It is clear, however, that the United States is not effectively using the maximum of its available resources to progressively realize the right to health. Although proponents of the PPACA argued that the legislation would reduce overall health care spending, there is still significant wasteful spending in the administration of the U.S. health care system. Over \$6 billion was spent in establishing the health care exchanges.²⁷¹ The Centers for Medicare and Medicaid Services (“CMS”) project that, between 2014 and 2022, the United States will spend almost \$3 trillion on private

²⁶⁶ *Id.*

²⁶⁷ CESCR General Comment 14: Right to Health, *supra* note 47, ¶ 30.

²⁶⁸ *Id.*

²⁶⁹ ICESCR, *supra* note 35, art. 2(1).

²⁷⁰ Human Rights Council, Report of the Working Group on the Universal Periodic Review: United States of America, U.N. Doc. A/HRC/WG.6/9/USA/1 ¶ 69 (Aug. 23, 2010).

²⁷¹ David Himmelstein & Steffie Woolhandler, *The Post Launch Problem: The Affordable Care Act's Persistently High Administrative Costs*, PHYSICIANS FOR A NAT'L HEALTH PROGRAM BLOG (May 27, 2015), <http://pnhp.org/blog/2015/05/27/the-bureaucratic-waste-of-aca-quantified/>.

insurance overhead and government health program administration.²⁷² Nearly two-thirds of this projected spending is attributed to more people enrolling in private health insurance plans that have high administrative costs and still make a profit.²⁷³ This is money that could be spent providing health care. The additional administrative spending of CMS projects will result in an average cost of \$1,375 per newly insured person, or 22 percent of total government expenditures on the PPACA.²⁷⁴ In contrast, the traditional Medicare program spends 2 percent of its budget on administrative costs.²⁷⁵ Had the U.S. enacted a universal health care program modeled on Medicare, the costs savings would have been significant for both individuals and the government.²⁷⁶

Moreover, by relying on for-profit entities to play such a substantial role in the U.S. health care system reforms, additional money that could be spent on health care will instead be distributed to executives as compensation, and to shareholders as profits. In 2014, insurance company and hospital chain profits went up due to the number of newly enrolled people in private health insurance plans and the resulting rise in those seeking medical care at private hospitals.²⁷⁷ Given that the United States chose to place for-profit companies at the heart of health care reform, it appears that the U.S. is not using maximum available resources to implement the right to health.²⁷⁸

²⁷² *Id.*

²⁷³ *Id.* The vast majority of the \$3 trillion will be spent on private insurance and private Medicaid/Medicare plans. Traditional Medicare/Medicaid programs cost significantly less.

²⁷⁴ *Id.*

²⁷⁵ *Id.*

²⁷⁶ GERALD FRIEDMAN, FUNDING HR 676: THE EXPANDED AND IMPROVED MEDICARE FOR ALL ACT: HOW WE CAN AFFORD A NATIONAL SINGLE PAYER HEALTH PLAN (July 13, 2013), http://www.pnhp.org/sites/default/files/Funding%20HR%20676_Friedman_7.31.13_proofed.pdf (asserting that the United States could save \$592 billion per year by cutting administrative costs associated with private insurance and reducing pharmaceutical prices); KENNETH THORPE ET. AL., NATIONAL COALITION ON HEALTH CARE, IMPACTS OF HEALTH CARE REFORM: PROJECTIONS OF COSTS AND SAVINGS 13 (2005), <http://www.pnhp.org/sites/default/files/Thorpe%20booklet.pdf> (asserting that the United States could save \$1.1 trillion over a decade by adopting a universal, single-payer health care system); Steffie Woolhandler, *Costs of Health Care Administration in the United States and Canada*, 349 N. ENG. J. MED. 768, 771, 773 (2003) (finding that private insurers have high overhead due to additional costs such as marketing and underwriting, and that systems such as that in the United States with multiple private insurers are costlier than single-payer systems); CONGRESSIONAL BUDGET OFFICE, PRELIMINARY ESTIMATE OF THE EFFECTS OF S. 491, AMERICAN HEALTH SECURITY ACT OF 1993 ON GOVERNMENT OUTLAYS AND NATIONAL HEALTH EXPENDITURES 5 (1993), <https://www.cbo.gov/sites/default/files/103rd-congress-1993-1994/reports/93doc07b.pdf> (finding that while health care expenditures would increase over the current baseline in the first year after implementation of a universal health care system, by year five, costs would be less than the current baseline).

²⁷⁷ Tim Mullane, *Like it or not: Obamacare's Juicing Health Care Stocks*, CNBC (Nov. 5, 2014), <http://www.cnbc.com/id/102152031>.

²⁷⁸ Experts have also advised that a simpler system with one payer and one benefit package for all would substantially reduce costs for fraud detection, also leaving more resources for health care. See, e.g., William C. Hsiao et al., *What Other States Can Learn from Vermont's Bold Experiment: Embracing A Single-Payer Health Care Financing System*, 30(7) HEALTH AFFAIRS 1232, 1237 (2011) ("A single-payer system also creates a comprehensive claims database that offers a heightened ability by insurers to detect fraud and abuse. The fragmentation of payers in the United States, each with only partial claims information, makes rooting out fraud and abuse much more difficult.").

Additionally, the U.S. has engaged in a series of retrogressive measures since the adoption of the PPACA that have had the effect of rolling back access to health care. Congress has cut hundreds of millions from community health center funding; it has also significantly increased the amount of the claw back penalty—the amount taxpayers must pay back if it turns out that they initially received too large of a subsidy.²⁷⁹ Additionally, the Supreme Court has issued rulings that roll back the Medicaid expansion and limit the contraception mandate for closely-held corporations claiming a religious objection to birth control. All these retrogressive measures undermine the progressive realization of the right to health care and impede access to health care as a human right in the United States.

D. INITIATIVES FOR A RIGHT TO HEALTH CARE AT THE FEDERAL LEVEL

The Affordable Care Act, while an improvement in a number of ways, is nonetheless, fundamentally flawed because it does not intend to ensure that all people living in the United States receive affordable, quality health care. Moreover, health care costs continue to rise for patients and government. A publicly-funded, universal health care system would cost less and provide better quality health care for everyone. Some have called for recognition of a federal right to health in previous decades, beginning with President Franklin Delano Roosevelt's call for a right to adequate medical care and the opportunity to enjoy good health in his 1944 inaugural address.²⁸⁰ However, no serious efforts have been made to grant legal recognition of a right to health care in the Federal Constitution or in federal legislation.²⁸¹ As the history of the drafting of the PPACA bears out, the U.S. Congress is not likely to recognize the human right to health care nor establish an equitable system of universal health care at the national level in the near future. This is due to the financial and political influence of stakeholders who profit under the current system and due to ideological opposition to the notion of universal health care.

Nonetheless, a grassroots movement at the federal level continues to demand single-payer health care. Many of the participating individuals and organizations recognize health care as a human right; they are calling upon the government to apply human rights principles to guide federal health care reform.²⁸² Most notably, in 2015, Senator Bernie Sanders made "health care as a right" a central part of his campaign for the Democratic

279 Neal Goswami, *Sanders: I'll Fight for New Health Centers*, BENNINGTON BANNER (April 12, 2011), http://www.benningtonbanner.com/ci_17830717?source=rss viewed.

280 Eleanor Kinney, *Recognition of the International Human Right to Health and Health Care in the United States*, 60 RUTGERS L. REV. 335, 346 (2008).

281 *Id.* at 347–48.

282 There are many designs for universal health care, including a national health service, such as that in the United Kingdom and Cuba, a single-payer (national health insurance) system such as that in Canada and Taiwan, or a largely employment-based system such as that in Germany and Japan. See Evans, *supra* note 24, at 241 (explaining basic models of health care). In the US, the Veterans Health Administration is a national health service model like the UK, Medicaid is a single-payer (national health insurance) system like Canada, and the majority of people have employment-based health insurance like Germany.

presidential nomination. As evidenced by his extraordinary success in the presidential primaries, Senator Sanders's proposal to enact a national, single-payer health care program has resonated with millions of Americans who are unhappy with the current health care system.²⁸³

Healthcare-Now! is one grassroots organization that is educating the U.S. public and advocating for the passage of single-payer health care as a means to realize the right to health care at the federal level.²⁸⁴ The organization's description on the petition website Change.org states: "We support building the movement necessary to implement a publicly-funded, single-payer healthcare system that is universal, equitable, transparent, accountable, comprehensive, and that removes financial and other barriers to the right to health."²⁸⁵ Healthcare-Now! has active members all over the country committed to using a wide range of strategies and tactics to build a national grassroots movement to win single-payer health care for all.²⁸⁶ It is part of the *Leadership Conference for Guaranteed Health Care*, along with Physicians for a National Health Program, Progressive Democrats for America and the California Nurses Association.²⁸⁷ It is also an endorser of Amnesty International's "Healthcare is a Human Right Coalition."²⁸⁸

Physicians for a National Health Program ("PNHP") is another national organization devoted to enacting a universal, comprehensive single-payer health care system in the United States.²⁸⁹ As the name suggests, PNHP is largely composed of physicians and other health care professionals and has chapters in every state.²⁹⁰ PNHP conducts research on the impact of universal health care, holds meetings and trainings, and collaborates with other organizations advocating for universal health care at the state and federal level.²⁹¹ PNHP's mission statement declares "high-quality health care is a right for all people and should be provided equitably as a public service rather than bought and sold as a commodity."²⁹²

283 See *Issues: Medicare for All*, BERNIE 2016, <https://berniesanders.com/medicareforall/> (last visited April 8, 2016).

284 *About Healthcare-NOW!*, HEALTHCARE-NOW!, <https://www.healthcare-now.org/about/> (last visited Feb. 23, 2016).

285 CHANGE.ORG, Healthcare-NOW!, <https://www.change.org/organizations/healthcare-now> (last visited Feb. 23, 2016).

286 *About Healthcare-NOW!*, *supra* note 284.

287 *Id.*; *Leadership Conference for Guaranteed Health Care Officially Launches*, HEALTHCARE-NOW!, <https://www.healthcare-now.org/blog/leadership-conference-for-guaranteed-health-care-officially-launches/> (last visited Feb. 23, 2016); *Healthcare-NOW! is Not Mobilizing for June 25th Rally in DC*, HEALTHCARE-NOW!, <https://www.healthcare-now.org/blog/healthcare-now-not-mobilizing-june-25th-rally-dc/> (last visited Feb. 23, 2016).

288 See *Amnesty International USA Calls Senate to Consider Single Payer Proposals*, HEALTHCARE-NOW!, <https://www.healthcare-now.org/blog/amnesty-international-usa-calls-on-senate-to-consider-single-payer-proposals/> (last visited Feb. 23, 2016).

289 *About PNHP*, PHYSICIANS FOR A NAT'L HEALTH PROGRAM, <http://www.pnhp.org/about/about-pnhp> (last visited Feb. 23, 2016).

290 *Id.*

291 *Id.*

292 *PNHP Mission Statement*, PHYSICIANS FOR A NAT'L HEALTH PROGRAM, <http://www.pnhp.org/about/pnhp-mission-statement> (last visited Feb. 23, 2016).

The Labor Campaign for Single Payer was founded in 2009 for the purpose of creating a national grassroots movement for universal health care.²⁹³ The organization receives support and funding from a broad array of labor unions but membership is open to anyone.²⁹⁴ On its website, the Labor Campaign for Single Payer declares that health care is a “fundamental human right,” and invites people to “sign the pledge” thereby declaring their belief that “[h]ealthcare is a human right!”²⁹⁵ The organization supports universal health care legislation at the federal level but also works with allies in states including Vermont, California, Washington, New York, Oregon, and Maine.²⁹⁶

Although there continues to be action at the grassroots level to support a federal single-payer health care system that recognizes health care as a human right, at this point, it appears more likely that a system of universal health care will first be introduced at the state level. Accordingly, the next section considers the potential for building a universal system of health care, as a human right, state by state.

IV. THE RIGHT TO HEALTH CARE AT THE STATE LEVEL

A. AN INTRODUCTION TO HEALTH CARE AT THE STATE LEVEL

Although the federal government plays an important role in regulating private health care insurance and in funding public insurance schemes and public provision of health care, state governments continue to play a crucial role. Importantly, both before and after the PPACA, health care financing systems and health outcomes varied widely between states.²⁹⁷ In 2013 for example, 20 percent of the population in Texas and Nevada were uninsured, whereas only 4 percent of the population in Massachusetts, and 5 percent of the population in Hawaii remained uninsured.²⁹⁸ The PPACA has had many positive impacts, particularly in states that had relatively poor health care systems pre-PPACA. On the other hand, the PPACA has had limited or even detrimental impacts in other states, including Vermont and Montana.²⁹⁹ Notably, the PPACA has not brought an end to initiatives

²⁹³ *Report on Jan. LCS-P Founding Conference*, LABOR CAMPAIGN FOR SINGLE PAYER, <http://www.laborforsinglepayer.org/report-on-jan-lcs-p-founding-conference/> (last visited Feb. 23, 2016).

²⁹⁴ *About*, LABOR CAMPAIGN FOR SINGLE PAYER, <http://www.laborforsinglepayer.org/about/> (last visited Feb. 23, 2016).

²⁹⁵ *Id.*

²⁹⁶ *Id.*

²⁹⁷ DAVID C. RADLEY ET AL., THE COMMONWEALTH FUND, *AIMING HIGHER: RESULTS FROM A SCORECARD ON STATE HEALTH SYSTEM PERFORMANCE* (2014), http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/apr/1743_radley_aiming_higher_2014_state_scorecard_corrected_62314.pdf.

²⁹⁸ *Health Insurance Coverage of the Total Population*, THE COMMONWEALTH FUND, <http://kff.org/other/state-indicator/total-population/> (last visited Feb. 23, 2016).

²⁹⁹ See, e.g., Abby Goodnough, *In Vermont, Frustrations Mount Over Affordable Care Act*, N.Y. TIMES (June 4, 2015), <http://nyti.ms/1JsCMJR>. In 2011, Montana Governor Brian Schweitzer sought a waiver from the federal Department of Health and Human Services to use federal health care funding to create a series of clinics across the state to provide health care to Medicaid beneficiaries, state

for universal health care—or the human right to health care—at the state level as it has not established a system of universal, equitable, and affordable health care.

Interestingly, the PPACA may actually make it easier for states to pursue alternative health care systems through the use of State Innovation Waivers—but only after implementing the PPACA mandated health care exchange. Section 1332 of the PPACA creates a waiver opportunity that allows states to implement alternative health care systems beginning in 2017.³⁰⁰ The State Innovation Waiver provides that states may modify the PPACA health care exchange or create alternative models as long as the proposed system will ensure at least the same level of coverage as under the PPACA.³⁰¹ Importantly, the waiver provision allows states to receive the aggregate federal funding (premium and small business tax credits, cost sharing reductions, etc.) that would have gone to state residents, and to use those funds to finance a new system.³⁰² The State Innovation Waiver could allow states to dramatically transform their health care systems. A number of states, including Vermont, Hawaii, Oregon, Arkansas, and Minnesota have expressed interest in applying for a waiver to address various aspects of their health care systems.³⁰³

In several states, there are initiatives for universal health care to address the ongoing affordability and coverage crisis in the United States. Some of these initiatives are based on the human right to health care, including the high-profile example in Vermont. This Section on the right to health care at the state level begins with a brief history of the right to health care in state constitutions, examines the Vermont legislation establishing a framework for universal health care, reviews some other state initiatives for universal health care, and finally, explores the role that these state initiatives could play in moving national universal health coverage forward.

employees, university employees, and state retirees. The health care clinics would also have been available to other individuals who wished to buy in. The proposal was modeled after the health care system in rural Saskatchewan in Canada, which is similar in size and demographics to Montana. According to Gov. Schweitzer, the PPACA would “bankrupt” Montana and he wanted to “claim jump it” by instituting a better alternative first. See Sarah Kliff, *Interview: Schweitzer’s Plan to Bring Canadian Health Care to Montana*, WASH. POST (Oct. 3, 2011), http://www.washingtonpost.com/blogs/wonkblog/post/interview-schweitzers-plan-to-bring-canadian-health-care-to-montana/2011/10/03/gIQA025JIL_blog.html. Governor Schweitzer’s request for a waiver was denied; Sylvia Moore, *Montana Sets up Single Payer: Guess What Happens* CALIFORNIA ONECARE (Aug. 9, 2013), <http://californiaonecare.org/montana-sets-up-single-payer-guess-what-happens/>.

³⁰⁰ PPACA, *supra* note 1, § 1332.

³⁰¹ DEBORAH BACHRACH, ET. AL., THE COMMONWEALTH FUND, INNOVATION WAIVERS: AN OPPORTUNITY FOR STATES TO PURSUE THEIR OWN BRAND OF HEALTH REFORM 1-2 (2015), http://www.commonwealthfund.org/~media/files/publications/issue-brief/2015/apr/1811_bachrach_innovation_waivers_rb_v2.pdf.

³⁰² Heather Howard & Galen Benshoof, *1332 Waivers and the Future of State Health Reform*, HEALTH AFFAIRS BLOG (Dec. 5, 2014), <http://healthaffairs.org/blog/2014/12/05/section-1332-waivers-and-the-future-of-state-health-reform/>.

³⁰³ LAUREN DUNN ET AL., WOODROW WILSON SCHOOL GRADUATE POLICY SHOP, 2017 AND BEYOND: USING THE ACA INNOVATION WAIVER TO REACH MINNESOTA’S TRIPLE AIM 11 (2015), <http://www.princeton.edu/sites/default/files/content/2017%20and%20Beyond%20-%20Minnesota%20and%20the%20201332%20Waiver%20-%20202.3.15%20Final.pdf>.

B. THE RIGHT TO HEALTH IN STATE CONSTITUTIONS

Although the right to health is not recognized in the Constitution of the United States, a number of state constitutions address health or health care. While some provisions merely recognize health care as an important value of public concern, others arguably contain enforceable rights.³⁰⁴ Thirteen state constitutions specifically mention health care but only six of these provisions have been judicially interpreted.³⁰⁵ Moreover, courts have been reluctant to interpret the provisions as creating a right to health or to health care.³⁰⁶ For example, the public health provision of the “Social Welfare Article” of the New York State Constitution provides:

The protection and promotion of the health of the 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.³⁰⁷

The Social Welfare Article was passed in 1938, and at the time of passage, constitutional delegates and the general public believed that the purpose of the public health provision was to create a comprehensive health care system to benefit all New Yorkers.³⁰⁸ Nonetheless, New York judges have been reluctant to interpret the provision this broadly.³⁰⁹ In the few court cases that have considered the public health provision, judges have largely focused on the power of municipalities to promulgate regulations intended to protect public health.³¹⁰

Nonetheless, activists in several states have launched initiatives to win official recognition of a right to health in state constitutions. For example, activists in Massachusetts began organizing in 2003 to adopt a constitutional amendment recognizing a right to health care.³¹¹ Under Massachusetts law, the Constitution may be amended provided that a

304 Eleanor Weeks Leonard, *State Constitutionalism and the Right to Health Care*, 12 U. PA. J. CONST. L. 1325, 1348 (2010).

305 *Id.* at 1347. See ALA. CONST. art. IV, § 93.12 (authorizing the State to establish and maintain health facilities and to appropriate funds to support these facilities); ALA. CONST. art. VII, § 4 (stating the legislature shall provide for the promotion and protection of public health); HAW. CONST. art. IX §§ 1, 3 (promoting and protecting public health and granting the State the power to provide financial assistance to the needy); ILL. CONST. pmbl. (establishing the constitution in order to among other things provide for the health and safety of the people); LA. CONST. art. XII, § 8 (authorizing the establishment of economic and social welfare and public health system); MO. CONST. art. IV, § 37 (declaring health and general welfare of the people to be matters of primary concern and establishing a department of social services); WY. CONST. art. 7, § 20 (stating the duty of the legislature to protect and promote the health and morality of the people).

306 Leonard, *supra* note 304, at 1348.

307 N.Y. CONST. art. XVII, § 3.

308 Alan Jenkins & Sabrineh Ardalan, *Positive Health: The Human Right to Health Care Under the New York State Constitution*, 35 FORDHAM URB. L. J. 479, 489-95 (2008).

309 *Id.* at 495.

310 *Id.*

311 KATHRIN RUEGG, NAT'L ECON. & SOC. RIGHTS INITIATIVE, EMBEDDING THE HUMAN RIGHT TO HEALTH CARE IN U.S. STATE CONSTITUTIONS: A PROGRESS REVIEW AND LESSONS FOR ADVOCATES 5 (2009), http://www.nesri.org/sites/default/files/Constitutional_amendment_report.pdf.

certain percentage of citizens sign an initiative petition.³¹² Once these signatures have been gathered, the initiative is presented for a vote at two consecutive Constitutional Conventions.³¹³ At least 25 percent of the legislature must vote in favor of the initiative at each Constitutional Convention before the amendment can be put on the ballot and, if approved by a majority of voters, ratified.³¹⁴

The proposed amendment created an “obligation and duty of the Legislature and executive officials” to enact and implement laws that would ensure that every resident of Massachusetts had comprehensive, affordable, and equitably financed health insurance coverage.³¹⁵ In 2003, the Health Care for Massachusetts Campaign gathered the signatures required to have the Legislature vote on the initiative.³¹⁶ The Massachusetts Legislature voted in favor of the Amendment in 2003 but at the 2005-2006 Constitutional Convention held in July 2006, the Legislature used a series of procedural measures to prevent a vote on the proposed initiative.³¹⁷ Because the legislature refused to vote on the initiative for a second time, the initiative was not placed on the 2008 ballot as proponents had hoped.³¹⁸

Initiative supporters filed a petition at the Supreme Judicial Court (SJC) requesting that the Secretary of State place the initiative on the November 2008 ballot despite the fact that the Legislature had not approved the initiative at a second Constitutional Convention. The SJC acknowledged that the Legislature had a duty to hold a vote on every initiative pending before it, however, it held that there was no judicially enforceable remedy for the Legislature’s constitutional violations.³¹⁹

Although the right-to-health ballot initiative technically failed, it was still widely regarded as creating momentum and demand for health care reform.³²⁰ In April 2006, the Massachusetts Legislature adopted sweeping health care reform legislation that later became the model for the PPACA.³²¹ In addition, stakeholders (who might have opposed health care reform in the absence of the right-to-health ballot initiative) may have supported the health care reform bill because they preferred the health care exchange model to the alternative rights-based initiative.³²² For example, many major insurers and hospitals conditioned their support for the health

312 MASS. CONST. amend. art. XLVIII, pt. 2, § 4.

313 *Id.* at pt. 4, § 4.

314 *Id.* at pt. 4, § 5.

315 RUEGG, *supra* note 311, at 5.

316 *Fact Sheet: The Constitutional Amendment for Affordable Health Care Coverage*, HEALTH CARE FOR MASSACHUSETTS CAMPAIGN, <http://www.healthcareformass.org/about/fact-sheet.shtml> (last visited Feb. 23, 2016).

317 *Id.*

318 RUEGG, *supra* note 311, at 5.

319 *Id.*

320 *Id.* at 6.

321 *Id.*

322 *Id.* at 7.

care exchange legislation on rejection of the right-to-health-care initiative.³²³

None of the constitutional initiatives in other states have come as close to succeeding as the initiative in Massachusetts; however, activists in Minnesota, Michigan, New Mexico, and Oregon have all launched efforts to recognize a right to health care under their state constitutions. In 2007, Rep. Thomas Huntley and Sen. Linda Berglin of Minnesota introduced an amendment that stated: “Every Minnesota resident has the right to health care. It is the responsibility of the Governor and the legislature to implement all necessary legislation to ensure affordable health care.”³²⁴ The Senate version of the amendment stalled in committee, while the House version received a second reading, but was then returned to a legislative committee where it later died.³²⁵ Michigan’s constitution already contains a provision on health,³²⁶ but in 2008, a coalition of organizations and advocates launched a petition to amend it to ensure that all residents had “affordable and comprehensive health care coverage through a fair and cost-effective financing system.”³²⁷ Unfortunately, the coalition was not able to gather the signatures required to place the initiative on the November 2008 ballot.³²⁸

In 2011, 2012, and 2013, New Mexico state Senator Jerry Ortiz y Pino introduced Senate Joint Resolution #5 to place a constitutional amendment before the voters.³²⁹ The New Mexico language was the most explicit in its support for the idea of health care as a human right. The proposed amendment stated:

Health care is a fundamental right that is an essential safeguard of human life and dignity, and the state shall ensure that every resident is able to realize this right by establishing a comprehensive system of quality health care that is accessible to each resident on an equitable basis, regardless of ability to pay.³³⁰

However, the amendment also made clear that the recognition of health care as a right would not commit the state to additional health care spending or health care reform.³³¹ Senate Joint Resolution #5 has not gained any traction in the New Mexico Senate, and although Senator Ortiz

³²³ *Id.*

³²⁴ *Id.* at 8.

³²⁵ *Id.*

³²⁶ MICH. CONST., art. IV, § 51 (“The public health and general welfare of the people of the state are hereby declared to be matters of primary public concern. The legislature shall pass suitable laws for the promotion and protection of the public health.”).

³²⁷ RUEGG, *supra* note 311, at 11.

³²⁸ *Id.*

³²⁹ *New Mexico Senator to Introduce Human Right to Health Care Amendment to State Constitution*, NAT’L ECON. & SOC. RIGHTS INITIATIVE (2011), <http://www.nesri.org/news/2011/01/new-mexico-senator-to-introduce-human-right-to-health-care-amendment-to-state-constitution>.

³³⁰ *Id.*

³³¹ S.J. Res. 5, 51st Leg. (N.M. 2013), <http://www.nmlegis.gov/Sessions/13%20Regular/resolutions/senate/SJR05.pdf>.

y Pino still serves in the Senate, he has not introduced the resolution in the 2014 or 2015 legislative sessions.

Finally, in Oregon in 2005, a group called “Hope for Oregon Families” launched a petition initiative to place a constitutional amendment on the ballot that would recognize health care as a fundamental right and require the Oregon Legislature to establish a system to provide access to affordable health care for every legal resident of the state.³³² Unfortunately, their efforts did not yield the signatures required to place it on the ballot.³³³ Although the amendment was introduced in the Oregon Legislature in 2007 and 2008, the amendment did not make it out of the Senate Rules Committee.³³⁴

In short, at this point, no state has succeeded in adopting a justiciable right to health care in its state constitution that provides an avenue for its residents to demand universal, affordable, and equitable health care of good quality.

C. THE RIGHT TO HEALTH IN STATE LEGISLATION

1. Vermont

There have also been proposals to enact legislation to establish universal, equitable, and affordable health care in several states. Vermont has come closest to doing so. Since the late 1980s, Vermont has worked progressively toward establishing a universal system of health care in the state.³³⁵ In the early 1990s, there was a strong effort to establish a single-payer system of health insurance for all Vermonters, which ultimately failed in 1994.³³⁶ More recently, in 2008, the Vermont Workers’ Center, a largely volunteer organization, launched the “Health Care is a Human Right” campaign. The campaign is a grassroots movement for universal health care in Vermont³³⁷ responding to many calls it had received from people struggling with the market-based health care system.³³⁸ Although legislators claimed to support universal health care, they maintained that it was not politically possible. Using a human rights-based approach, the

³³² RUEGG, *supra* note 311, at 13.

³³³ *Id.*

³³⁴ *Id.*

³³⁵ See Howard M. Leichter, *Health Care Reform in Vermont: A Work in Progress*, 12(2) HEALTH AFFAIRS 71, 73 (1993) (The 1988 law, the Prenatal and Children’s Health Program—also known in Vermont as Dr. Dynasaur—provided health insurance to uninsured children up to age seven and pregnant women with family incomes above Medicaid eligibility level but below 225 percent of the poverty line.); see generally Howard M. Leichter, *Health Care Reform in Vermont: The Next Chapter*, 13(5) HEALTH AFFAIRS 78 (1994); Ashley M. Fox & Nathan J. Blanchet, *The Little State That Couldn’t: The Politics of “Single-Payer” Health Coverage in Vermont*, 40(3) J. HEALTH POL., POL’Y & L. 447, 471-72 (2015).

³³⁶ Leichter 1994, *supra* note 335, at 96.

³³⁷ *Building a Grassroots Movement for the Human Right to Healthcare*, VT. WORKERS’ CTR., <http://www.workerscenter.org/building-grassroots-movement-human-right-healthcare> (last visited Feb. 23, 2016) [hereinafter *Building a Grassroots Movement*].

³³⁸ *History*, VT. WORKERS’ CTR., <http://www.workerscenter.org/about-vermont-workers-center/history> (last visited Feb. 23, 2016).

Center set out in 2008 to change what was politically possible in Vermont.³³⁹

According to the Commonwealth Fund Scorecard, in 2009, the Vermont health system ranked second in the country, tied with Hawaii and Massachusetts.³⁴⁰ The state received top marks in every measure: it was in the top quartile for access and affordability; prevention and treatment; avoidable hospital use and cost; healthy lives; and equity.³⁴¹ Despite the high ranking, in 2008, 7.6 percent of the state population—47,287 Vermonters, including 3869 children—lacked health insurance.³⁴² Many more people were underinsured and unable to access health care services.³⁴³ The Vermont Household Insurance Survey found that in 2008 over 25 percent of Vermont residents lived in families who had difficulty paying medical bills, and over 16 percent of families reported that they had been contacted by a collection agency about medical bills.³⁴⁴

During the first year, the “Healthcare is a Human Right” campaign focused building a strong base of support among Vermonters using a variety of strategies.³⁴⁵ It began by partnering with progressive unions, faith-based community groups, disability rights organizations, and supportive businesses.³⁴⁶ Volunteers canvassed neighborhoods, wrote letters to the editor, staffed tables at farmers’ markets, and marched in local parades.³⁴⁷ One of the most effective organizing tools was a series of “human rights hearings” held across the state.³⁴⁸ These hearings gave local residents an opportunity to share their experiences in the health care system with their neighbors and their community; it also gave the Center an opportunity to educate everyone in attendance on the human right to health care.³⁴⁹ As the Center explains: “[W]e put the healthcare system on trial by bringing forth all the ways it is failing our communities and violating our basic right to health.”³⁵⁰ The Center also collected personal stories of Vermonters and compiled them into a report, “Voices of the Vermont

³³⁹ *Id.*

³⁴⁰ RADLEY ET. AL., *supra* note 297, at 12. Minnesota ranked in first place in 2009 and again in 2014.

³⁴¹ *Id.*

³⁴² BRIAN ROBERTSON & MARK NOYES, MARKET DECISIONS, COMPREHENSIVE REPORT: 2014 VERMONT HOUSEHOLD HEALTH INSURANCE SURVEY 16 (2014), <http://hcr.vermont.gov/sites/hcr/files/2015/2014%20VHHIS%20Comprehensive%20Report%20.pdf>.

³⁴³ BRIAN ROBERTSON ET AL., MARKET DECISIONS, COMPREHENSIVE REPORT: 2008 VERMONT HOUSEHOLD HEALTH INSURANCE SURVEY 5 (2008), http://hcr.vermont.gov/sites/hcr/files/VHHIS/VHHIS_2008_Comprehensive_Report.pdf.

³⁴⁴ *Id.*

³⁴⁵ Mariah McGill, *Using Human Rights to Move Beyond the Politically Possible*, 44 CLEARINGHOUSE REV. 459, 460 (2011) [hereinafter McGill, *Using Human Rights*], <http://dev.nesri.org/sites/default/files/McGillClearinghouseReview1.pdf>; Mariah McGill, *Human Rights from the Grassroots Up: Vermont’s Campaign for Universal Health Care*, 14 HEALTH & HUM. RTS. 106, 106-7 (2012) <http://www.hhrjournal.org/wp-content/uploads/sites/13/2013/06/McGill-FINAL2.pdf>.

³⁴⁶ *Building a Grassroots Movement*, *supra* note 337 (unpaginated).

³⁴⁷ McGill, *Using Human Rights*, *supra* note 345, at 460.

³⁴⁸ *Id.* at 461.

³⁴⁹ *Id.* at 461.

³⁵⁰ *Building a Grassroots Movement*, *supra* note 337 (unpaginated).

Healthcare Crisis,” which was released in December 2008. These personal stories humanized the health care crisis and helped people understand the connection between human rights and the suffering of individual Vermonters.³⁵¹ The first year of campaign efforts culminated in a rally in Vermont’s capitol on May 1, 2009.³⁵²

In the fall of 2009, the campaign pivoted and began a concerted effort to reach out to legislators and demand legislative reform in the 2010 session.³⁵³ It began with ten “People’s Forums on Healthcare” around the state, which over eighty Vermont legislators attended.³⁵⁴ Local residents were invited to testify to their legislators regarding their experiences in the health care system,³⁵⁵ and campaign leaders laid out five human rights principles key to the human right to health care—universality, equality, transparency, participation, and accountability.³⁵⁶ Legislators were asked to support these principles and comprehensive health care reform in the 2010 legislative session.³⁵⁷ These People’s Forums were effective because when legislators were confronted with testimony from voters in their district regarding the shortcomings of the current system, it became very difficult for them to maintain that the status quo was acceptable.³⁵⁸ Many legislators began expressing support for the notion of health care as a human right and began publicly pledging to work on health care reform in the 2010 legislative session.³⁵⁹

On the first day of the 2010 legislative session, the campaign delivered thousands of postcards to the Statehouse calling for legislative action to make health care a human right in Vermont.³⁶⁰ The Center also prepared a “People’s Toolkit” with analytical and advocacy tools, including a human rights report card, which analyzed various health care proposals based on the five human rights principles. The campaign formed “People’s Teams” to ensure that campaign volunteers were a constant presence at the Statehouse and attended every committee meeting on health care, clad in red t-shirts.³⁶¹ On many occasions, campaign volunteers outnumbered health insurance and pharmaceutical lobbyists.³⁶² At the end of the session, Act 128—An Act Relating to Health Care Financing and Universal Access to Health Care in Vermont—was passed by both the House and the Senate

351 McGill, *Using Human Rights*, *supra* note 345, at 461.

352 *Building a Grassroots Movement*, *supra* note 337 (unpaginated).

353 McGill, *Using Human Rights*, *supra* note 345, at 462.

354 *Building a Grassroots Movement*, *supra* note 337 (unpaginated).

355 McGill, *Using Human Rights*, *supra* note 345, at 462.

356 *Building a Grassroots Movement*, *supra* note 337 (unpaginated).

357 *Id.*

358 McGill, *Using Human Rights*, *supra* note 345, at 462.

359 *Id.*

360 Gillian MacNaughton et al., *The Impact of Human Rights on Universalizing Health Care in Vermont, USA*, 17 HEALTH AND HUM. RTS. J. 83 (2015).

361 McGill, *Using Human Rights*, *supra* note 345, at 463; *Building a Grassroots Movement*, *supra* note 337 (unpaginated); MacNaughton et al., *supra* note 360.

362 McGill, *Using Human Rights*, *supra* note 345, at 463.

and became law on May 27, 2010, without the signature of Republican Governor James Douglas.³⁶³

Act 128 does not explicitly state that health care is a “human right,” but it states that health care is a “public good” for all Vermonters and also incorporates the human rights principles advanced by the campaign.³⁶⁴ Specifically, it provides that it is the policy of the State of Vermont to ensure *universal* access to health care and that systemic barriers (*discrimination*) must not prevent people from accessing health care.³⁶⁵ The Act also states that any health care plan must be *transparent* in design, *efficient* in operation, and *accountable* to the people it serves.³⁶⁶ Although Act 128 does not explicitly refer to a right to health care, it encompasses the international human rights principles necessary to achieve this right.

Act 128 also established a health care commission, which hired Dr. William Hsiao to design three universal health care models and present them to the legislature by January 2011.³⁶⁷ Dr. Hsiao recommended that Vermont adopt a “public/private” single-payer health care system with a standard benefits package and a uniform system of payment.³⁶⁸ In February 2011, recently elected Governor Peter Shumlin, unveiled H. 202, a bill to establish a single-payer health care system in Vermont that was modeled after Hsiao’s recommendations.³⁶⁹ The proposed legislation did not contain a statement recognizing health care as a human right, but again it did incorporate the human rights principles advanced by the campaign.³⁷⁰

Despite some concerns regarding cost-sharing, the campaign supported the bill and continued to mobilize Vermonters to improve it as much as possible and to ensure that it eventually passed both houses in 2011.³⁷¹ However, at the last minute, an amendment was added to the Senate version that excluded undocumented immigrants from coverage under the universal health care system.³⁷² Center organizers responded by reminding Vermonters that all people are entitled to health care as a human right

363 *No. 128. An Act Relating to Health Care Financing and Universal Access to Health Care in Vermont*, 2010 VT. ACTS & RESOLVES 305 [hereinafter *Act 128*]; McGill, *Using Human Rights*, *supra* note 345, at 464.

364 *No. 128, supra* note 363, §§ 2, 9401(a).

365 *Id.* at § 2.

366 *Id.*

367 WILLIAM C. HSIAO ET. AL., ACT 128 HEALTH SYSTEM REFORM DESIGN: ACHIEVING AFFORDABLE UNIVERSAL HEALTHCARE IN VERMONT (Feb. 17, 2011), http://www.leg.state.vt.us/jfo/healthcare/FINAL%20REPORT%20Hsiao%20Final%20Report%20-%2017%20February%202011_3.pdf.

368 *Id.* at 127.

369 H. 202 (Vt. 2011).

370 *Id.* at § 1.

371 Anne Galloway, *Updated: Vermont Senate Gives Final Nod to Universal Health Care Bill in 21-9 Vote*, VTDIGGER (Apr. 27, 2011), <http://vtdigger.org/2011/04/27/vt-senate-gives-final-nod-to-universal-health-care-bill-in-21-9-vote/>; Dave Gram, *Vermont House Passes Single-Payer Health Care Bill*, BOSTON GLOBE (Mar. 24, 2011), http://www.boston.com/news/local/vermont/articles/2011/03/24/vt_house_resumes_debate_on_health_care_bill/.

372 Shay Totten, *Show us Your Papers*, SEVEN DAYS (May 4, 2011), <http://www.7dvt.com/2011show-us-your-papers>.

regardless of their immigration status.³⁷³ The simplicity of this message—that human rights are universal—resonated with many Vermonters and the amendment was eventually stripped from the legislation.³⁷⁴ H. 202, now Act 48, was signed into law on May 26, 2011, by Governor Peter Shumlin.³⁷⁵ In a period of less than three years, the Vermont Workers' Center successfully mobilized thousands of Vermonters to change what was politically possible and ensure that human rights principles were incorporated into Vermont law as guidelines for all health care reform.³⁷⁶

Additionally, Act 48 created a framework for implementing a comprehensive, publicly-financed, universal health care system known as Green Mountain Care; and the Act established a Green Mountain Care Board responsible for overseeing the development and the implementation of the new plan.³⁷⁷ Act 48 also authorized the creation of a health insurance exchange as required under the PPACA and the establishment of an exchange in which Vermonters could purchase private insurance policies by 2013.³⁷⁸ The full implementation of the universal single-payer care system relied on Vermont receiving a waiver under the PPACA to begin operating an alternative program in 2017.³⁷⁹ Act 48 provided that Vermont would seek a federal waiver to transform the health care exchange into a universal single-payer health care system to be known as Green Mountain Care.³⁸⁰ The Green Mountain Care system was envisioned to provide comprehensive, affordable, publicly-financed health care coverage for all residents as a public good.³⁸¹

Unfortunately, Vermont Health Connect, Vermont's health care exchange established under the PPACA, has been plagued with difficulties leaving thousands of Vermonters waiting months for health insurance and costing the State almost \$200 million.³⁸² The terrible problems with Vermont Health Connect caused many people and legislators to question

373 James Haslam, *We are not Arizona*, VT. WORKERS' CTR. (Apr. 26, 2011), <https://www.workerscenter.org/blog/anonymous/we-are-not-arizona>.

374 Anne Galloway, *Lawmakers call for Study of Migrant Worker Health Care*, VTDIGGER (May 3, 2011), <http://vtdigger.org/2011/05/03/health-care-conference-committee-hammers-out-details-on-day-one/>.

375 No. 48. *An Act Relating to a Universal and Unified Health System*, 2011 VT. ACTS & RESOLVES 239; Anne Galloway, *Shumlin Signs Nation's First Single-Payer Health Care Bill Into Law*, VTDIGGER (May 27, 2011), <http://vtdigger.org/2011/05/27/shumlin-signs-nations-first-single-payer-bill-into-law/>.

376 Fox & Blanchet, *supra* note 335, at 471-72; MacNaughton et al, *supra* note 360; see generally Jonathan Kissam, *The Vermont Breakthrough: Grassroots Organizing Moves a State towards Health Care for All*, SOCIAL POLICY (June 2011), http://www.nesri.org/sites/default/files/Vermont_Breakthrough_Grassroots_Organizing-Kissam.pdf; Anja Rudiger, *Reviving Progressive Activism: How a Human Rights Movement Won the Country's First Universal Health Care Law*, NEW POLITICS (Nov. 6, 2011), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=1984318.

377 No. 48, *supra* note 375, §§ 9374, 9375.

378 *Id.* §§ 1801(b), 1803 2(b)(1)(a).

379 *Id.* § 2.

380 *Id.*

381 *Id.* at § 1821.

382 Morgan True, *Vermont Health Connect Costs Could Hit \$200 million*, VTDIGGER (Mar. 9, 2015), <http://vtdigger.org/2015/03/09/vermont-health-connect-costs-hit-200-million/>.

whether the Vermont government had the capability of implementing a universal single-payer, publicly-financed health care system.³⁸³ Additionally, the lingering effects of the recession and a looming budget deficit made many ordinary Vermonters and legislators wary of pursuing a single-payer health care system, which would likely require payroll and income tax increases.³⁸⁴ After a very difficult re-election battle in November 2014, Governor Shumlin announced in December 2014 that he was withdrawing his support for single-payer health care “at this time,” citing concerns about affordability.³⁸⁵ On the other hand, commentators have argued that Governor Shumlin chose the most expensive policy options in his proposal, which made the proposal more expensive than it needed to be.³⁸⁶

Despite the setback created by the Governor’s reversal on universal health care, there are hopeful signs that legislators will take up universal health care again in the near future. During the 2015 legislative session, legislators authorized and financed a study to explore the costs and feasibility of implementing a universal primary care system as a first step towards a full universal health care system.³⁸⁷ Additionally, the Vermont Workers’ Center drafted a financing plan to demonstrate that Vermont could afford to implement a single-payer health care system full stop, and hope to find legislators willing to sponsor a bill based on this proposal in the 2016 legislative session.³⁸⁸ In addition, the human rights principles at the heart of Act 128 and 48 have been adopted and internalized by many legislators, policymakers, and health care advocates in Vermont.³⁸⁹ For example, the principles hang on the walls of the House Health Care Committee Room at the Vermont Statehouse, and people report that the principles are used regularly by legislators exploring various health care proposals and often serve a valuable function as a “gut check.”³⁹⁰ Therefore, while the campaign for universal health care in Vermont continues, the human rights framework has played an influential, and in some ways surprising, role in past and current health care debates.³⁹¹

383 Interview with James Haslam, Executive Director of the Vermont Workers’ Center (March 5, 2015); Interview with Rep. Sarah Copeland Hanzas, Vermont House of Representatives Majority Leader (March 11, 2015).

384 Interview with Copeland Hanzas, *supra* note 383; Interview with Robin Lunge, Director of Health Care Reform, Agency of Administration, State of Vermont (March 25, 2015).

385 Morgan True & Anne Galloway, *Shumlin Backs off Single Payer Plan*, VTDIGGER (Dec. 17, 2014), <http://vtdigger.org/2014/12/17/shumlin-says-single-payer-not-affordable-now/>.

386 Anne Galloway & Morgan True, *Analysis: Shumlin Built ‘Lead Airplane’ for Single Payer*, VTDIGGER (Jan. 7, 2015), <http://vtdigger.org/2015/01/07/analysis-shumlin-built-lead-airplane-single-payer/>; Fox & Blanchet, *supra* note 335, at 481-82; Interview with Senator Anthony Pollina, Member, Vermont Senate Committee on Health and Welfare (July 22, 2015).

387 No. 54. *An Act Relating to Health Care*, 2015 VT. ACTS & RESOLVES 16.

388 Interview with Mary Gerisch, Steering Committee Member, Vermont Workers’ Center (March 12, 2015).

389 MacNaughton et al., *supra* note 360, at 2.

390 Interview with Representative Bill Lippert, Chair of Vermont House of Representatives Healthcare Committee (March 23, 2015); Telephone Interview with Dan Barlow, Public Policy Manager, Vermont Businesses for Social Responsibility (March 16, 2015).

391 See MacNaughton et al., *supra* note 360, at 7.

2. States Following Vermont's Human Rights Initiative

The Vermont experience has inspired human rights-based movements for universal health care in a number of other states. The Vermont Workers' Center, in partnership with the National Economic and Social Rights Initiative ("NESRI"), has formed a national Health-Care-is-a-Human-Right collaborative.³⁹² Organizations in Maine, Maryland, Pennsylvania, Oregon, and Washington have begun using Vermont's roadmap to advocate for universal health care in their states.³⁹³ Each of these movements features sustained grassroots mobilization and positions health care as part of a broader focus for justice and economic, social, and cultural rights.³⁹⁴

a. Maine

In 2009, Maine's health care system ranked ninth in the nation.³⁹⁵ It was in the top quartile of states for equity, access and affordability, prevention and treatment, and was in the second quartile for avoidable hospital use and cost, and healthy lives.³⁹⁶ Despite these high scores, 10 percent of Mainers lacked health insurance or were underinsured.³⁹⁷ In 2013, a coalition of organizations—led by the Maine People's Alliance, the Maine AFL-CIO, the Maine State Nurses Association, and the Southern Maine Workers' Center—launched the Maine "Health Care is a Human Right" campaign.³⁹⁸ The Maine campaign has embraced the human rights principles adopted by the Vermont campaign and the same strategy to build a grassroots movement in Maine for universal health care.³⁹⁹ The campaign holds events all over the state and grassroots mobilization efforts are ongoing.⁴⁰⁰ Unfortunately, Maine Governor Paul LePage vetoed Medicaid expansion in Maine, and it is highly unlikely that efforts to enact universal health care will succeed while he is in office.⁴⁰¹

392 *Healthcare is a Human Right*, NESRI, <http://www.nesri.org/programs/healthcare-is-a-human-right-collaborative> (last visited Feb. 23, 2016).

393 *Id.*

394 *Id.*

395 RADLEY ET. AL., *supra* note 297, at 12. By 2014, Maine ranked 7th.

396 *Id.*

397 *US Department of Health and Human Services*, HEALTH RESOURCES AND SERVICES ADMINISTRATION, <http://hab.hrsa.gov/stateprofiles/2009/states/me/State-Population-Data.htm> (last visited Feb. 23, 2016); *Mainers Detail Experiences with Broken Health Care System*, ME. PEOPLES' ALL., <https://www.mainepeoplesalliance.org/content/mainers-detail-experiences-broken-health-care-system> (last visited Feb. 23, 2016).

398 *Mainers Detail Experiences*, *supra* note 397.

399 *Health Care*, ME. PEOPLES' ALL., <https://www.mainepeoplesalliance.org/content/health-care-0> (last visited Feb. 23, 2016).

400 *Maine Health Care is a Human Right*, FACEBOOK, <https://www.facebook.com/MaineHealthCareIsAHumanRight> (last visited Feb. 23, 2016).

401 Mario Moretto, *LePage Vetoes Medicaid Expansion, Calls the Effort 'Ruinous' for Maine's Future*, BANGOR DAILY NEWS (Apr. 9, 2014), <http://bangordailynews.com/2014/04/09/politics/lepage-vetoes-medicaid-expansion-calling-the-effort-ruinous-for-maines-future/>.

b. Maryland

In 2009, Maryland's health care system ranked twenty-fourth in the nation, according to the Commonwealth Fund.⁴⁰² The state ranked in the second quartile in both affordability and access, and prevention and treatment; it ranked in the third quartile in equity and healthy lives; lastly, it ranked in the bottom quartile in avoidable hospital use and cost.⁴⁰³ Health Care is a Human Right-Maryland was launched in 2012 with the support of Physicians for a National Health Plan-Maryland, Health Care Now-Maryland, United Workers, and the National Economic and Social Rights Initiative.⁴⁰⁴ Like Maine, the Maryland campaign has adopted the Vermont campaign's principles and strategies for moving towards universal health care.⁴⁰⁵ It has established strong chapters in eight counties and continues to grow.⁴⁰⁶ In October 2013, the Maryland campaign held its first statewide rally, and in December 2014, it released "Voices of Maryland's Health Care Crisis and the Rising Human Rights Movement."⁴⁰⁷ The report, which is modeled after "Voices of the Vermont Health Care Crisis" released by the Vermont Workers' Center in 2010, reveals the depth of the health care crisis in Maryland.⁴⁰⁸ According to the report, even after the ACA is fully implemented in Maryland, almost 400,000 people will remain uninsured.⁴⁰⁹ The report also demonstrated deep support among Maryland residents for the notion of health care as a human right and for a system of universal health care that is publicly funded through taxes.⁴¹⁰

c. Oregon

As of 2009, Oregon was tied with Maryland for twenty-fourth place on the Commonwealth Fund scorecard.⁴¹¹ Oregon is in the top quartile for avoidable hospital use and cost, in the second quartile in healthy lives, and in the third quartile in equity, access and affordability, and prevention and treatment.⁴¹² Like Vermont, efforts to pass a single-payer health care system date back over a decade. In 2003, a ballot initiative to enact universal health care was defeated at the ballot box. Single-payer opponents poured \$1.4 million into defeating the measure, while single-payer proponents, led

402 RADLEY ET. AL., *supra* note 297, at 12. By 2014, Maryland had moved to 17th place in the health care system rankings.

403 *Id.*

404 NESRI, HEALTH CARE IS A HUMAN RIGHT-MD., *Voices of Maryland's Health Care Crisis and the Rising Human Rights Movement* (2014)
<http://www.nesri.org/sites/default/files/Voices%20of%20Maryland%20final.pdf>.

405 *Id.* at iv, 3.

406 *Id.* at 2.

407 *Id.* at i.

408 *Id.*

409 *Id.* at 14.

410 NESRI, *supra* note 404, at iii. According to the report, 95 percent of people surveyed believed that health care is a human right and 75 percent supported the establishment of a universal, publicly-funded health care system.

411 RADLEY ET. AL., *supra* note 297, at 12.

412 *Id.*

by Health Care for All Oregon, spent only \$35,000.⁴¹³ In 2011, Oregon House Member Michael Dembrow introduced legislation to enact single-payer health care, but the legislation died in committee.⁴¹⁴

In 2012, twenty-eight organizations met to launch a new human rights-based campaign for universal health care under the banner of Health Care for All Oregon.⁴¹⁵ The Oregon campaign has adopted the five human rights principles advanced by the Vermont campaign, and has added a sixth principle declaring health care as a “public good.”⁴¹⁶ The campaign’s current efforts are aimed at mobilizing a grassroots movement, garnering support for a universal health care system, and gaining recognition of health care as a human right. It is also collecting signatures to begin the ballot initiative process on amendments to the Oregon Constitution that would recognize a right to health care and require the Oregon legislature to enact a system of universal health care that would fulfill that right.⁴¹⁷ Organizers hope to have the ballot initiatives appear on the 2016 presidential ballot.⁴¹⁸

d. *Pennsylvania*

Pennsylvania ranked fourteenth in 2009 on the Commonwealth scorecard.⁴¹⁹ It was in the top quartile for access and affordability, prevention and treatment, and equity; it was in the second quartile for avoidable hospital use and cost, and healthy lives.⁴²⁰ Despite these relatively good rankings, many Pennsylvanians still felt that the current system was not ensuring universal health care or addressing a variety of other social justice issues. In 2012, these Pennsylvanians came together to form “Put People First PA” (“PPFPA”), an organization dedicated to “giv[ing] voice to ordinary people” struggling to meet their basic needs.⁴²¹ The following year, PPFPA launched the “Health Care is a Human Right” campaign after their membership identified health care access as the most pressing issue facing working people.⁴²² PPFPA has adopted the Vermont human rights framework for its health care campaign, as well as a similar

413 Beatrix Hoffman, *Health Care Reform and Social Movements in the United States*, 93 AM. J. PUB. HEALTH 75 n.41 (2003).

414 *Health Movement History*, HEALTH CARE FOR ALL OR., <http://hcao.org/history/> (last visited Feb. 23, 2016).

415 *Id.*

416 *Our Mission*, HEALTH CARE FOR ALL OR., <http://hcao.org/our-mission/> (last visited Feb. 23, 2016).

417 *Initiative Petitions*, HEALTH CARE FOR ALL OR., <http://hcao.org/new-page-3/> (last visited Feb. 23, 2016).

418 Christen McCurdy, *Single-Payer Healthcare May Go Before Voters in 2015*, THE LUND REPORT (June 20, 2013), <https://www.thelundreport.org/content/single-payer-healthcare-may-go-voters-2016>.

419 RADLEY ET. AL., *supra* note 297, at 12.

420 *Id.*

421 *Who Are We?*, PUT PEOPLE FIRST PA., <http://www.putpeoplefirstpa.org/who-are-we/> (last visited Feb. 23, 2016).

422 *Our History*, PUT PEOPLE FIRST PA., <http://www.putpeoplefirstpa.org/our-history/> (last visited Feb. 23, 2016).

organizing strategy.⁴²³ The Pennsylvania campaign is presently focused on conducting a health care survey regarding the experience of Pennsylvanians in the current health care system and will use the survey results to inform the campaign's efforts.⁴²⁴

e. Washington

Washington ranked eighteenth in 2009 on the Commonwealth Fund scorecard.⁴²⁵ It was in the top quartile on healthy lives and on avoidable hospital use and cost, in the second quartile on access and affordability, and in the third quartile on prevention and treatment and in equity.⁴²⁶ Health Care is a Human Right-Washington ("HCHRWA") is a coalition dedicated to creating a health care system in Washington that reflects human rights principles.⁴²⁷ The HCHRWA coalition consists of fourteen organizations—including labor unions, faith communities, physicians, advocates for economic justice, and others.⁴²⁸ It uses a human rights framework for organizing and advocacy, which includes the five principles espoused by the Vermont Workers' Center. The HCHRWA has also added two additional principles: equality and quality.⁴²⁹ HCHRWA acknowledges the important role the PPACA has played in expanding health care coverage in Washington but notes that even after the PPACA is implemented, 10 percent of state residents will still be uninsured with many others underinsured.⁴³⁰ Consequently, they argue that a universal health care system is still needed despite the passage of the PPACA.⁴³¹ HCHRWA's current efforts are focused on generating support for legislation introduced in the 2015 legislative session that would declare the state's intent to ensure comprehensive, affordable health care coverage in line with HCHRWA's human rights principles for all residents by 2020.⁴³²

Although the movements following Vermont have not yet succeeded in passing legislation establishing universal health care or recognizing a human right to health care, they are all raising awareness of the deficiencies in the current health care system and the need for something better. In recent interviews, many of the people involved in Vermont's health care

⁴²³ *Human Rights*, PUT PEOPLE FIRST PA., <http://www.putpeoplefirstpa.org/968-2/> (last visited Feb. 23, 2016); *Key Strategies*, PUT PEOPLE FIRST PA., <http://www.putpeoplefirstpa.org/key-strategies/> (last visited Feb. 23, 2016).

⁴²⁴ *Blogroll*, PUT PEOPLE FIRST PA., <http://www.putpeoplefirstpa.org/blog/> (last visited Feb. 23, 2016).

⁴²⁵ RADLEY ET. AL., *supra* note 297, at 12. By 2014, the Washington health care system ranked 15th.

⁴²⁶ *Id.*

⁴²⁷ *About Us*, HEALTH CARE IS A HUMAN RIGHT-WASH., <http://healthcareisarightwa.com/> (last visited Feb. 23, 2016).

⁴²⁸ *Id.*

⁴²⁹ *Our Principles*, HEALTH CARE IS A HUMAN RIGHT-WASH., <http://healthcareisarightwa.com/> (last visited Feb. 23, 2016).

⁴³⁰ *Fact Sheet*, HEALTH CARE IS A HUMAN RIGHT-WASH., <http://healthcareisarightwa.com/> (last visited Feb. 23, 2016).

⁴³¹ *Activists Toolkit*, HEALTH CARE IS A HUMAN RIGHT-WASH., <http://healthcareisarightwa.com/> (last visited Feb. 23, 2016).

⁴³² *Id.*

reform efforts suggested that a key element of Vermont's success in 2011 was that health care reform campaigns over the preceding two decades had, even while failing to bring about universal health care, raised awareness and educated Vermonters about universal health care to a large degree.⁴³³ Therefore, continuing to organize and advocate for universal health care as a human right—even without immediate, tangible results—is likely important to the success of future health care reform efforts in each of these states.

D. OTHER UNIVERSAL HEALTH CARE INITIATIVES

In addition to human rights-based movements for universal health care, there are other universal health care initiatives in a number of states. These initiatives focus on enacting publicly-funded universal health care, but are not specifically advocating for a human right to health care. This section highlights two of these movements.⁴³⁴

1. California

The California legislature has twice passed legislation establishing a single-payer health care system only to have the legislation vetoed both times by Governor Arnold Schwarzenegger.⁴³⁵ The California single-payer initiative began with an organization called Health Care for All California ("HCAC") in 1998; in 2011, the movement was joined by another organization, California One Care.⁴³⁶ HCAC is funded through dues paid by members who are part of regional chapters organized throughout the state.⁴³⁷ HCAC advocates for equal access to universal, affordable and quality health care—all human rights principles—but does not use a human rights framework or assert that health care is a human right.⁴³⁸

Between 1998 and 2005, HCAC was involved in many legislative proposals and studies; however, it was not until 2005 that momentum for single-payer legislation began to build in the California legislature.⁴³⁹ That year, Senator Kuehl introduced SB 840, the California Health Insurance Reliability Act, which would have established a single-payer health care

433 Haslam & Copeland Hanzas, *supra* note 383; Gerisch, *supra* note 388; Lunge, *supra* note 384.

434 After this article was submitted for publication, activists in Colorado succeeded in getting a referendum on enacting a single-payer health care system on the 2016 ballot. In November 2016, voters in Colorado will decide whether the state should enact a universal health care system, to be financed by a tax on employers and employees. David Olinger, *Colorado to Vote on Single-Payer State Health-Care System*, DENVER POST (Nov. 9, 2015), http://www.denverpost.com/news/ci_29093230/colorado-vote-single-payer-state-health-care-system.

435 *What is the Single-Payer Movement in California*, HEALTH CARE FOR ALL – CAL., <http://www.healthcareforall.org/what-single-payer-movement-california> (last visited Feb. 23, 2016).

436 *Who We Are*, HEALTH CARE FOR ALL – CAL., <http://www.healthcareforall.org/what-single-payer-movement-california> (last visited Feb. 23, 2016); CALIFORNIA ONE CARE, <http://californiaonecare.org/> (last visited Feb. 23, 2016).

437 *Id.*

438 *What We Believe*, HEALTH CARE FOR ALL – CAL., <http://www.healthcareforall.org/what-we-believe> (last visited Feb. 23, 2016).

439 *What is the Single-Payer Movement in California*, *supra* note 435.

system.⁴⁴⁰ The legislation passed in the California House and the Senate, but was then vetoed by Governor Schwarzenegger.⁴⁴¹ In 2007, SB 840 was reintroduced and passed in the Senate and the Assembly, only to be vetoed again by Governor Schwarzenegger in 2008.⁴⁴² In 2009, Senator Mark Leno introduced SB 810, which retained the language of SB 840; although the Senate passed the bill, it died in the Assembly.⁴⁴³ Governor Schwarzenegger had vowed to veto the bill, and democratic representatives did not want to take a tough vote that had no chance of succeeding in an election year.⁴⁴⁴

At the beginning of the 2011 and 2012 legislative sessions, Sen. Leno once again introduced SB 810. Although, the state now had a democratic governor and a two-thirds democratic majority, the legislation failed to garner enough support for passage.⁴⁴⁵ At the beginning of the 2013 session, Senator Leno announced that he would not re-introduce SB 810.⁴⁴⁶ Observers believe that the failure to pass SB 810, despite having a democratic governor and a super majority of Democrats, was due to a desire to support President Obama's health care reform legislation and fear on the part of many legislators that passing single-payer legislation could be perceived as deserting the President.⁴⁴⁷ While HCAC and California One Care continue their work for single-payer health care, SB 810 has not been reintroduced.

2. New York

Advocates have been working for single-payer health care in New York State since 1992. Most notably, New York House Health Committee Chair Richard Gottfried has introduced single-payer legislation every year since 1992, but until the 2015 session, the full New York State Assembly had never taken up and voted on the legislation.⁴⁴⁸ On May 27, 2015, the New York State Assembly voted ninety-two to fifty-two in favor of the legislation.⁴⁴⁹ A05062 would establish the New York Health Program, a single-payer system that would provide comprehensive health coverage for New York residents.⁴⁵⁰ The program would be financed by assessments

⁴⁴⁰ *Id.*

⁴⁴¹ *Id.*

⁴⁴² *Id.*

⁴⁴³ *Id.*

⁴⁴⁴ *Id.*

⁴⁴⁵ Tom Gallagher, *California's Disappearing Health Care Reform*, SALON (May 2, 2013), http://www.salon.com/2013/05/02/what_happened_to_californias_single_payer_health_care_bill_partne/.

⁴⁴⁶ *Id.*

⁴⁴⁷ Lenny Potash, *Why Did Single-Payer Health Care Fail in California?*, PHYSICIANS FOR A NAT'L HEALTH PLAN (Feb. 17, 2012), <http://www.pnhp.org/news/2012/february/why-did-single-payer-health-care-fail-in-california>.

⁴⁴⁸ Press Release, Richard Gottfried, Assembly Passes Universal Health Care Bill (May 27, 2015), <http://www.dickgottfried.org/new-york-health-act-passes-assembly/>.

⁴⁴⁹ *Id.*

⁴⁵⁰ S.B. A05062, N.Y. State Assemb. (N.Y. 2015), http://assembly.state.ny.us/leg/?default_fld=&bn=A05062&term=2015&Summary=Y&Actions=Y&Vot

collected by the state based on ability to pay.⁴⁵¹ New York residents would pay a graduated payroll tax based on their income and a progressively graduated rate on non-payroll tax income (capital gains, dividends, and interest).⁴⁵² A report analyzing the economic impact of the proposal found that the state would save over \$44 billion in the first year with \$70 billion saved by 2019.⁴⁵³ While people with incomes under \$75,000 would benefit the most under the legislation, 98 percent of New Yorkers would see some reduction in their health care spending.⁴⁵⁴ Moreover, the program would cover all residents, regardless of immigration status, and would dramatically increase access to care by eliminating co-payments, deductibles, and other fees at the point of service.⁴⁵⁵

Despite the obvious benefits to patients and the anticipated cost savings, the legislation has an uphill climb in the New York Senate, which is dominated by Republicans who are not supportive of single-payer health care.⁴⁵⁶ Democratic Governor Andrew Cuomo has not yet taken a position on the legislation.⁴⁵⁷ The legislation also faces stiff opposition from many members of the medical community.⁴⁵⁸ Still the fact that the legislation passed the New York State Assembly, after being stalled for over twenty years, is remarkable.

The passage of AO5062 was due to concerted organizing efforts by a number of groups including the Campaign for New York Health, New York for Single Payer, and Healthcare-Now!NYC.⁴⁵⁹ These organizations worked to raise awareness about the benefits of a single-payer health care system and to mobilize New Yorkers' to demand change. The failures of the PPACA also bolstered support for the legislation among many members of the public and the Assembly.⁴⁶⁰

es=Y&Memo=Y&Text=Yundefined&utm_source=Press+Release+-+NYH+passage&utm_campaign=5-27-15+NYH&utm_medium=email.

451 *Id.* at §2.

452 Gerald Friedman, *Economic Analysis of the New York Health Act*, (2015), http://www.dickgottfried.org/wp-content/uploads/2015/04/Friedman-Fiscal-Study-NYHA-April-2015-FINAL.pdf?utm_source=Press+Release+-+NYH+passage&utm_campaign=5-27-15+NYH&utm_medium=email.

453 *Id.*

454 *Id.*

455 *We Can Do Better*, CAMPAIGN FOR N.Y. HEALTH, <http://www.nyhcampaing.org/> (last visited Feb. 23, 2016).

456 Chris Kardish, *In New York, Single-Payer Hopeful Isn't Giving Up*, GOVERNING THE STATES AND LOCALITIES, <http://www.governing.com/topics/health-human-services/gov-new-york-single-payer-richard-gottfried.html> (last visited Feb. 23, 2016).

457 *NY State Assembly Passes Single-Bill, LABOR FOR SINGLE PAYER*, <http://www.laborforsinglepayer.org/ny-state-assembly-passes-single-payer-bill/> (last visited Feb. 23, 2016).

458 *Id.*

459 CAMPAIGN FOR NEW YORK HEALTH, <http://www.nyhcampaing.org/> (last visited Feb. 23, 2016); NEW YORK FOR SINGLE PAYER, <http://www.singlepayernewyork.org/> (last visited Feb. 23, 2016); HEALTHCARE-NOW!-NYC, http://www.hcn-nyc.org/?page_id=19 (last visited Feb. 23, 2016).

460 Dan Goldberg, *N.Y. Assembly Passes Universal Health Care Bill*, PHYSICIANS FOR A NATIONAL HEALTH PROGRAM (May 27, 2015), <http://www.pnhp.org/news/2015/may/ny-assembly-passes-universal-health-care-bill>.

The rise of universal health care initiatives in states across the country demonstrates that Vermont is not an anomaly. Many people around the country are increasingly realizing that the health care system in the United States is fundamentally flawed and that the PPACA, while addressing some aspects of the health care crisis, is not sufficient to ensure affordable, quality health care for all U.S. residents. While none of the efforts have to date resulted in a universal, publicly-funded health care system, the mere fact that so many initiatives across the country have sprung up in recent years suggests that people and policymakers remain deeply dissatisfied with the state of the U.S. health care system and are determined to address the systemic root of the health care crisis in a way that the PPACA does not.

Should a state succeed in implementing a human rights-based universal health care program, the impact would be profound—not just for the residents of the state, but also for the United States as a whole. Once one state can demonstrate that a universal health care system will cover everyone and cost less, residents in other states will begin to demand a similar system, and universal health care will likely spread throughout the United States. Canada's single-payer health care system began in the rural province of Saskatchewan, and after its success there, eventually spread to the rest of the country.⁴⁶¹ It is highly likely that universal health care would spread if just one state in the U.S. were able to enact and implement it.

V. CONCLUSION

The PPACA's passage and implementation is a remarkable achievement, particularly given the political atmosphere in Congress. The law has expanded access to health insurance for millions of people, which has in turn expanded access to health care in many cases. Moreover, it has incorporated much-needed consumer protections from insurance companies. The PPACA, however, falls far short of what the residents of the United States need. Health insurance and health care are still unaffordable for many, and the law systematically excludes millions of people from health insurance coverage. Moreover, the law is costly and inefficient because it was designed to set up systems and hurdles that impede universal access to health care. Merely setting up the exchanges cost over \$6 billion and counting, and the law's reliance on private, profit-driven insurance companies, as well as its high administrative costs and complexity, will result in increased costs in the future.⁴⁶²

Despite the clear failings of the PPACA and the demonstrated need for a truly universal health care system, the federal government is unlikely to

461 Lisa Dublay, et. al., *Advancing Toward Universal Coverage: Are States Able to Take the Lead?*, 7 J. HEALTH CARE L. & POL'Y 1, 6 (2004).

462 Lena Sun & Niraj Chokshi, *Almost Half of Obamacare Exchanges Face Financial Struggles in the Future*, WASH. POST (May 1, 2015), http://www.washingtonpost.com/national/health-science/almost-half-of-obamacare-exchanges-are-struggling-over-their-future/2015/05/01/f32eeea2-ea03-11e4-aae1-d642717d8afa_story.html.

move in this direction. Therefore, we must look to the states to adopt universal health care systems. The PPACA leaves an opening for states to do so through the use of the State Innovation Waivers. A number of states are considering using the State Innovation Waivers to establish universal health care programs.⁴⁶³ In addition to Vermont and New York, Delaware, Illinois, Minnesota, Montana, and Pennsylvania have announced that they would like to use the waiver to enact single-payer health care programs in their states.⁴⁶⁴ In Montana, Governor Schweitzer has already begun to implement a single-payer system through the establishment of two free health care clinics for government employees and retirees.⁴⁶⁵ The state has contracted with a private company and pays all administrative costs, salaries, and the total cost of each visit.⁴⁶⁶ The clinics serve thousands of people free of charge and have already saved Montana \$1.5 million in health care costs.⁴⁶⁷

Initiatives for universal health care are springing up all over the country and organizers agree that widespread, grassroots pressure is a critical component to success.⁴⁶⁸ Vermont's human rights-based movement has thus far been the most successful at organizing the grassroots to press for legislation to establish a framework for universal health care. Although Vermont has not yet implemented a universal health care system, the Vermont "Healthcare is a Human Right" campaign demonstrates the power that human rights-based organizing and advocacy can have in the health care reform arena.

463 Marea B. Tumber, *The ACA's 2017 State Innovation Waiver: Is ERISA a Roadblock to Meaningful Health Care Reform?*, 10 U. MASS L. REV. 388, 405 (2015).

464 Kimberly Min, *Waiver for State Innovation: A Call for Increased Success or a Projected Failure?* 26 HEALTH LAWYER 32, 34 (2013).

465 Zaid Jilani, *Montana Gov. Brian Schweitzer Will Seek Health Care Law Waiver to Establish Single-Payer in His State*, THINK PROGRESS (Sept. 29, 2011), <http://thinkprogress.org/health/2011/09/29/332031/montana-governor-waiver-for-single-payer/>.

466 Dan Boyce, *Montana's State Run Clinic Sees Early Success*, NAT'L PUBLIC RADIO (July 30, 2013), <http://www.npr.org/2013/07/30/206654000/montanas-state-run-free-clinic-sees-early-success>.

467 *Id.*

468 Mark Dudzic & Jenny Brown, *Fight for Health Care Justice Moves to the States*, LABOR NOTES (June 13, 2014), <http://www.labornotes.org/2014/06/fight-health-care-justice-moves-states>.