

US Efforts to Realise the Right to Health through the Patient Protection and Affordable Care Act

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1. Introduction

The political acceptance and policy implementation of the right to health long remained uncertain in the United States (US), leaving it until recently as the only developed nation without policies to realise universal health coverage. By re-engaging longstanding debates on government obligations to secure the health of every American, the 2010 Patient Protection and Affordable Care Act ('Affordable Care Act' or ACA) draws on an internationally recognised conception of a human right to health, seeking to progressively realise the 'highest attainable standard of physical and mental health' through policies that ensure the availability, accessibility, acceptability, and quality of health care. With the US Supreme Court upholding the constitutionality of most key aspects of the Affordable Care Act, this precedent-setting decision has created an imperative for health care reform in the United States and a model for realising universal health coverage pursuant to the right to health.

This article examines the evolution, implementation and implications of US efforts to realise health-related rights through health care policy. In the evolution of norms for health, Section 2 examines the intertwined history of US

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development of a right to health in international law and implementation through national health care reforms. Culminating in the promulgation of the 2010 Affordable Care Act, Section 3 analyses how this national policy effort corresponds with the principles of the international right to health – even though it neglects any explicit recognition of the right to health. With the Affordable Care Act immediately challenged as a violation of the US Constitution, Section 4 looks to the first major challenges to the Affordable Care Act, analysing the Supreme Court’s decision on these challenges. As the Supreme Court has now largely upheld the Government’s constitutional authority for health care reform, Section 5 considers the continuing challenges to the Affordable Care Act and the precedential impact of this decision on rights-based health reforms throughout the world. This article concludes with a hopeful assessment of the role of the United States as it moves progressively toward universal health coverage and frames an agenda for renewed American participation in global efforts to realise the highest attainable standard of health.

2. The Intertwining of an Evolving Right to Health in US Health Care Policy

Affecting both foreign and domestic policy, the US Government has played a key role in the development of a right to health under international law and the implementation of these rights-based norms through US health care policy. In responding to the existential threats of the Second World War, President Franklin Delano Roosevelt announced in 1941 that the Allied Alliance would be founded upon four ‘essential human freedoms’: freedom of speech, freedom of religion, freedom from fear and freedom from want. Reflecting threats to human dignity, it was the final of these ‘Four Freedoms’, freedom from want that introduced a state obligation to provide for the health of its people.¹ As the basis by which the United States came together with the international community to create a new post-war system of human rights under international law, the United Nations (UN) would seek to prevent deprivations like those that had taken place in the Great Depression and World War.²

As the United States had not previously developed a national health care policy, dropping national health insurance from the 1935 Social Security Act, President Roosevelt’s 1944 State of the Union Address called for a ‘second Bill of Rights’ that would entitle every American to the ‘right to adequate medical

1 Roosevelt, *The Public Papers and Addresses of Franklin D. Roosevelt: 1940*, 2nd edn (New York: Macmillan, 1941).

2 ‘United Nations Conference on Food and Agriculture’ (1943) 37 Supplement *American Journal of International Law* 159.

care and the opportunity to achieve and enjoy good health.’³ Seeking to carry out this vision following Roosevelt’s death, President Harry S. Truman in 1945 became the first President to propose a national health insurance plan, outlining a comprehensive, prepaid medical insurance programme to be realised for all Americans. Although these early efforts did not succeed in bringing about universal health care—with the United States diverging from the progressive post-war experiences of European nations—such efforts spurred incremental efforts to expand government involvement in health care through the 1943 Emergency Maternal and Infant Care Act (ensuring that the families of military servicemen would receive health care) and the 1948 Hospital Survey and Construction Act (funding hospitals in underserved communities).⁴

Working through the UN to declare a universal set of interrelated rights for health, the US government had a defining influence on the early evolution of the right to health under international law.⁵ With Eleanor Roosevelt representing the United States in drafting these rights⁶ (framed by detailed proposals on health from the American Law Institute⁷), the 1948 Universal Declaration of Human Rights (UDHR) proclaimed a right to health by which:

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 and necessary social services.⁸

In support of this expansive vision of social welfare for public health, states established the World Health Organisation (WHO) as a means to realise rights-based global health policy.⁹ In structuring the mission of the WHO under the right to health, the Preamble of the 1946 WHO Constitution declared that ‘the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being’, holding that ‘governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures’.¹⁰

3 Sunstein, *The Second Bill of Rights: FDR’s Unfinished Revolution and Why We Need It More Than Ever* (New York: Basic Books, 2004).

4 Bachman and Meriam, *The Issue of Compulsory Health Insurance: A Study Prepared at the Request of Senator H. Alexander Smith, Chairman of the Subcommittee on Health of the Senate Committee on Labor and Public Welfare* (Washington: Brookings Institution, 1948); and Peon, *Harry S. Truman Versus the Medical Lobby* (Columbia: University of Missouri Press, 1979).

5 For an analysis of US support for economic and social rights in the UDHR, see Marks, ‘The Past and Future of the Separation of Human Rights into Categories’ (2009) 24 *Maryland Journal of International Law* 209.

6 Glendon, *A World Made New: Eleanor Roosevelt and the Universal Declaration of Human Rights* (New York: Random House Digital Inc., 2001).

7 Committee of Advisers on Essential Human Rights, American Law Institute, ‘Statement of Essential Human Rights’ (1946) 243 *Annals of the American Academy of Political and Social Science* 18.

8 GA Res 217A(III), 10 December 1948, A/810 at 71.

9 Parran, ‘Chapter for World Health’ (1946) 61 *Public Health Reports* 1265.

10 Preamble of the Constitution of the World Health Organisation 1946, 14 UNTS 185.

Notwithstanding US support for these human rights obligations under international law, the evolution of the right to health was largely marginalised in national health care policy discourse. As other nations moved to develop universal health care systems, the expanding American system of private employer-sponsored insurance¹¹ and the strident opposition of the American Medical Association would blunt calls for sweeping government action.¹² Challenged during the civil, labour and elder rights movements of the 1950s and 1960s—as activists rallied against the inequities of market-based health insurance—a growing demand for health care presented an opportunity for the reemergence of policy reforms founded upon the right to health.¹³ With President John F Kennedy repeatedly invoking the plight of the elderly uninsured, President Lyndon B Johnson took on this commitment to progressively realise universal health care following Kennedy's assassination.¹⁴ While President Johnson's policy proposals did not provide health coverage for all Americans, the 1965 enactment of Medicare (covering the needs of the elderly through federal payment for care) and Medicaid (providing for the indigent through matching federal funds to state health programs) offered the first formal government recognition of rights-based obligations for the health of the most vulnerable members of society.¹⁵

Despite this national affirmation, the ideological divisions of the Cold War served to weaken US support for the development of a human right to health under international law.¹⁶ As the right to health was seen as a basis for Soviet criticism of capitalist inequalities in health, the United States came to advance a limited view of the right to health, viewing human rights as relevant only

- 11 Blumenthal, 'Employer-Sponsored Health Insurance in the United States: Origins and Implications' (2006) 355 *The New England Journal of Medicine* 82. Employer-sponsored health insurance arose in the United States primarily due to wage controls imposed on employers during the Second World War, leading employers to increase health insurance and other benefits. This system was solidified further in 1954 when the Internal Revenue Service ruled that employer contributions to health insurance were exempt from taxation. See Cancelosi, 'VEBAs to the Rescue: Evaluating One Alternative for Public Sector Retiree Health Benefits' (2009) 42 *John Marshall Law Review* 879.
- 12 Birn, Brown, Fee and Lear, 'Struggles for National Health Reform in the United States' (2003) 93 *American Journal of Public Health* 86.
- 13 Hoffman, 'Health Care Reform and Social Movements in the United States' (2003) 93 *American Journal of Public Health* 75.
- 14 Blumenthal and Marone, 'The Lessons of Success - Revisiting the Medicare Story' (2008) 359 *New England Journal of Medicine* 2384.
- 15 Falk, 'Medical Care in the U.S.A.: 1932–1972' (1973) 51 *Milbank Quarterly* 1. From a rights-based perspective, critics have distinguished these health programmes on the basis that Medicare entitlements are tied to individual contributions (and thus seen to be 'earned'), whereas Medicaid entitlements are tied to financial need (and thus seen to be charity); see Oberlander, *The Political Life of Medicare* (Chicago: University of Chicago Press, 2003); and Engel, *Poor People's Medicine: Medicaid and American Charity Care Since 1965* (Durham: Duke University Press, 2006).
- 16 Meier, 'Global Health Governance and the Contentious Politics of Human Rights: Mainstreaming the Right to Health for Public Health Advancement' (2010) 46 *Stanford Journal of International Law* 1.

to freedoms from state intrusion.¹⁷ Enacting a compromise between the conflicting human rights ideologies of the Cold War Superpowers, the UN codified the social and economic obligations of the UDHR in the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR), elaborating a 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health' by which governments would bear specific obligations for:

- (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- (b) the improvement of all aspects of environmental and industrial hygiene;
- (c) the prevention, treatment and control of epidemic, endemic, occupational and other diseases; and
- (d) the conditions which would assure medical service and medical attention to all in the event of sickness.¹⁸

With analysts already describing the US as suffering from a 'national health care crisis' in the early 1970s, escalating health care costs and rising disparities in health outcomes led President Richard Nixon to renew national health care reform efforts.¹⁹ Addressing this crisis, Senator Ted Kennedy promoted health care as a fundamental right for all Americans, arguing in moral terms that:

I am shocked to find that we in America have created a health care system that can be so callous to human suffering, so intent on high salaries and profits, and so unconcerned for the needs of our people . . . Our system especially victimizes Americans whose age, health, or low income leaves them less able to fight their way into the health care system.²⁰

Proposing universal health care as the means to realize this right, Senator Kennedy introduced the 1971 Health Security Act, which aimed to establish a 'single-payer' system to provide government health insurance for all Americans.²¹ In response, President Richard Nixon offered a compromise

17 Evang, *Health of Mankind* (London: Churchill, 1967); and Szasz, 'The Right to Health' (1968) 57 *Georgetown Law Journal* 734.

18 Article 12, International Covenant on Economic, Social and Cultural Rights 1966, 993 UNTS 3. The US signed the ICESCR (which entered into force on 3 January 1976) on 5 October 1977, but has not ratified it. As of 3 October 2012, there are 160 states parties: see Craven, *International Covenant on Economic, Social and Cultural Rights: A Perspective on Its Development* (Oxford: Oxford University Press, 1995).

19 Sidel and Sidel, *A Healthy State: An International Perspective on the Crisis in United States Medical Care* (New York: Pantheon Books, 1977).

20 Furrow, 'Health Reform and Ted Kennedy: The Art of Politics . . . and Persistence' (2011) 14 *New York University Law Journal of Legislation and Public Policy* 445.

21 A single-payer health insurance refers to a system in which the government is the sole administrator of health insurance – collecting and paying out all health insurance costs in place of a private health insurance market.

proposal that would have expanded health care coverage through private employers and offered government subsidies for the poor (similar to the approach later adopted by Presidents Clinton and Obama). However, liberals opposed this effort in favour of a single-payer approach, leading to a stalemate in health care policy.²² Leaving an opportunity for only incremental change, 1972 amendments to the Social Security Act extended Medicare only to cover the non-elderly disabled.²³

With opportunities for national health care advancements limited for President Jimmy Carter, the United States provided influential support for an evolving international consensus on health care obligations at the 1978 International Conference on Primary Health Care.²⁴ Leading to the Declaration of Alma-Ata, the United States supported primary health care as a broader global objective, reaffirming the human rights principles of the WHO Constitution and reinforcing Government commitments to realise health through the fulfillment of health care and social systems:

Health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.²⁵

While such rights-based global health policy initially found support from US policy makers, the rise of the neoliberal economic policy—and with it, reflexive government opposition to global health policy—closed any opportunity to advance primary health care.²⁶ With the 1980 election of President Ronald Reagan, the prospects for both the international right to health and national health care reform were drastically diminished, as conservative ideology pre-empted any discussion of expanding health care access.²⁷

Given an unrelenting rise in insurance costs and health disparities, President Bill Clinton's 1993 effort to enact universal health coverage seemed poised to succeed in a political environment receptive to an overhaul of US

22 Senator Kennedy later remarked that his refusal to make a deal on health care reform with President Nixon was his biggest regret: see Altman and Shactman, *Power, Politics, and Universal Health Care: The Inside Story of a Century-Long Battle* (Amherst: Prometheus Books, 2011).

23 Social Security Amendments of 1972 Public Law 92–603; 86 Stat. 1329.

24 Bourne, *New Directions in International Health Cooperation: A Report to the President* (Washington: US Government, 1978).

25 WHO and UNICEF, *Primary Health Care: Report of the International Conference of Primary Health Care Alma-Ata, USSR* (Geneva: World Health Organization, 1978).

26 Chorev, *The World Health Organization Between North and South* (Ithaca: Cornell University Press, 2012).

27 US President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Securing Access to Health Care: A Report on the Ethical Implications of Differences in the Availability of Health Services* (Washington: US Government, 1983).

health care policy. Seeking consensus around a market-oriented means to realise universal care (with managed competition among 'health maintenance organisations'), President Clinton sought to avoid the rhetoric of a rights-based approach to policy reform.²⁸ Yet as Republican lawmakers and interest groups scaled back their support for the individual elements of reform (retrenching in general opposition to any expanded government involvement in health care) and Democratic lawmakers remained torn between those who preferred greater government involvement through a single-payer system and those who preferred market-based reforms, this sweeping reform effort faltered.²⁹ Much like previous attempts to achieve comprehensive reform, proponents settled for an incremental expansion of care to a specific vulnerable group, as seen in the 1997 State Children's Health Insurance Program, which provides health insurance coverage for the children of low-income working families.

With the UN continuing to advance the right to health at the international level,³⁰ this evolving right was clarified further by the UN Committee on Economic, Social and Cultural Rights (CESCR), whose 2000 General Comment on the right to health interprets it as an 'inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health'. Specific to health care, General Comment No 14 outlined government obligations to assure that all health care services should be made available, accessible (physically and economically), acceptable and of sufficient quality.³¹ While the United States continued to denounce the ICESCR under President George W. Bush—whose State Department described General Comment No 14 as going 'far beyond what the treaty itself provides and what the states parties believe to be the obligation they have accepted'³²—this CESCR interpretation of the right to health would increasingly come to frame US policy efforts at the state and national level.³³

Developed through the evolution of international law, the human right to health now offers a normative framework for setting national policy to

28 Chapman, *Health Care Reform: A Human Rights Approach* (Washington: Georgetown University Press, 1994).

29 Skocpol, *Boomerang: Health Care Reform and the Turn Against Government*, 2nd edn (New York: W.W. Norton & Company, 1997).

30 In addition to a wide range of international treaties developed under the auspices of the UN, a right to health care can be seen to have evolved through the development of regional agreements and national constitutions: see Kinney, 'Recognition of the International Human Right to Health and Health Care in the United States' (2008) 60 *Rutgers Law Review* 335.

31 Committee on Economic, Social and Cultural Rights, General Comment No 14; Right to the highest attainable standard of health (art. 12), 11 August 2000, E/C.12/2000/4; 8 IHRR 1 (2001) at para 17.

32 Gorove, 'Shifting Norms in International Health Law' (2004) 98 *American Society of International Law Proceedings* 18 (summary of remarks by Katherine Gorove, Office of the Legal Adviser, United States Department of State).

33 Yamin, 'The Right to Health Under International Law and Its Relevance to the United States' (2005) 95 *American Journal of Public Health* 1156.

guarantee universal health coverage.³⁴ Yet in stark contrast with other developed nations, America's fragmented public/private system has created wide disparities in health insurance coverage and left nearly seventeen per cent of Americans (over fifty million individuals) without any coverage.³⁵ Recognising the ongoing failure of market-based approaches to health care—with the United States spending far more on health care but achieving far worse health outcomes than other developed nations—advocates continued to look to the international right to health in framing their efforts to reform US health care policy.³⁶

3. The Affordable Care Act as a Rights-Based Approach to Health?

Signed into law on 23 March 2010, the Affordable Care Act represents a comprehensive effort to increase access to health care, reign in rising costs and improve equitable outcomes, bringing the United States closer to other nations in realising the right to health. While the Affordable Care Act was neither presented nor drafted as a means to implement human rights, it nevertheless furthers government efforts to address multifaceted imperatives based on the right to health.³⁷ In parallel with the international legal obligations of the human right to health, the United States has implemented this right through an evolving series of policies that track the core elements of the right to health: (i) reduction in infant mortality; (ii) improvement in environmental and industrial hygiene; (iii) prevention and control of epidemics; and (iv) the

34 See Report of the UN Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (Paul Hunt), 3 March 2006, E/CN.4/2006/48.

35 Kaiser Health News, *The Census Bureau's Annual Insurance Coverage Status Check*, 16 September 2010. With other nations realising near-universal health coverage through publicly funded health care systems, the US private health insurance sector provides employer-sponsored health insurance to approximately fifty per cent of Americans, with five per cent purchasing insurance individually and another twenty per cent receiving insurance coverage through government programs like Medicare and Medicaid or direct care through the Veterans Affairs health care system: see Kaiser Family Foundation, *Health Insurance Coverage in the U.S., 2010*, available at: <http://www.kff.org/uninsured/7995.cfm> [last accessed 7 October 2012]. Further, as this coverage data includes only US citizens, this accounting substantially undercounts the neglect of human rights in the fulfilment of health care: see Kinney, 'Realizing the International Human Right to Health for Non-Citizens in the United States' (2011) 1 *Notre Dame Journal of International, Comparative and Human Rights Law* 102.

36 Rudiger and Meier, 'A Rights-Based Approach to Health Care Reform', in Berachochea, Weinstein and Evans (eds), *Rights-Based Approaches to Public Health* (New York: Springer Publishing Company, 2010) 69.

37 Friedman and Adashi, 'The Right to Health as an Unheralded Narrative of Health Care Reform' (2010) 304 *The Journal of the American Medical Association* 2639; and Gable, 'The Patient Protection and Affordable Care Act, Public Health, and the Elusive Target of Human Rights' (2011) 39 *Journal of Law, Medicine and Ethics* 340.

creation of conditions that assure access to medical services.³⁸ Building upon a long line of past health care and public health policies to secure the public's health, the Affordable Care Act represents an expansive effort to meet America's obligations to implement the right to health by facilitating access to medical services.

In the context of the 2008 Presidential campaign, then-Senator Barack Obama was pressed in a Presidential Debate to address the specific question 'Is health care in America a privilege, a right, or a responsibility?' Focusing on inequities in insurance coverage, Obama responded:

Well, I think it should be a right for every American. In a country as wealthy as ours, for us to have people who are going bankrupt because they can't pay their medical bills – for my mother to die of cancer at the age of 53 and have to spend the last months of her life in the hospital room arguing with insurance companies because they're saying that this may be a pre-existing condition and they don't have to pay her treatment, there's something fundamentally wrong about that.³⁹

Elevating the right to health as a principal justification for universal health care reform, this statement appeared initially to herald a change in the parameters of the national health care debate, presenting health care reform as a moral imperative.⁴⁰ However, as the Obama Administration pursued legislation to establish universal health insurance, these hopeful assertions on the right to health never advanced beyond rhetoric and never drew upon international human rights law.⁴¹

During debates on the Affordable Care Act, proponents of a rights-based 'single-payer' approach to health were repeatedly turned back by those who favoured a market-based approach to increasing access to insurance coverage.⁴² Without a basis for a rights-based approach to health (combined with the American tradition of employer-provided health insurance and the American influence of the private-sector health insurance industry), single-payer government insurance models were rejected early in the health

38 See General Comment No 14, supra n 31; and Meier and Bhattacharya, 'Health Care as a Human Right', in Kronenfeld, Parmet and Zezza (eds), *Debates on U.S. Health Care* (New York: Sage, 2012) 42.

39 Commission on Presidential Debates, 'October 7, 2008 Debate Transcript' (2008), available at: <http://www.debates.org/index.php?page=october-7-2008-debate-transcript> [last accessed 19 October 2012].

40 Zeleny and Hulse, 'Obama Calls Health Plan a "Moral Obligation"', *The New York Times*, 19 August 2009, available at: <http://www.nytimes.com/2009/08/20/us/politics/20obama.html> [last accessed 29 October 2012].

41 Record, 'Litigating the ACA: Securing the Right to Health Within a Framework of Negative Rights' (2012) 38 *American Journal of Law and Medicine* 537.

42 Staff of the Washington Post, *Landmark: The Inside Story of America's New Health-Care Law and What It Means for Us All* (New York: Public Affairs, 2010).

care debate.⁴³ Even more modest government-centred proposals, such as having a ‘public option’ for health insurance (to compete with private insurance providers), were abandoned to market-based alternatives for expanding health insurance coverage.⁴⁴ Lacking authority for a right to health in the United States,⁴⁵ there remained no legal imperative for government insurance or care, and the ‘moral commitment’ for health care was set aside in favour of economic efficiency in the insurance marketplace.

Nevertheless, the Affordable Care Act adopts significant national reforms consistent with human rights norms, seeking to realise in the US health care system (i) mandatory health insurance coverage; (ii) regulated private insurance marketplaces; (iii) expanded public health insurance systems; and (iv) strengthened public health initiatives.

A. Individual Health Insurance Mandate

The health insurance reforms advanced by the Affordable Care Act seek to increase access to health care through expanded access to health insurance,⁴⁶ realising access to insurance through interlocking mechanisms that require all individuals to obtain health insurance coverage while limiting insurers from capping policy coverage amounts, charging higher rates based on an individual’s health, or excluding coverage based on pre-existing medical conditions. This minimum coverage requirement—a mandate that all individuals have health insurance—requires all non-exempt individuals to obtain health insurance or face a tax penalty.⁴⁷ Designed to broaden the insurance risk pool to include the entire population, this mandate disincentivises individuals from

43 Pear and Calmes, ‘Obama Advances His Case; Health Bill’s Cost Challenges’, *The New York Times*, 15 June 2009, available at: <http://www.nytimes.com/2009/06/16/health/policy/16obama.html> [last accessed 29 October 2012].

44 Halpin, and Harbage, ‘The Origins and Demise of the Public Option’ (2010) 29 *Health Affairs* 1112.

45 Leonard, ‘State Constitutionalism and the Right to Health Care’ (2009) 12 *University of Pennsylvania Journal of Constitutional Law* 1325. Providing a limited statutory right to emergency care, the 1986 Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. § 1395dd (1986), prohibits hospital emergency rooms from denying care to anyone in need of emergency medical treatment or in active labour.

46 While access to health insurance does not necessarily result in access to care, projections estimate that a universal insurance system will greatly expand utilisation of health services and improve health outcomes: see Card, Dobkin and Maestas, ‘The Impact of Nearly Universal Insurance Coverage on Health Care Utilization and Health: Evidence from Medicare’ (2008) 98 *American Economic Review* 2242.

47 The mandate, set out in section 5000A ACA, provides that any non-exempt individual must either purchase insurance (through processes described herein) or pay a tax penalty, calculated as a percentage of household income (and not to exceed the price of the forgone insurance).

waiting until an illness to purchase health insurance.⁴⁸ Supporting equity through universal access to health insurance, the required participation of all Americans in the health insurance market pools financial risk, allowing the insurance premiums of healthy individuals to subsidise the coverage of those with pre-existing medical conditions. In conjunction with the establishment of minimum coverage standards for insurance plans, universal availability of health insurance promotes rights-based quality, ensures equity in access to minimum basic services and facilitates conditions that assure medical attention in the event of illness.⁴⁹

B. Private Health Insurance Market

To expand access to insurance, the Affordable Care Act supports private health insurance markets – reducing the cost of obtaining health insurance and thereby expanding access to medical care. With exorbitant costs serving as the primary obstacle to coverage, the Affordable Care Act seeks to control costs using market-based mechanisms, regulatory oversight and insurance subsidies. Facilitating an expansion of private health care insurance, the existing employer-based health insurance market remains the centrepiece of the health insurance system, with growth in the individual health insurance marketplace through the development of state ‘insurance exchanges’, enhancing autonomy for health by improving a means to choose among competing health plans with defined benefits.⁵⁰ Enlarging the insurance pool to include those most likely to forgo insurance, the Affordable Care Act allows for dependent children to remain on their parents’ health plans until the age of 26 years.⁵¹ Finally, by expanding subsidies to assist lower-income individuals to purchase private insurance coverage (with subsidies set on a sliding scale for

48 Jackson, ‘Obama: Health care ruling a victory for all Americans’, *USA Today*, 28 June 2012, available at: <http://content.usatoday.com/communities/theoval/post/2012/06/Supreme-Court-rules-on-Obama-health-care-plan-718037/1#.UI5mrI0aPmM> [last accessed 29 October 2012].

49 Section 1302(b) ACA. The Affordable Care Act does not speak directly of seeking equity, but instead strives to reduce health ‘disparities’ across the population: see Majette, ‘Global Health Law Norms and the PPACA Framework to Eliminate Health Disparities’ (2012) 55 *Howard Law Journal* 887.

50 As new entities created by the Affordable Care Act to improve transparency in insurance markets, the aim is that state insurance exchanges—applicable only to individuals and small businesses—will help consumers better understand their health plan options by providing standardised information on costs, benefits and preventive care services: see Kaiser Family Foundation, *Explaining Health Care Reform: What Are Health Insurance Exchanges?* (2009), available at: <http://www.kff.org/healthreform/upload/7908.pdf> [last accessed 7 October 2012].

51 Galewitz, ‘Census: Uninsured Numbers Decline as More Young Adults Gain Coverage’, *Kaiser Health News*, 12 September 2012, available at: <http://www.kaiserhealthnews.org/Stories/2012/September/12/census-number-of-uninsured-drops.aspx> [last accessed 29 October 2012].

income), the government seeks to offset insurance costs for those whose incomes are too low to pay for insurance but too high to qualify for public health insurance.

C. Public Health Insurance

Complementing this private system through an expansion of the public health insurance market, the Affordable Care Act enlarges the low-income population covered by Medicaid, increasing access to health care for the poor. As states had previously provided wide variations in Medicaid eligibility—anywhere from under twenty per cent to over two hundred per cent of the Federal Poverty Level⁵²—an individual's access to care varied by state, with this Medicaid 'entitlement' dependent on budget allocations, annual resources, and political will.⁵³ Alleviating this shifting standard of health protection, the Affordable Care Act sets a minimum level of coverage across the nation, requiring states to expand Medicaid benefits to include all non-elderly residents who earn less than one hundred and thirty-three per cent of the Federal Poverty Level and simplifying the Medicaid application process to facilitate access.⁵⁴ With this expansion financed almost entirely by the federal government, the Affordable Care Act's Medicaid expansion was projected to cover an additional seventeen million individuals (approximately half of the Act's total coverage increase) while supporting equity in the social safety net by reallocating health care resources towards the most vulnerable uninsured populations.⁵⁵

D. Public Health Promotion

Through coordinated evidence-based practice, the Affordable Care Act creates several new programmes to catalyse a public health focus on preventing disease and promoting health. Established by the Affordable Care Act, the National Prevention, Health Promotion and Public Health Council creates an organisational framework to provide 'recommendations to the President and Congress concerning the most pressing issues confronting the U.S. and

52 Established annually by the US Department of Health and Human Services to determine eligibility for a number of federal welfare programmes, the Federal Poverty Level is set to define the minimum annual income required by a person or family to provide for a designated set of basic needs: see US Department of Health and Human Services, *2012 HHS Poverty Guidelines* (2012), available at: <http://aspe.hhs.gov/poverty/12poverty.shtml> [last accessed 7 October 2012].

53 Jost, *Disentitlement? The Threats Facing Our Public Health-Care Programs and a Rights-Based Response* (Oxford: Oxford University Press, 2003).

54 See § 2001 and 2002 ACA.

55 Rosenbaum, 'Realigning the Social Order: The Patient Protection and Affordable Care Act and the U.S. Health Insurance System' (2011) 7 *Journal of Health and Biomedical Law* 1.

changes in federal policy to achieve national wellness, health promotion, and public health goals.⁵⁶ Supported under a Prevention and Public Health Fund, the first stable source of funding for US public health initiatives, the Affordable Care Act has developed a mechanism to invest in the Council's long-term recommendations and launch a wide range of prevention and wellness programmes.⁵⁷ By integrating prevention into primary care practices, the Council and Public Health Fund unifies systems for individual health care and community public health, incentivising individual utilisation of preventive care (by eliminating economic barriers, such as, patient co-payments, for these services) and supporting community and employer initiatives to address the underlying determinants of health.⁵⁸ This integrated population-based approach to health—coordinating public health initiatives across more than a dozen federal agencies—seeks to uphold structures and environments that facilitate healthy choices and ameliorate underlying determinants of the public's health.⁵⁹

Consistent with the human right to health, the Affordable Care Act frames an unprecedented reform of the US health care system as a means to increase the availability of insurance and make health coverage accessible to all. Reflective of the transformative potential of the Affordable Care Act, scholars contemplated whether this bill—as part of a larger trend toward the implementation of positive rights—signalled a statutory reinterpretation of the US Constitution to incorporate a right to health.⁶⁰ Yet immediately after President Obama signed the Affordable Care Act into law, opponents filed a series of constitutional challenges leading to the US Supreme Court's judgment in *National Federation of Independent Business v Sebelius*.⁶¹

56 42 U.S.C. § 300u–10; Hardcastle, Record, Jacobson and Gostin, 'Improving the Population's Health: The Affordable Care Act and the Importance of Integration' (2011) 39 *Journal of Law, Medicine and Ethics* 317.

57 See Forsberg and Fichtenberg, *The Prevention and Public Health Fund: A Critical Investment in our Nation's Physical and Fiscal Health* (Washington: American Public Health Association 2012); and Koh and Sebelius, 'Promoting Prevention through the Affordable Care Act' (2010) 363 *New England Journal of Medicine* 1296.

58 Gostin and Jacobson, 'Restoring Health to Health Reform: Integrating Medicine and Public Health to Advance the Population's Well-Being' (2011) 159 *University of Pennsylvania Law Review* 1783.

59 Majette, 'PPACA and Public Health: Creating a Framework to Focus on Prevention and Wellness and Improve the Public's Health' (2011) 39 *Journal of Law, Medicine & Ethics* 366; and Koh and Sebelius, *supra* n 57.

60 See, for example, Rubin, 'The Affordable Care Act, the Constitutional Meaning of Statutes, and the Emerging Doctrine of Positive Constitutional Rights' (2012) 53 *William and Mary Law Review* 1639.

61 *National Federation of Independent Business v Sebelius*, *Secretary of Health and Human Services*, 567 U.S. 05 (2012).

4. The First Challenge Answered

The constitutional challenges to the Affordable Care Act avoided the issues surrounding the Government's positive obligations to facilitate access to care (through a mandate to obtain insurance) and provide access to care (through an expansion of Medicaid). Instead, these legal challenges were confined to the congressional authority under which the law was promulgated rather than the public policy implications of the Affordable Care Act on the fulfilment of the right to health. Lower court judges split in upholding or striking down various aspects the law, paving the way for March 2012 arguments before the US Supreme Court. The Court heard substantive arguments on the constitutionality of both: (i) the individual mandate; and (ii) the expansion of Medicaid.⁶²

A. The Individual Insurance Mandate

With the Affordable Care Act requiring that all individuals retain health insurance (beginning on 1 January 2014), opponents seized on the so-called 'individual mandate' to decry the law's restrictions on individual liberty and assert that the mandate unconstitutionally forced individuals to purchase health insurance against their will.⁶³ One Court of Appeals accepted this theory, invalidating the individual mandate on the grounds that the federal government lacked constitutional authority to compel individuals to enter into private insurance contracts.⁶⁴ The Supreme Court took up the issue to decide the scope of the federal government's regulatory authority. It was widely understood that the government's market-based approach to health care (rather than direct government provision of health care or health insurance) had

62 In addition to these substantive challenges on the constitutionality of the Affordable Care Act, the Supreme Court also considered procedural questions specific to (1) whether the Court would need to defer ruling until the 2014 implementation of the law and (2) whether the law was 'severable' and could stand in part if either the individual mandate or Medicaid expansion were found unconstitutional.

63 Moffit, *Obamacare and the Individual Mandate: Violating Personal Liberty and Federalism* (Heritage Foundation, 2011), available at: <http://www.heritage.org/research/reports/2011/01/obamacare-and-the-individual-mandate-violating-personal-liberty-and-federalism> [last accessed 7 October 2012]. Depicting a slippery slope leading to government requirements that individuals purchase all manner of consumer products, scholars and jurists alike examined the prospect of the government forcing individuals to buy broccoli: see Mariner, Annas and Glantz, 'Can Congress Make You Buy Broccoli? And Why that's a Hard Question' (2011) 364 *The New England Journal of Medicine* 201; and Barnett, 'Commandeering the People: Why the Individual Health Insurance Mandate is Unconstitutional' (2011) 5 *New York University Journal of Law and Liberty* 58.

64 *State of Florida v U.S. Department of Health and Human Services* 648 F.3d 1235 (2011).

exposed it to the challenge that it had exceeded its constitutional authority, which could not have been challenged under a single-payer system.⁶⁵

Although the Government recognised that sixteen million additional Americans would remain uninsured without the insurance mandate,⁶⁶ the Government's petition to the Supreme Court downplayed the normative importance of access to care, focusing on the impact of the mandate on the insurance market and maintaining that the federal government had authority to regulate this market under its constitutional powers to regulate interstate commerce and, in the alternative, to levy taxes. In regulating interstate commerce in the purchase of health insurance, the Government argued principally that 'because of human susceptibility to disease and accident, we are all "never more than an instant" from the "point of consumption" of health care. Nothing in the Commerce Clause requires Congress to withhold federal regulation until that moment.'⁶⁷ Distinguishing the health care market, the Government reasoned that health insurance differs from other areas of commerce, in that all people will eventually enter the health care market and any delay in obtaining health insurance, the financing mechanism for health care, imposes substantial costs on others in the system.⁶⁸

Most constitutional scholars predicted that the Supreme Court would uphold the individual mandate under the Commerce Clause of the Constitution, with the Court previously giving extreme deference and expansive interpretation to interstate commerce powers. However, in a surprising development, a majority of Justices (Chief Justice Roberts, joined by the four more conservative Justices – Alito, Kennedy, Scalia and Thomas) concluded that the individual mandate was indeed outside the scope of the Commerce Clause, while a different majority of Justices nevertheless upheld the individual mandate under the Taxation Clause of Constitution.⁶⁹ Under Congress's power 'to lay and collect Taxes', five Justices (Chief Justice Roberts, joined by the four more liberal Justices – Breyer, Ginsburg, Kagan and Sotomayor) found that since the individual mandate was enforced through a financial penalty for not obtaining health insurance, the penalty provision 'may reasonably be

65 Rights-based advocates contended that if the Affordable Care Act had been struck down, a single-payer health care system would be on stronger constitutional footing: see Rudiger and Meier, *supra* n 36.

66 Petition for Certiorari No 11-398 at n 7.

67 *Ibid.* The Government also contended that requiring health insurance was crucial for precluding freeriding on the part of the uninsured and adverse selection in insurance markets once the Affordable Care Act's full guaranteed regulations and coverage expansions took effect: see Jost, 'The Affordable Care Act Largely Survives The Supreme Court's Scrutiny – But Barely' (2012) 31 *Health Affairs* 1660.

68 Tribe, 'The Constitutionality of the Patient Protection and Affordable Care Act: Swimming in the Stream of Commerce' (2012) 35 *Harvard Journal of Law and Public Policy* 873.

69 *NFIB v Sebelius*, *supra* n 61 at 27 (Opinion of Roberts CJ). The rejection of the federal Government's Commerce Clause arguments by the Court could have harmful implications on the ability of Congress to regulate other determinants of the public's health, but the impact of this precedent remains uncertain: see Jost, *supra* n 67.

characterized as a tax' and therefore a constitutional exercise of Congress's power.⁷⁰ By extension, all of the other provisions of the Affordable Care Act were upheld and remained in effect, with the exception of the federal government's ability to enforce the expansion of Medicaid on state governments.⁷¹ Writing in dissent, the remaining four Justices—Alito, Kennedy, Scalia and Thomas—would have invalidated the entire Affordable Care Act, concluding that the individual mandate exceeded commerce and taxation powers and could not be severed from the rest of the ACA.⁷²

B. The Medicaid Expansion

States challenging the constitutionality of the Affordable Care Act also targeted the Medicaid expansion, which authorised the disbursement of substantial federal resources to support states in expanding Medicaid coverage to all individuals earning up to 133 per cent of the Federal Poverty Level.⁷³ Opposition to the Medicaid expansion arose in part from the same impetus to limit federal powers that animated the legal challenges to the individual mandate, warning that the federal government was using conditional spending to limit state authority.⁷⁴ The states challenging the expansion claimed that the threat to withhold a state's entire Medicaid funding if it did not expand Medicaid created a coercive dynamic that exceeded Congress's authority under the Spending Clause of the Constitution.⁷⁵

The Supreme Court's prior jurisprudence interpreting the Spending Clause power of Congress suggested great deference to conditional spending requirements to incentivise state participation in collaborative programmes.⁷⁶ Based on this deferential precedent, none of the lower courts hearing challenges to the Affordable Care Act ruled the Medicaid expansion unconstitutional. As such, the inclusion of this question in oral arguments before the Supreme Court and the subsequent decision of seven Justices to invalidate this spending condition surprised US constitutional law scholars. Finding that the Affordable Care Act's Medicaid expansion constituted a new programme rather than an extension of the existing programme, the Court held that the federal government cannot 'withdraw existing Medicaid funds for failure to

70 Ibid. at 44 (Opinion of Roberts CJ).

71 Ibid. at 58–59.

72 Ibid. at 3–4 (Opinions of Scalia, Kennedy, Thomas and Alito JJ).

73 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)(2012).

74 State opposition also was predicated in part on the concern that even with the federal government covering one hundred per cent of the expansion cost initially and ninety per cent going forward, state budgets would still be impacted as Medicaid rolls swelled.

75 Interpreted to grant the federal government broad powers to spend money to achieve policy goals and incentivise collaborative programs with state governments, the US Constitution's Spending Clause grants Congress the power 'to pay the Debts and provide for the common Defence and general Welfare of the United States.' See Article 1(8) US Constitution.

76 *South Dakota v Dole* 483 U.S. 203 (1987).

comply with the requirements set out in the expansion.⁷⁷ The Court found the penalty for non-compliance to be too coercive to fall under the constitutional spending power of the federal government.

Although the Supreme Court made clear that its ruling does not affect the current Medicaid program or other Affordable Care Act provisions pertaining to Medicaid, the Court's restructuring of the Medicaid expansion threatens the assurance of universal access to care promised by passage of the Act, which depended on Medicaid for half of its projected increase in insurance coverage.⁷⁸ Without this guarantee of a nationwide expansion of Medicaid, the realisation of health care for all could fail to materialise for millions of Americans in poverty who are unable to afford health insurance in private markets.

5. Implications of US Health Care Policy on the Continuing Evolution of the Right to Health

Given the contentious history of US engagement with human rights, the Affordable Care Act succeeds in realising many rights-based achievements by avoiding the specific language of rights and obligations of international law. Corresponding with international law, following both the spirit and substance of the UDHR and ICESCR, the right to health care now exists as a 'statutory right' in the United States, defined and framed by the domestic legislation that has progressively realised access to care.⁷⁹ Rather than guaranteeing access only to a limited segment of the population, as accomplished through the incremental legislative advancements leading up to it, the Affordable Care Act builds upon these institutions to provide insurance coverage to all.⁸⁰ Promoting justice across the insurance system through mandatory participation requirements and safeguards against 'free riding', with equitable cost sharing through subsidies for those who cannot afford coverage, this restraint on individual liberty is intended to fulfill the government's obligation to ensure universal access to care.⁸¹ While guarantees of universal insurance coverage

77 *NFIB v Sebelius*, supra n 61 at 56 (Opinion of Roberts CJ). The Court further clarified (*ibid.*) that its ruling did not prevent the federal government from withdrawing funds provided for the expansion under the Affordable Care Act if a state that has agreed to the Medicaid expansion fails to comply with the requirements of the Act.

78 Rosenbaum and Westmoreland, 'The Supreme Court's Surprising Decision on the Medicaid Expansion: How Will the Federal Government and States Proceed?' (2012) 31 *Health Affairs* 1667.

79 Kinney, supra n 30; and Rubin, supra n 60. As a statutory right is not a true 'entitlement' because it can be denied or limited through subsequent statute: see Jost, supra n 53.

80 Hoffman, *Health Care for Some: Rights and Rationing in the United States Since 1930* (Chicago: University of Chicago Press, 2012).

81 Donaldson and Bryan, 'Compulsion: The Key to US Health Care Reform' (2012) 17 *Journal of Health Services Research and Policy* 106.

do not match perfectly with rights-based obligations to guarantee health care, the Affordable Care Act provides—in the absence of publicly provided care—a transformational measure of progress for assessing utilisation of the health care services that underlie realisation of the highest attainable standard of health.

A. Challenges in the United States

With its constitutionality confirmed by the Supreme Court, the Affordable Care Act rests on solid legal ground with binding precedent that must be followed by lower courts in resolving future challenges to the constitutionality of the law.⁸² Yet challenges remain in achieving successful implementation and navigating political obstacles through US health system reforms.

With the full range of Affordable Care Act programmes going into effect over the next two years, implementation challenges will arise at the federal, state and individual levels. At the federal level, promulgating regulations for various components of the Act will be necessary for the (i) enforcement of the penalties for non-compliance with the individual health insurance mandate; (ii) establishment of demonstration projects in coordination between federal and state actors; and (iii) measurement of achievements in access, equity and quality. At the state level, several states already have expressed their opposition to provisions that establish insurance exchanges and expand Medicaid coverage.⁸³ With the Affordable Care Act providing federal subsidies to purchase insurance only to individuals with incomes above one hundred and thirty-three per cent of the Federal Poverty Level, the Supreme Court ruling limits the federal government's authority to cover or subsidise health insurance costs for individuals below this level in states that decline the Medicaid expansion funding.⁸⁴ Should states not accede to the Medicaid expansion, up to eleven-and-a-half million of the most impoverished Americans will continue to lack health coverage,⁸⁵ undermining the Act's original equity-based framework to

82 Additional legal challenges to the Affordable Care Act may arise, particularly around the question of whether subsidies for health insurance will apply to individuals who purchase their insurance through the federally facilitated health insurance exchanges. Some have argued that the ACA only applies these subsidies to state exchanges. While the Government disputes this position, such a challenge, if successful, could undermine financial support for many individuals intended to be covered by the ACA.

83 Despite this opposition, officials in many Republican-led states have made efforts to prepare for the Affordable Care Act's deadlines to establish state insurance exchanges: see Goodnough, 'Liking it or Not, States Prepare for Health Law', *The New York Times*, 23 September 2012, available at: <http://www.nytimes.com/2012/09/24/us/like-it-or-not-states-prepare-for-health-law.html> [last accessed 29 October 2012].

84 Jost, *supra* n 53.

85 Kenney, Dubay, Zuckerman and Huntress, *Opting Out of the Medicaid Expansion under the ACA: How Many Uninsured Adults Would Not Be Eligible for Medicaid?* (Washington: Urban Institute, 2012), available at: <http://www.urban.org/UploadedPDF/412607-Opting-Out-of-the-Medicaid-Expansion-Under-the-ACA.pdf> [last accessed 7 October 2012].

standardise and expand Medicaid coverage for millions of poor Americans.⁸⁶ Even assuming state participation, implementation hurdles will then shift to the individual level, creating an imperative to assure that qualified individuals enrol in the expanded Medicaid programme, seek access to necessary care and realise health benefits.⁸⁷

Compounding these implementation challenges with dramatic political challenges, the Affordable Care Act has sought to codify access to health care, creating new 'entitlements' under national law and expanding the social safety net for health. Yet, like all policy reforms, these statutory rights are 'inherently unstable', capable of being reversed at any moment by subsequent legislation.⁸⁸ Following resistance to the law's passage in 2010, opposition leaders in the most recent US election cycle vowed to repeal the Affordable Care Act, privatise Medicare in ways that may limit guarantees of care, replace federal Medicaid entitlements with state controlled programs and reduce national spending to address the public's health.⁸⁹ With full control of the executive branch apparatus, opponents of the Affordable Care Act could effectively eviscerate the implementation of portions of the law by refusing to complete regulations, enforce penalties or fund initiatives.⁹⁰ Dependent on future Congressional appropriations for their implementation, many of the demonstration projects contained in the law—designed to test approaches for more effective and efficient provision of health care services—could be neglected. If such sustained support is not forthcoming due to political opposition, these

86 Rosenbaum and Westmoreland, *supra* n 78. Notwithstanding this concern, history suggests that states opposing cost sharing programmes often come to participate, with the authors assuming that states will be likely to expand Medicaid in the coming years to gain access to significant additional federal resources: see Perkins, *50 Reasons Medicaid Expansion is Good for Your State* (Washington: National Health Law Program, 2012), available at <http://consumersforhealthcare.org/sites/default/files/50.reasons.pdf> [last accessed 7 October 2012]. Given the lack of a federal mandate, however, it remains to be seen whether the Department of Health and Human Services will allow states to partially expand Medicaid to a lower level of coverage than the full threshold (one hundred and thirty-three percent of the Federal Poverty Level) required by the Affordable Care Act.

87 Brown and Sparer, 'Poor Program's Progress: The Unanticipated Politics of Medicaid Policy' (2003) 22 *Health Affairs* 31.

88 Orentlicher, 'Rights to Healthcare in the United States: Inherently Unstable' (2012) 38 *American Journal of Law and Medicine* 326.

89 Jones, 'The Fate of Health Care Reform - What to Expect in 2012' (2012) 366 *New England Journal of Medicine* 7. After electoral gains in 2010, the Republican-controlled House of Representatives has voted thirty-three times to repeal all or part of the Affordable Care Act, including once after the Supreme Court ruling; see Mascaro, 'House GOP Leads Passage of Healthcare Law Repeal', *Los Angeles Times*, 11 July 2012, available at: <http://articles.latimes.com/2012/jul/11/news/la-pn-house-healthcare-repeal-20120711> [last accessed 29 October 2012].

90 Despite the stated intentions of opponents to repeal the Affordable Care Act—in whole or part—a dramatic reversal of the policies and trends set in motion by this law is extremely unlikely given the legislative hurdles to replacing the Act: see Gostin, 'How Realistic Is Romney's Pledge to "Repeal and Replace" the Affordable Care Act?' (2012) *JAMA Online*, available at: <http://newsatjama.jama.com/2012/10/18/jama-forum-how-realistic-is-romneys-pledge-to-repeal-and-replace-the-affordable-care-act/> [last accessed 29 October 2012].

projects and their potential benefits for health may not accrue. While the political vulnerability of the Act is likely to decrease as popular support for its provisions is solidified, the absence of a rights-based approach to these statutory entitlements renders these advances susceptible to erosion with shifting political tides.

Without recognition of, or accountability for, a human right to health, additional changes will be necessary to assure the success of the Affordable Care Act. The United States continues to face an enormous comparative gap between health care expenditures and public health outcomes,⁹¹ and there is a fiscal imperative to 'bend the cost curve' (through policies not yet promulgated) to slow the rate of health care cost inflation without such rationing leading to disparate access to care.⁹² While inadequate funding and attention to social determinants of health continue to exacerbate health disparities, particularly among low-income and minority populations, the expansion of health insurance coverage will begin to rectify this injustice, with insurance coverage leading to health care access and improved health outcomes. With health policy advancements now shifting from the federal to state level, human rights are re-entering the policy debate, framing state efforts to realise a rights-based approach to both access to health care and the underlying determinants of health.⁹³ If the history of health reform in the United States is a guide, the reforms advanced by the Affordable Care Act will set a foundation for future initiatives to improve access and equity in the health system and provide a basis for revisiting rights-based models to achieve health at the federal level. As with all health system reform efforts, the Affordable Care Act will only be the start of a lengthy debate over policies necessary to progressively realise the highest attainable standard of health.

B. Precedents for the World

In global efforts to realise universal health coverage,⁹⁴ the Affordable Care Act highlights an alternate policy path by which nations can adapt international human rights to meet national political contexts. With the goal of universal health coverage framed by the right to health, nations have arrived at differing

91 World Health Organization, *WHO Global Health Expenditure Atlas* (2012), available at: <http://www.who.int/nha/atlas.pdf> [last accessed 7 October 2012].

92 Sisko et al., 'National Health Spending Projections: The Estimated Impact of Reform Through 2019' (2010) 29 *Health Affairs* 1933.

93 McGill, 'Human Rights from the Grassroots Up: Vermont's Campaign for Universal Health Care' (2012) 14 *Health and Human Rights* 1; National Economic and Social Rights Initiative, *Federal Health Reform: Market Failures and Rights-Based Alternatives* (2012), available at: <http://www.nesri.org/programs/federal-health-reform-market-failures-and-rights-based-alternatives> [last accessed 7 October 2012].

94 With the aim of providing access to health services to everyone in a society without causing financial hardship, 'universal health coverage' has come to be seen as a human right and a focal point for global health governance efforts to address who is covered by a national

policy approaches to implementing social commitments to realise access to health care – resulting from divergent political struggles, ideological compromises and incremental reforms.⁹⁵ Yet even among the diverse health systems that have implemented policies for universal health coverage, the architecture of the US health insurance market stands apart.⁹⁶ While other nations considering health care to be a public good and have established government-sponsored health systems, the United States has consistently treated health care as a private commodity, denying the existence of so-called ‘positive rights’⁹⁷ and framing justice in health care through a normative focus on efficiency.⁹⁸ For those nations facing similar constraints in developing a universal single-payer health system, the Affordable Care Act can serve as a model in developing an incremental rights-based approach to progressively realise health care for all. Exemplifying how a market-based health system can take critical strides toward fulfilling a rights-based approach to health care, the Affordable Care Act succeeds in developing health care policy to (i) mandate health insurance access to all; (ii) expand the social safety net; and (iii) prioritise the public’s health.

As a rights-based approach to realising universal access to care through market-based health insurance, the Affordable Care Act seeks to enlarge the ranks of the insured through a health insurance mandate—pooling the financial risk of illness, prohibiting discrimination in the purchase of insurance and providing government subsidies to support coverage. By mandating that every individual have health insurance, allowing individuals to act collectively in pooling financial risk across the population, the Government is able to realise health capability by guaranteeing access to health insurance for all.⁹⁹ To prevent discrimination by the insurance industry, the government seeks to regulate the purchase of insurance, preventing for-profit corporations from denying coverage on the basis of pre-existing conditions, limiting the ability to rescind insurance coverage following an illness and specifying the services to be covered in insurance exchanges. With the government subsidising this coverage, insurance costs are matched to financial ability, allowing all but the

health system, for what health care services, and with what level of financial contribution: see World Health Organization Assembly Res 58.33, *Sustainable Health Financing, Universal Coverage and Social Health Insurance*, 25 May 2005.

95 Savedoff, de Ferranti, Smith and Fan, ‘Political and Economic Aspects of the Transition to Universal Health Coverage’ (2012) 380 *The Lancet* 924.

96 Marmor and Oberlander, ‘The Patchwork: Health Reform, American Style’ (2011) 72 *Social Science and Medicine* 125.

97 Cross, ‘The Error of Positive Rights’ (2001) 48 *UCLA Law Review* 457.

98 Chapman, *supra* n 28.

99 Gable, *supra* n 37; Savedoff et al., *supra* n 95. In realising health capability, the Affordable Care Act removes the financial risk of illness by insuring against the catastrophic costs of care, shifting from out-of-pocket spending for care and guaranteeing financial protection through health insurance: see Ruger, ‘An Alternative Framework for Analyzing Financial Protection in Health’ (2012) 9 *PLoS Medicine* e1001294.

most impoverished to purchase insurance. Given the growth of private sector health insurance in both developed and developing nations,¹⁰⁰ where the government is neither the exclusive provider nor the exclusive financier of health care, this US insurance mandate provides an example of the role of for-profit enterprise in the realisation of the right to health,¹⁰¹ highlighting how governments can regulate the profit motives of industry to assure that access to insurance leads to access to care.

Supporting insurance coverage through an expansion of the social safety net, the Affordable Care Act guarantees universal coverage through an expansion of government sponsored health insurance. With the government serving as the institution of redistribution, insurance financing through the national treasury provides care for the poor with taxes from relatively wealthier individuals.¹⁰² Moving away from patient fees as a basis for health care financing (with patient fees disproportionately limiting care for the poor), the Affordable Care Act expands Medicaid coverage for the most marginalised, meeting rights-based obligations to ‘take suffering seriously’.¹⁰³ Facilitating equity, the Affordable Care Act is rooted in a uniform set of minimum health care entitlements – combining under one redistributive system the purchase of private insurance with the ‘earned’ benefits of Medicare and the social protections of Medicaid.¹⁰⁴ This minimum standard of coverage for all, securing the basic services underlying individual dignity, exemplifies US progress in fulfilling the right to health.¹⁰⁵ Whereas even the most advanced health care systems have not eliminated inequities in health outcomes, this expansion of coverage under the Affordable Care Act will serve as a basis for considering the overlap between medical care and social justice.

In prioritising public health in future policy reforms and appropriations, the Affordable Care Act has created a policy precedent by which evidence-based interventions can focus on the structural forces that extend beyond the traditional purview of health care providers. Building from a universal entitlement to free preventive care services, the Affordable Care Act seeks to coordinate government efforts to address underlying determinants of health.¹⁰⁶ The identification of specific social determinants of health suggests that the recognition of unhealthy structural forces must become an integral component of

100 Preker, Zweifel and Schellekens, *Global Marketplace for Private Health Insurance: Strength in Numbers* (Washington: World Bank, 2010).

101 Kinney, ‘Realizing the International Human Right to Health: The Challenge of For-Profit Health Care’ (2010) 113 *West Virginia Law Review* 49.

102 Majette, *supra* n 49.

103 Yamin, ‘Will We Take Suffering Seriously? Reflections on What Applying a Human Rights Framework to Health Means and Why We Should Care’ (2008) 10 *Health and Human Rights* 45.

104 Rubin, *supra* n 60.

105 Kinney, *supra* n 30.

106 Gostin and Jacobson, *supra* n 58.

broader health policies.¹⁰⁷ By forming and funding a national strategy to broadly and consistently address underlying determinants of health, these public health components of the Affordable Care Act more closely align US health policy with international health and human rights norms requiring governments to establish comprehensive whole-of-government plans to address public health concerns through a focus on health in all policies.¹⁰⁸ With WHO Director-General Margaret Chan declaring that universal health coverage is ‘the single most powerful concept that public health has to offer’, the American model provides a path to link health care reform with public health promotion.

As part of a global transition to address the organisation and financing of health care systems, the Affordable Care Act buttresses international efforts to realise universal health coverage.¹⁰⁹ In spite of America’s for-profit health care system, the Affordable Care Act represents a significant shift, promoting a normative foundation for national efforts to set a universal standard of health care.¹¹⁰ Rather than looking only to the ratification of international law treaties, US fulfilment of the right to health should be assessed by the content of its health policy, the performance of its health system, and the results for the public’s health. Avoiding past limitations in US health policy, the Affordable Care Act invokes the strongest US proclamation of a moral imperative for expanding health access. While cautious of the precedent set by the US Supreme Court in upholding key tenets of the Affordable Care Act, the American model nevertheless presents a compelling example of efforts to realise the right to health through a market-based health care system.

6. Conclusion

Echoing President Roosevelt’s proclamation seventy years earlier, President Obama stood before the United Nations in 2011 and declared that ‘freedom from want is a basic human right’.¹¹¹ As a recognition of the US obligation to

107 Parmet, *Populations, Public Health, and the Law* (Washington: Georgetown University Press, 2009); and Marmot and Bell, ‘Action on Health Disparities in the United States: Commission on Social Determinants of Health’ (2009) 301 *Journal of the American Medical Association* 1169.

108 Majette, *supra* n 49; Backman et al., ‘Health Systems and the Right to Health: An Assessment of 194 Countries’ (2008) 372 *The Lancet* 2047; and Puska and Stahl, ‘Health in All Policies - The Finnish Initiative: Background, Principles, and Current Issues’ (2010) 31 *Annual Review of Public Health* 315.

109 World Health Organization, Mexico City Political Declaration on Universal Health Coverage, 2 April 2012, available at: <http://www.who.int/healthsystems/topics/financing/MexicoCityPoliticalDeclarationUniversalHealthCoverage.pdf> [last accessed 7 October 2012].

110 Gable, *supra* n 37.

111 Remarks by President Obama in Address to the United Nations General Assembly, 21 September 2011, available at: <http://www.whitehouse.gov/the-press-office/2011/09/21/-remarks-president-obama-address-united-nations-general-assembly> [last accessed 7 October 2012].

realise an international right to health through national health care policy, the 2011 US report to the Universal Periodic Review process of the UN Human Rights Council heralded the promulgation of the Affordable Care Act, recognising that:

The Act makes great strides toward the goal that all Americans have access to quality, affordable health care. The law is projected to expand health insurance coverage to 32 million Americans who would otherwise lack health insurance, significantly reduces disparities in accessing high-quality care, and includes substantial new investments in prevention and wellness activities to improve public health.¹¹²

At the intersection of international human rights and domestic health policy, advocates of rights-based reforms aim to construct a sustainable movement for an ideological shift away from the American model of commodifying needs through the market and toward a collective fulfilment of human rights. With nations throughout the world transitioning to progressively realise universal health coverage, the Affordable Care Act reflects American commitment to the right to health and legitimises American engagement in global health governance. As the Affordable Care Act is challenged and revised in the years to come, the international human right to health will play a seminal role in defining the scope and content of government obligations, with these US efforts playing a demonstrative role in the continuing evolution of international law to realise the highest attainable standard of health.

112 Report of the United States of America, Submitted to the UN High Commissioner for Human Rights in Conjunction with the Universal Periodic Review, 23 August 2010, A/HRC/WG.6/9/USA/1, at para 70.