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HEALTH LAW, PUBLIC LAW, AND SOCIAL JUSTICE

SIDNEY D. WATSON*

I have taught Health Law for almost three decades. In the early years, the course was primarily about private law, the application of contract and tort principles in the context of health insurance coverage and medical care. Federal law of Medicare, Medicaid, EMTALA, and federal civil rights laws always made an appearance. Other federal statutes were added as they came along: HIPAA, the Americans with Disabilities Act, and GINA. Over the years, the course focused more and more on federal statutes until the passage of the Affordable Care Act (“ACA”) in 2010 completed the transition.

Health law is now a public law course.¹ It focuses on federal statutes, and students need to understand the role of Congress, federal agencies, the states, and federal courts. The course explores myriad forms of federalism including Medicaid’s cooperative federalism, the ACA’s “fall back” federalism where the federal government steps in only if the states opt out, and old-fashioned federal law preemption of state law. Health law is now statutory interpretation and administrative law principles in the context of health insurance coverage and health care.

Health law continues to be applied law: public law that affects health, health insurance, health care, and public health. About a third to a half of my health law course is devoted to providing students with a better understanding of medical decision making, the organization of health care delivery system, insurance theory, health disparities, and the social determinants of health—how where we live, work, play, and pray impact health.

Most importantly, Health Law remains a powerful lens through which to explore issues of social justice, social welfare, and law. We all get sick and need medical care. Many of my students and their families have had serious health problems and struggled to access medical care. Some have been bankrupted financially because of the costs of medical care. They know

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1. See Abbe R. Gluck, *Why Health Lawyers Must Be Public-Law Lawyers: Health Law in the Age of the Modern Regulatory State*, 18 J. HEALTH CARE L. & POL’Y 323 (2015). My thanks to Abbe Gluck, Abigail Moncrieff, and others who have stressed that the now statutory nature of the body of health law demands that we conceptualize the field of public rather than private law.

something about health and health care. This course is an opportunity to explore what equity, fairness, and justice mean when we talk about health and healthcare.

I. WHERE TO START: INTRODUCING STUDENTS TO HEALTH LAW, PUBLIC LAW, AND SOCIAL JUSTICE

The first three classes of my Health Law course are billed as an “Introduction to Federalism and Health Policy.” The first day is about health, health care, legal rights, and duties. The second day focuses on the Supreme Court, the ACA, and health policy. The third day explores the Supreme Court, the ACA, and constitutional law. This introduction covers the Supreme Court decisions in both *King v. Burwell*² and *National Federation of Independent Business v. Sebelius*³ I begin the course by immersing students in statutory analysis, constitutional federalism, and public policy to make it clear that health law is public law, to highlight some of the recurring issues in the course, and begin the conversation about health law and social justice.

A. *Day 1: Health, Health Care, Legal Rights, and Moral Duties*

For the first class, I ask the students to consider three questions as they read the assignment: What does it mean to have a “right to health” or a “right to health care”? Does society have a moral obligation to provide access to health care and, if so, how far does this obligation extend? What does the structure of a country’s health care system tell us about its approach towards the right to health care?⁴

The day’s reading includes three pages from the Furrow and Johnson casebook,⁵ excerpts from the *President’s Commission for the Study of Ethical Problems in Medicine* entitled “An Ethical Framework for Access to Health Care,”⁶ and T. R. Reid’s book on health care systems around the world, *The Healing of America*.⁷ The casebook provides an introduction to health insurance and its role in financing health care. It introduces students to Deborah Stone’s classic description of two visions of justice—social solidarity and actuarial fairness—that compete in American health insurance policy and

2. 135 S. Ct. 2480 (2015).

3. 132 S. Ct. 2566 (2012).

4. This is how Professor Nadia Sawicki began her 2015 Health Law class. She shared her syllabus and this idea with me. My appreciation to Professor Sawicki and the many other generous health law colleagues who have shared so many good ideas over the years.

5. BARRY R. FURROW, THOMAS L. GREANEY, SANDRA H. JOHNSON, TIMOTHY S. JOST & ROBERT L. SCHWARTZ, *HEALTH LAW: CASES, MATERIALS AND PROBLEMS* 3–6 (7th ed. 2013).

6. BONNIE STEINBOCK, ALEX JOHN LONDON & JOHN D. ARRAS, *ETHICAL ISSUES IN MODERN MEDICINE: CONTEMPORARY READINGS IN BIOETHICS* 191 (7th ed. 2009).

7. T. R. REID, *THE HEALING OF AMERICA: A GLOBAL QUEST FOR BETTER, CHEAPER, AND FAIRER HEALTH CARE* (2009).

result in *The Struggle for the Soul of Health Insurance*.⁸ The “Ethical Framework” excerpt presents the ethical arguments for a societal obligation to provide access to health care and the distinction between legal rights and moral obligations. T. R. Reid’s book discusses how health care systems reflect a country’s history, politics, and national values.

The first class opens with a story from T. R. Reid’s book: Nikki White, twenty-two years old and a recent college graduate, is diagnosed with lupus, a serious but treatable disease. Because Nikki is sick and this is pre-ACA, she cannot get private health insurance. She also cannot qualify for Medicaid. Nikki dies at age 32. Her doctor says, “Nikki didn’t die from lupus It was a lack of access to health care that killed Nikki White.”⁹

Nikki White’s story gives the students a real life, real person context to begin discussing the legal and ethical questions posed for the day and that underlie all of health law: Should society have a moral obligation to provide access to health care? Is health care different from things like food and rent that we typically leave to the market? How far does a moral obligation to provide health care extend? How do other countries create a “right to health care”? How do those rights reflect those countries’ history and values? Where might those laws be found, in the Constitution, statutory law, somewhere else? How are legal rights different from legal obligations?

By the end of the class, students have had the opportunity to discuss why health and health care are important or, as they sometimes phrase it, “special” for both individuals and society. As one student said, “Individuals need good health to thrive, and society needs healthy people who can be productive members of society.” The first class sets a framework for thinking about health and health care as a social good and a social obligation, and the role of law in allocating that social good. It places health law firmly in the public law realm. It brings issues of social justice to the forefront.

The students also start to think about how law sometimes creates rights and other times imposes obligations, an important concept that we return to often when studying the ACA that imposes a tax penalty obligation to have affordable health insurance rather than a right to health insurance. The students typically explore what makes a law a “right” and whether rights must be enforceable to be “law,” again, fundamental concepts for many ACA provisions and other health law statutes that do not provide for a private right of action.

The students begin to explore the four recurring principles and problems of health policy and health law: how to balance access, cost, quality, and choice. The “Ethical Framework” reading prompts discussion about how to define

8. See Deborah A. Stone, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POL., POL’Y & L. 287 (1993).

9. REID, *supra* note 7, at 2.

adequate and equitable access to health insurance coverage and care. Adequate cannot mean all beneficial care, but how should adequate be defined? Equity requires not just that adequate care be available, but that patients be able to access care without excessive burdens, be they the financial cost of care or non-financial costs like wait times and travel times. Students begin to think about costs at different levels: for the patient, family, government, and society. They begin to see how quality and choice lurk within each issue and every discussion.

Finally, the first day of class begins to identify some societal values that drive health law. What should be the roles of the public or private sectors? What are the relative roles for the individual, family, society, or government? What is the role of markets? Should law be enacted at the federal, state, or local level?

B. Day 2: Supreme Court, ACA, and Health Policy

For the second class, students read an edited version of the Supreme Court decision in *King v. Burwell*, which decided that the ACA's premium tax credit subsidies are available to help people purchase individual insurance in states that use the federal Exchange as well as in states that set up their own Exchange.¹⁰ I ask students to come to class prepared to discuss three questions related to the case: (1) What challenges have states and the federal government faced with health insurance reform efforts intended to expand access to health insurance and how does the ACA try to address these challenges? (2) What health policies underlie the ACA and what role do these policies play in the majority and minority's legal reasoning? (3) What do Justice Roberts and Justice Scalia's opinions tell us about the passage of the ACA that is important for lawyers to know as they interpret the act's provisions for their clients?

In class, we begin again with Nikki White's story: Why couldn't she get health insurance? What was the access problem the ACA was trying to solve in the individual market? What was the challenge that confounded earlier state efforts? What is the solution that both Massachusetts and the ACA adopted?

The beginning of Justice Roberts's opinion in *King v. Burwell* provides the students with a good introduction to insurance concepts like guaranteed issue, community rating, adverse selection, and how and why health insurance pools "death spiral."¹¹ It also offers a brief history of failed state health insurance reform efforts in the individual market. The opinion then explains how Massachusetts and the ACA rely on three interlocking provisions—guaranteed issue and community rating, premium tax credit subsidies, and a coverage mandate—to expand the individual health insurance pool by attracting younger

10. 135 S. Ct. 2480, 2488–96 (2015).

11. *Id.* at 2482.

and healthier people in an attempt to reduce premiums and lower insurance costs. This discussion gives students a concrete example of the complex interplay of access, cost, quality, and choice in the health insurance context.

I provide the students with a good bit of history about the passage of both Massachusetts Health Reform and the ACA. The description of Massachusetts's experience focuses on how its process relied on bringing together all the key stakeholders, identifying alternative law reform strategies, and working toward consensus on how the state reform law would be structured. I stress that Massachusetts pushed to build consensus because an earlier reform effort passed the legislature but failed in the implementation phase because of opposition from a key stakeholder, the hospital industry. I also point out that the Massachusetts health reform bill passed with strong bipartisan support and was highly popular, with even the Boston Red Sox helping to promote it.

I have the students identify who they think should be at the table to talk about a Massachusetts health reform law and their list looks very similar to the group that came to the table in Massachusetts: consumer groups, faith leaders, large employers, small employers, labor unions, hospitals, insurers, health care professionals (not just doctors), and employers, state agency officials, and legislative leaders. This exercise helps the students begin thinking about who is impacted by health law, how different people and different provider groups may be differently impacted, and who tends to weigh in as stakeholders during the lawmaking process. As we move through the course, we repeatedly refer back to these groups asking how different laws may impact their interests and concerns.

I then contrast how different the debate and process were for passage of the ACA. The ACA remains politically unpopular, in part, because it was passed on a party line vote using procedural legislative maneuvers that many citizens feel are suspect. I try to make this discussion an opportunity for students on both sides of this political debate to understand why the American public continues to be angry and divided over the ACA.

I want the students to move beyond the political debate to begin to understand how the extraordinary process by which the ACA was passed impacts the structure and language of the ACA and the challenges and opportunities it presents for lawyers advising clients.¹² I refer the students to a paragraph in Justice Roberts's opinion that talks about how the ACA contains "more than a few examples of inartful drafting," was written behind closed doors, used the budget reconciliation process, and "does not reflect the type of care and deliberation that one might expect of such significant legislation."¹³ I

12. For an excellent article detailing this process and how it effects the work of health lawyers, see Gluck, *supra* note 1.

13. *King*, 135 S. Ct. at 2492.

explain the legislative process by which ACA was passed. I want the students to understand the federal legislative process by which health laws are generally enacted, including the roles of several key committees. I want them to understand the special rules that attach to Budget Reconciliation bills and the important role they play in health policy. Most importantly, I want the students to understand that the ACA is a statute that did not go through a conference committee and what that means for lawyers: not only is there no conference committee report, but the legislation itself was never scrubbed, no one carefully reviewed the bill prior to passage to clean up grammar and punctuation errors, and make sure that terms and language are consistent throughout.

With this background in legislative process and why they should expect inconsistencies and vagaries in the ACA, the class returns to *King v. Burwell* to examine the case through the lens of administrative law and statutory interpretation. At my school, students take Health Law in the fall of their second year. They have not yet taken a course in statutory analysis or administrative law so I walk them through the case. I explain what *Chevron* deference is, why the issue of whether a statutory term is “ambiguous” is key, and why neither party argued for *Chevron* deference in this case. I also explain why Justice Roberts’s conclusion that interpreting the meaning of premium tax credit provision is “too big and important to leave to an agency” (my term, not his) is a big deal for the field of administrative law and something they will see revisited when they take that course.

We conclude the class by talking about Justice Roberts’s approach to statutory analysis in *King v. Burwell* that reads the contested sections of the ACA “with a view to their place in the overall statutory scheme.”¹⁴ I emphasize how Justice Roberts’s approach places health policy at the forefront of ACA statutory analysis. Health lawyers need to understand not only how the ACA was passed, but what its proponents were trying to do and how the various provision interact with each other to be able to interpret the statute.

C. Day 3: Supreme Court, ACA, and Constitutional Law

The assignment for day three is the portion of the *NFIB v. Sebelius* decision that addresses the constitutionality of the individual tax penalty mandate. In reading the case excerpt, I ask the students to focus on four questions: How does the individual mandate impact access, quality, cost, and choice? What constitutional authority does Congress have to impose the individual mandate? What constitutional authority does Congress have to regulate private insurance? What, if any, authority do states have to impose an individual mandate?

14. *Id.*

I begin class by asking: How does the individual mandate impact access, quality, cost, and choice? This gives the students an opportunity to discuss how the three legs of the ACA individual market reforms—guaranteed issue combined with community rating, premium tax credits, and the individual tax penalty mandate—work together in an attempt to grow the risk pool for the individual market. The health policy portion of today’s class focuses on the role of the tax penalty.

I then ask the students to hark back to the Massachusetts health reform process and think about what other options the stakeholder groups might consider in lieu of a tax penalty? The students quickly come up with ideas for criminal law and civil law penalties not tied to income taxation, drawing on analogies from auto insurance and driver license requirements. Some are familiar with auto-enrollment system used for Medicare Part A. Others suggest lower premiums or a premium surcharge as an incentive to enroll when younger and stay enrolled.

This discussion serves a few purposes. One, it clarifies the difference between laws that require a person to do something, true legal mandates, and the “play or pay” nature of Massachusetts health reform and the ACA. Under both, no one is forced to purchase health insurance, but some people who do not will pay a tax penalty. This is one of the issues the Court had to address in *NFIB*. This discussion helps flesh out the distinction.

Two, it gives students an opportunity to consider why Massachusetts and the ACA would pick a “play or pay option” rather than a true mandate. It also raises the question of why policy makers would want to get health coverage embroiled in something as unpopular as income taxes and the IRS.

Three, it helps the students start to realize how little coercive power the ACA’s individual tax penalty mandate carries. The penalty amounts are relatively small compared to the cost of health insurance, many people are exempt from the tax penalty, and the IRS has few tools, other than deductions from income tax refunds, to collect the penalty. It is neither a crime nor a civil wrong not to purchase health insurance. The choice not to buy merely carries with it a potential tax consequence. Is this a legal duty to have health insurance or some more akin to an expression of a moral obligation?

Revisiting Massachusetts health reform also provides a good jumping off point to discuss constitutional federalism, the limits of congressional power, and *NFIB v. Sebelius*. I ask the students what federal constitutional authority Massachusetts has to impose a health insurance mandate on people? I point them to Justice Roberts’s comment in *NFIB*, “The Commerce Clause is not a general license to regulate an individual from cradle to grave Any police power to regulate individuals as such, as opposed to their activities, remains

vested in the States.”¹⁵ I also have them read with me a paragraph from *Jacobson v. Massachusetts*, a 1905 Supreme Court case, describing the scope of the police power as embracing reasonable regulation to protect public health and public safety.¹⁶ We also discuss the similarities between the Massachusetts individual tax penalty mandate and of the requirement to be vaccinated that the Supreme Court upheld in *Jacobson v. Massachusetts*.

We then turn to *NFIB v. Sebelius*, a case about constitutional law, not statutory analysis. I point out that Justice Roberts says repeatedly the case is about federal versus state powers, not about health policy. The issue is whether Congress had the constitutional authority to impose a tax penalty insurance mandate.

We begin with the taxing power issue, using the day’s earlier discussion to flesh out the Government’s argument in *NFIB* that the tax penalty mandate was not an order to buy insurance but a tax on those who do not. We revisit how the politics surrounding the passage of the ACA and President Obama’s promise of no new taxes plays out in the language of the statute and the litigation. The students get an opportunity to opine whether the ACA language calling the payment a “penalty” rather than a “tax” was thoughtful legislative drafting or nearly fatal poor draftsmanship, saved by a five-to-four Supreme Court majority.

For the Commerce Clause, we do a little parsing of the five-to-four decision on whether the individual tax penalty mandate regulates activity or inactivity, but I leave most of that discussion to the students’ Constitutional Law class. We spend more time getting clear that all the parties and justices agree that both health insurance and health care are activities in interstate commerce and thus subject to Congress’s constitutional authority to regulate.

We end the day with a caution that health law is now highly federalized public law. There are limits on congressional power, and careful lawyers and policy makers must pay attention to those limits. However, Congress has a great deal of authority to regulate health care and most of the Health Law course will be about those federal laws. The states have important roles to play—as in the decision whether or not to set up a health insurance exchange or to expand Medicaid. We will be examining many different forms of federalism. We will be looking at both constitutional and statutory limits on federal-state relationships.

We conclude our introduction to health law by returning to Nikki White. As we study the ACA and other federal statutes, what rights and duties do they impose on Nikki and other Americans? What obligations do they impose on the state and federal government? How do these statutes define adequate health

15. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2591 (2012).

16. *Jacobson v. Massachusetts*, 197 U.S. 11 (1905) (excerpted in FURROW ET AL., *supra* note 5, at 74–78).

coverage and care? What burdens do they impose on Nikki, her family and society? What does equity, fairness, and justice mean as we talk about health and healthcare?

