Legal Issues Arising From the Health Care Reform Issue

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This paper outlines legal issues arising from the new federal health care reform law, especially the issue of the constitutionality of the requirement to purchase health insurance. It also examines some recent Canadian constitutional law cases to anticipate possible future legal challenges to health care reform in the United States.

INTRODUCTION

The question of the reform of the American system of financing health care has, of course, recently been a central focus of debate in American politics. Because the author of this paper is something of a "political junkie" and keeping current on this issue seemed a desirable part of being a law professor at the current moment, I decided to investigate and examine what legal issues have been involved in the health care reform debate.

To a fair degree, what I discovered was that the health care issue is primarily focused on politics, ethics, and economics, rather than on legal issues. But a variety of legal issues have surfaced in law journals and on legal internet blogs. One issue relates to the possible repeal of the obscure Antitrust exemption given to the insurance industry in the McCarran-Ferguson Act. The exemption turns out to be a partial one, the proposed repeal a partial repeal, and the effects of any repeal made very hard to predict by the existence of the State Action exception and the complexities of its operation within an extensive network of state regulation of insurance companies. Another issue arising has been how the proposed reform of the employer-based insurance system will interact with certain provisions in ERISA (Employee Retirement Income Security Act). There are also questions that could well be framed as legal, rather than strictly political issues, with regard to the status of abortion as a procedure covered by federally-funded health insurance, and with regard to some of the political and procedural maneuvering involved in attempts to gain a majority for the reform bills in Congress.

However, I chose to focus in this paper on two issues. The first is probably the legal issue that has generated the most current attention: the question of whether or not the federal mandate on individuals to buy health insurance would be Constitutional. The second issue I will discuss doesn't relate to the current, partial reform passed by the Congress but rather to the probable ultimate desideratum and goal of many of the reform advocates--a "single payer" system in which all payment is by government rather than private insurance (as in Canada). Would a single payer system face a severe constitutional challenge and what would the probable grounds for such a challenge be?

IS A FEDERAL MANDATE TO BUY PRIVATE HEALTH INSURANCE CONSTITUTIONAL?

A federal mandate to purchase health insurance was part of the reform bill. The mandate is subject to a sliding scale of federal subsidization of the purchase for lower income people and doesn't take effect until 2013. But it has already become part of a debate highlighted prominently on mainline internet sites and in the pages of the Wall Street Journal (Rivkin and Casey, 2009) and Washington Post (Will, 2010). The debate has featured disagreement among very prominent Constitutional Law professors about whether or not such a mandate would be constitutional. An interesting feature of the debate is the seeming cocksureness of experts on both sides of the debate. It is striking that the debaters have tended to argue that such a mandate is "of course, Constitutional", or "of course, a violation of the Constitution." In either case the issue is treated as a "no-brainer" beyond reasonable doubt or dispute.

Such a mandate is probably necessary to the type of halfway house reform that retains private insurance rather than moving to an all-government payer system. This is because, if the law is going to require private insurance companies to insure individuals with pre-existing conditions at non-astronomic rates , then everyone has to be in the insurance pool so that there is a group that can serve as a cross-subsidy source to make such a requirement financially feasible (Rivkin and Casey, 2009). The 16% or so of Americans who have no health insurance include many low income people who aren't low income enough to qualify for Medicaid but are too low income to afford private insurance. This group accounts for roughly half of the uninsured, or about 8% of the population, and their insurance premiums will be subsidized (Goodman, 2008). But the other half of the uninsured are composed either of people with very adequate financial means (many well over the median income level) and/or people who could afford insurance but are young and hence relatively low risk (O'Neill and O'Neill, 2009). For such individuals, a good case can be made that refusal to purchase insurance is rational--their risks are lower, most of the health care problems that might happen to them could be paid for if necessary out of pocket, and, if a relatively catastrophic or "big ticket" item struck them, they would be legally guaranteed emergency room treatment. It is these relatively well off but low-risk uninsureds that the reform needs to be able to include to be solvent.

Some journalist commentators have been under the false impression that a federal mandate to purchase would be clearly legal, on the analogy of the long-established and judicially-sustained mandates to purchase auto insurance in the law of the states. But this analogy is probably inapt for two reasons. First, one could avoid the auto insurance mandate by not driving, whereas there would be no way to avoid a health insurance mandate short of suicide or emigration. In other words, the auto insurance mandate conditions a voluntary (though highly convenient) activity whereas a health insurance mandate conditions existence (or at least existence within the borders of the United States). This is not the strongest problem with the auto insurance analogy, though. In fact, it may not be much of a problem: for example, the recent state-level mandate to buy health insurance enacted in Massachusetts during the administration of Governor Romney has withstood court challenge (Fountas v. Commisioner, 2009).

The more serious potential problem with the auto insurance analogy is that the federal government is not a government that has traditionally been regarded by the courts as having general powers (i.e., the "police power"), but rather must rely on the powers delegated to it in the Constitution whenever it wants to legislate on a particular matter (Heritage, 2005). The debate between proponents and opponents of the mandate's constitutionality centers on whether such a mandate falls within the Constitution's Interstate Commerce clause or not. In the 1930's, of course, the reach of the Commerce Clause was greatly extended by the New Deal Court's expansion of the "affecting commerce" rationale. After initially rejecting two important pieces of federal legislation—the NRA and the AAA—during the first administration of Franklin Roosevelt on grounds that the Commerce Clause did not provide the needed authority, the Court (after a change in its composition) went full steam the other way. The most expansive case of the era was Wickard v. Filburn (1942). In this familiar case a farmer who had reserved his crop for local sales and home consumption in order to avoid having to comply with the federal Agricultural program was held to be nevertheless subject to the act. The actions that he had engaged in were strictly intrastate, but the court held that if large numbers of similarly situated farmers had acted the same way, it

would drastically affect the interstate markets for the relevant crops and therefore would undermine the Federal government's constitutionally-delegated ability to regulate interstate commerce.

Subsequent to Wickard v. Filburn the Commerce Clause was held to provide legal cover for some uses that were clearly not primarily meant to regulate commerce, including much of the Federal criminal code, and the Civil Rights Act of 1964. Indeed, the Commerce Clause never lost as a Constitutional argument to ground a federal program for a half century (1942-1995, to be exact). In the last fifteen years, however, two cases, to the surprise of many commentators, put some limit or boundary to the applicability of the Commerce Clause. In United States v. Lopez (1995), a federal statute criminalizing the possession of a gun near a school was held not to come under the Commerce Clause's delegated power because possessing a gun is not a commercial activity, even though gun violence affects commerce. The other case was United States v. Morrison (2000). In Morrison the court struck down a suit for damages for rape under the federal Violence Against Women Act. The court held that a noneconomic activity--an act of violence--could not be aggregated to establish a substantial connection to interstate commerce. Taken together these cases seemed to indicate that the Supreme Court, while certainly not moving into the business of reversing wholesale the Commerce Clause-based expansion of federal power of the 1930's, was calling a halt to further extensions of the Commerce Clause to activities that clearly were not commercial and was indeed refusing to engage in further pretextual uses of the clause to legislate on essentially non-commercial matters.

These two cases were followed by a sharply contrasting case, however, Gonzalez v. Raich (2005). In Gonzalez the court upheld a federal statute prohibiting home growing of marijuana and subsequent home consumption of it for medical use. This is seemingly a reversion back to Wickard v. Filburn in the sense that a non-commercial economic activity was held to be reachable under the Commerce Clause because of the aggregate effect of such activity on a federal Commerce-Clause based policy. This case might perhaps be distinguishable from gun possession or rape (Lopez and Morrison) in that growing/producing an otherwise illegal substance even for home consumption with a medical goal might create a potential for such goods to enter the illegal market already regulated by the Feds. But Gonzalez certainly upheld a very expansive interpretation of the Commerce Clause; the activities involved were not clearly commerce. The case may well be incompatible with and weaken or invalidate the precedential value of Lopez and Morrison, even though there was no explicit overruling of the two earlier cases.

With that as the historical legal background of Commerce Clause cases, it must be noted that the issue posed by the current federal health insurance mandate is somewhat different from the issue in the previous three cases. Indeed, as stated in a 1993 study by the CBO's legal staff it is a "novel "question (Barnett, Stewart, and Gaziano, 2009), namely: Is the non-buying of health insurance by an individual reachable by federal power under the Commerce Clause? One could argue that not buying something is not only not commerce, it's also not an "activity" or "action" of any kind. Even under an expansive interpretation of Commerce Clause powers, can the Congress regulate non-activity that is related to a commercial market by compelling someone to engage in commerce? Can Congress by compulsion in effect bring into being the commercial activity that they then exercise their Commerce Clause authority to regulate?

Professor Erwin Chemerinsky of the University of California Irvine School of Law replies in Politico (Chemerinsky, 2009) and in the Washington Post, in essence, "of course they can." Chemerinsky dismisses the activity/inactivity distinction as without Constitutional merit. Inaction is itself an action, he maintains. In Chemerinsky's view the decision not to buy insurance is a commercial decision and thus "commerce" and that could lawfully subject one to federal government regulation. By contrast, Professor Randy Barnett of Georgetown University says "of course they can't" (Barnett, 2010). Under general police powers such as those possessed by state governments, a legislature might be able to force or coerce a commercial transaction to be engaged in for the public's welfare. But under the Commerce Clause there has to be at least some private action that is either commerce or related to commerce before Congress can regulate it under the commerce clause. Mandate opponents such as Barnett argue by analogy: If the federal government could compel the commercial transaction of buying insurance in order to create financial solvency in a scheme that achieves an important public policy goal (universal access to health

care), then why could it not compel other transactions to be engaged in that would shore up the solvency of a public health scheme or that would avoid shifting of medical costs to the taxpayer? Why couldn't the federal government require citizens to have annual physical exams, for example, or to pay a fine if they don't? Could the feds require overweight people to enroll in federally certified obesity treatment centers or pay a fine if they don't? In both cases the public policy goal-- of better preventative care which would avoid possible cost-shifting to the taxpayer---would seem to be essentially the same as the one which supports the buy insurance mandate.

It is hard for this author to see a relevant, principled distinction between a requirement to buy insurance and a mandate to engage in other such health-care expense-saving expenditures. This seems to lead either to the conclusion that the Feds could also impose penalties in the future for such non-activities in commerce as not getting an annual checkup. Perhaps this conclusion would be philosophically tolerable to many, though it seems to involve a shift in the traditional relationship of the citizen to the state. Or, given this potential further expansion of state authority over the citizen under the commerce clause, perhaps the court would rethink and begin a slow retreat from the use of the commerce clause to ground extensive federal government power. If I were to hazard a prediction, I would guesstimate the current court would uphold the mandate 5-4 (the 4 Democrats joined by Justice Kennedy against the 4 more conservative Republicans). The court would probably be nervous about overturning a major political policy decision emanating from the elected branch of government (Taylor, 2009). Of course, during the New Deal era they did exactly that and more than once, and it would not be impossible that that piece of history would repeat. A lot might depend (unfortunately, I'd say, however one views the issue) on the degree of public support or lack thereof for the reform at the time the court decision was made.

There is an alternative delegated power that might well be more promising for mandate proponents, though it has its own uncertainties. The Taxing power was broadened by being tied to the General Welfare clause in the 1930's in a way in which the Commerce Clause never was (United States v. Butler, 1936). In other words, taxes can be levied for the General Welfare (as determined primarily if not necessarily exclusively by Congress). The limits, if any, to the Taxing power are generally regarded by commentators as broader, but they are also vaguer and there are fewer relevant cases because nearly everything since the '30's has been based on the Commerce Clause. It is likely that the fine, therefore, that would accompany violation of the mandate to buy insurance, will be labeled by the statute as a "tax." However, its purpose is not primarily to raise revenue but to coerce people into buying insurance and as such it may be characterized as a "penalty", something distinguishable from a "tax."

WHAT CONSTITUTIONAL CHALLENGES WOULD A SINGLE-PAYER SYSTEM FACE?

Health care reform in the United States may eventually lead to the adoption of a "single payer" system, similar to what exists today in Canada. There is a current very relevant development in the constitutional law of Canada that may give an indication of what constitutional issues such a system would face if ever adopted in the United States. Different aspects of the Canadian health care system have often been used by both sides of the issue as a benchmark in the American health care debate. The Canadian system has enjoyed high levels of public approval and support in Canada (though polling data show the support levels declining significantly in the last few years). This has been pointed to with admiration and as something we should emulate by the relatively liberal side of the American debate. On the other hand the Canadian system includes significant health care rationing via the use of waiting lists for non-emergency treatments, a fact viewed with alarm and as something we need to avoid by the relatively conservative side of the American debate.

What hasn't been frequently reported south of the frigid border, however, is that the constitutionality of the Canadian single payer system, at least as currently structured, has been under severe legal challenge and put in serious doubt since 2005. The seminal case is Chaoulli vs. Quebec (2005). In this case a 73-year old retiree was forced to wait a year, while in considerable pain and discomfort, for hip replacement surgery. The province of Quebec prohibited paying privately (i.e., outside of the single payer system) for

surgery, and also prohibited purchasing private insurance which he could have used to finance the surgery in the United States (Johnson, 2008). His only option--paying out of pocket for surgery in the United States--was beyond his financial means. The denial of the right to buy private insurance and the seeming guarantee of access to health care which turned out to be in fact, as one Justice put it, "merely access to a waiting list" was alleged to violate Canada's Bill of Rights equivalent, the Charter of Human Rights and Freedoms.

The actual ruling in Chaoulli was complex: Though Canada has a 9-person Supreme Court as the United States does, two seats were vacant at the time of the decision. Three of the justices in the 4-Justice majority held that the waiting lists generated under Canada's single payer system violated the Charter rights of "personal inviolability," "security," and "liberty"(Johnson, 2008). They held also that this was a violation of a "fundamental right", not something that could be characterized as a mere "economic right." These three Justices did not actually hold that waiting lists of any length would per se violate these basic rights. Suppression of a citizen's right to seek private insurance and/or private treatment might be constitutionally acceptable, they maintained, in order to "preserve the integrity of the public health system." But this would only be a tolerable conclusion if the government's provision of that right was efficient, quick, and effective, so as to work no substantial hardship on the citizen (Johnson, 2008). A fourth justice, forming a majority of 4-3 in the case, agreed with the decision in favor of Chaoulli but on different grounds. This justice held that the waiting lists violated Quebec's provincial charter, but ruled that she needn't reach the issue of whether it also violated Canada's federal charter (Johnson, 2008). The other three justices dissented, holding that, given the important public policy objective of equal access to health care which was furthered by Canada's system, the Charter was not violated (Johnson, 2008).

Besides a considerable volume of outraged press commentary from a Canadian punditocracy overwhelming supportive of the single payer system, the Chaoulli case generated two aftereffects. One was legislative attempts by Quebec, Ontario, and other provinces to adopt reforms designed to reduce waiting lists and thus avoid judicially-mandated overhauls or even dismantling of the health payments system. These reforms have achieved some limited success in reducing the problem of waiting lists, though only at very substantial expense (Johnson, 2008). The Ontario government has moved to implement waiting list "benchmarks" or target averages which, to an American with insurance at least, themselves seem pretty deficient: an average 6 week wait for radiation therapy to begin, 21 weeks after diagnosis for cataract surgery, 26 weeks for hip and knee replacements, and 26 weeks for "lower urgency" cardiac bypass surgery (Johnson, 2008).

The other aftereffect has been a whole series of cases in other provinces asking for rulings that the single payer system in each province violated their provincial charters and/or the national charter. The facts of three of these cases are interesting enough to briefly outline because they show the types of cases that would likely ultimately make their way to American courts in the future should such a system ultimately be adopted in the United States.

McCreith & Holmes v. Ontario (2007) was a consolidation of two separate cases. Lindsay McCreith was a 66-year old who was diagnosed in Ontario with a possible brain tumor and given an MRI appointment four and a half months away from his initial examination. Worried about the spread of a possible cancer, he went to Buffalo, N.Y., where an MRI led to the diagnosis of a malignant brain tumor. With this diagnosis in hand he returned to Ontario and was given a surgical date that would have been eight months from the original examination date. Instead he returned to Buffalo and paid $27,600 out of pocket for surgery on the tumor. The Holmes case involved Shona Holmes, a mother of two small children, who began losing her vision in March of 2005. An MRI revealed a tumor--not a malignancy, and not life threatening--but a threat to her vision. She was given a specialist appointment after her examination, but with a four-month wait as her vision continued to deteriorate severely. At that point she went across the border to the Mayo Clinic and had surgery to remove the tumor, which restored her vision. She incurred large debt to pay for her expenses out-of-pocket because of the prohibition in the province of private insurance.

A final illustration is the Alberta case of Bill Murray (Murray v. Alberta, 2007). Murray was 57 and had a severely arthritic hip. He waited a year for an appointment with an orthopedic specialist, who

recommended a hip "resurfacing" surgery. But government officials determined that Murray was too old for the surgery, and denied governmental payment for it; in the absence of private insurance he couldn't afford it out-of-pocket.

Of course the Canadian constitution is not the American Constitution, but the analogies are very strong. In fact the United States has a much stronger and more well-established tradition of judicial review of legislative action than Canada has, as well as a more litigious population. In the United States both the Due Process and Equal Protection clauses would be implicated by any rationing arising under a single payer system. Since the preservation of one's health is probably a "fundamental right", this would activate a "strict scrutiny" test under the Supreme Court's 14th Amendment cases. If a single payer system generated, as is likely, waiting list problems it would probably be extremely vulnerable to Constitutional challenge.

CONCLUSION

The current "Obamacare" reform will probably face its primary legal challenge in the form of a challenge to the mandate to buy health insurance. Though there is substantial doubt, the current reform will likely survive this challenge unless the Supreme Court decides to begin a basic re-examination of the use of the Commerce Clause as a kind of omnibus, all-purpose delegated power. But further alteration of the health care system in the direction of a Canadian or European-style system would very likely lead to successful constitutional challenges, at least unless a private insurance and treatment "outlet" or option is available and left open under any such future reform.

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