



Health Care: Constitutional Rights and Legislative Powers

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Summary

The health care reform debate raises many complex issues including those of coverage, accessibility, cost, accountability, and quality of health care. Underlying these policy considerations are issues regarding the status of health care as a constitutional or legal right. This report analyzes constitutional and legal issues pertaining to a right to health care, as well as the power of Congress to enact and fund health care programs. The United States Supreme Court's decision in *NFIB v. Sebelius*, which upheld most of the Patient Protection and Affordable Care Act (Affordable Care Act/ACA), is also discussed.

The United States Constitution does not set forth an explicit right to health care, and the Supreme Court has never interpreted the Constitution as guaranteeing a right to health care services from the government for those who cannot afford it. The Supreme Court has, however, held that the government has an obligation to provide medical care in certain limited circumstances, such as for prisoners.

Congress has enacted numerous statutes, such as Medicare, Medicaid, and the Children's Health Insurance Program, that establish and define specific statutory rights of individuals to receive health care services from the government. As a major component of many health care entitlement statutes, Congress has provided funding to pay for the health services provided under law. Most of these statutes have been enacted pursuant to Congress's authority to "make all Laws which shall be necessary and proper" to carry out its mandate "to ... provide for the ... general Welfare." Congress has also used other constitutional powers, such as its power to regulate interstate commerce and its power to levy taxes, to enact legislation relating to health insurance and health care.

In 2010, Congress enacted the Affordable Care Act, a comprehensive health care reform law which includes a requirement, effective in 2014, that most individuals purchase health insurance, and which significantly expands the Medicaid program. A number of lawsuits were filed challenging various provisions of this legislation, and, on June 28, 2012, the Supreme Court upheld the majority of ACA's provisions. Significantly, the Court upheld the requirement that individuals purchase health insurance as a valid exercise of Congress' taxing power, but the Court limited Congress' power to spend for the general welfare by holding that Congress cannot threaten the states with the loss of all federal Medicaid funds if the states decline to expand Medicaid coverage as mandated by ACA.

In addition, several states have passed laws, amended their state constitutions, or entered into interstate compacts to attempt to "nullify" or "opt out" of the federal individual health insurance mandate and other federal health care provisions. Direct conflicts between federal laws and state nullification statutes or state constitutional amendments would raise constitutional issues which are likely to be resolved in favor of federal law under the Supremacy Clause of the United States Constitution.

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

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Health Care Rights Under the U.S. Constitution

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

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

Explicit Rights in the U.S. Constitution

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

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

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

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

⁴ This report does not analyze the scope of a right to health or health care under various international agreements or under the governing documents of other countries. For further information, see, e.g., JOHN TOBIN, *THE RIGHT TO HEALTH IN INTERNATIONAL LAW* (Oxford University Press 2012); Puneet K. Sandhu, *A Legal Right to Health Care: What Can the United States Learn From Foreign Models of Health Rights Jurisprudence?* 95 CAL. L. REV. 1151 (2007); and, Marcela X. Berdion, *The Right to Health Care in the United States: Local Answers to Global Responsibilities*, 60 SMU LAW REVIEW 1633 (2007).

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

⁶ *Id.* at 958-959.

have been proposals to add a specific right to health care as an amendment to the U.S. Constitution. For example, in 1944, President Franklin D. Roosevelt, in his State of the Union address, advanced his idea of a “Second Bill of Rights” which would include “[t]he right to adequate medical care and the opportunity to achieve and enjoy good health.”⁷ More recently, Representative Jesse L. Jackson Jr. introduced H.J.Res. 30 on February 14, 2011, a bill which proposes an amendment to the U.S. Constitution ensuring a right to health care. The proposed amendment reads, “Section 1. All persons shall enjoy the right to health care of equal high quality. Section 2. The Congress shall have power to enforce and implement this article by appropriate legislation.”

The Right to Health Care at the Government’s Expense

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

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

Substantive Due Process: Impact on Fundamental Rights

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

⁷ 12 Pub. Papers 41 (January 11, 1944).

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

Amendment.⁹ A litigant challenging a federal action has the burden of proving that the governmental action places an undue burden on the exercise of an individual's fundamental right. The standard of review used in cases involving fundamental rights is called "strict scrutiny." Using this heightened standard of review, if the Court determines that a fundamental right has been unduly burdened, the governmental action will only be upheld if the government can demonstrate that the action is necessary to achieve a compelling governmental interest.¹⁰

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

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

In *Harris v. McRae*,¹⁹ the Supreme Court held that the Medicaid program's refusal, under the Hyde Amendment, to pay for medically necessary abortions did not burden a woman's fundamental right to choose an abortion. The Court applied the rational basis standard of review and found that poor pregnant women were not denied equal protection of the laws because the abortion provisions were rationally related to a governmental "interest in protecting the potential life of the fetus."²⁰ The Court also noted that while the Due Process Clause of the Fourteenth Amendment affords protection against unwarranted government interference with freedom of

⁹ See, generally, the discussion regarding fundamental rights in CRS, UNITED STATES CONSTITUTION: ANALYSIS AND INTERPRETATION, by Kenneth R. Thomas, p. 1763 *et seq.*

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

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

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

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

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

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

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

¹⁷ 432 U.S. 464 (1977).

¹⁸ *Id.* at 473-474.

¹⁹ 448 U.S. 297 (1980).

²⁰ *Id.* at 324.

choice regarding certain personal decisions, it “does not confer an entitlement to such funds as may be necessary to realize all the advantages of that freedom.”²¹ The Court stated further,²²

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

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

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

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

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

²¹ *Id.* at 318.

²² *Id.*

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

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

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

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

²⁷ 397 U.S. 254 (1970).

²⁸ *Id.* at 264-65.

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

Equal Protection: Wealth as a “Suspect Class”

For a classification that treats people differently—such as health care services for some poor persons but not all who are in need—to rise to the highest level of constitutional protection, the classification must be found to be a “suspect classification” by the Supreme Court. According to the Court, the constitutional guarantee of equal protection is not a source of substantive rights, but rather a “right to be free from invidious discrimination in statutory classifications and other governmental activity.”³⁰ In cases where the Court determines state or federal governmental classifications to be “suspect,” it will apply the strict scrutiny standard of review. Thus, the Court has applied the strict scrutiny test to suspect classifications based on race,³¹ ethnicity,³² and national origin.³³

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

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

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

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

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

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

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

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

³⁵ 397 U.S. 471 (1970).

³⁶ *Id.* at 485.

³⁷ *Id.* at 487.

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

Exception: Under Government Control

The Supreme Court has held that persons under governmental control, in circumstances where they are dependent upon the government for their basic needs, have a right to a minimal amount of medical care. However, the Supreme Court has not based its decisions defining a right to medical care for persons with limited freedoms on a fundamental right to health care.³⁹ Rather, in the case of prisoners, the Supreme Court has held that they are entitled to adequate food, clothing, shelter, and medical care as a component of the protections accorded by the Eighth Amendment.⁴⁰ “[D]eliberate indifference to serious medical needs of prisoners constitutes the ‘unnecessary and wanton infliction of pain,’ ... proscribed by the Eighth amendment,” said the Court, raising the possibility of pain and suffering that can amount to cruel and unusual punishment.⁴¹ In like manner, involuntarily confined mentally disabled patients have a right to safe conditions, including food, shelter, and medical care, as well as minimally adequate training to avoid placement in physical restraints, as part of their substantive liberty interests guaranteed by the Due Process Clause of the Fourteenth Amendment.⁴²

Health Care Legislation Under the U.S. Constitution

While the United States Constitution and Supreme Court interpretations do not identify a constitutional right to health care at the government’s expense, Congress has enacted numerous statutes which establish and define statutory rights of individuals to receive medical services from the government. In addition, other statutes, such as Title VI of the Civil Rights Act of 1964⁴³ which prohibits discrimination under federally funded programs, affect the manner of delivery of services under federal grants. Congress’ authority to enact health care legislation derives from the enumerated powers set forth in Article I, Section 8 of the Constitution. Congress’ power to tax and spend for the general welfare and its power to regulate interstate commerce have been the primary sources of constitutional authority for most health care legislation.

Specific Sources of Constitutional Authority

The most frequently utilized grant of power in the United States Constitution for the enactment of health care legislation is found in Article I, Section 8, clause 1, which states, in part, that “[t]he

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

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

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

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

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

Congress shall have Power to lay and collect Taxes, ... to ... provide for the ... general Welfare of the United States.”⁴⁴ The last paragraph of this section provides that Congress shall have the authority “to make all Laws which shall be necessary and proper for carrying into Execution the foregoing Powers.”⁴⁵ The “foregoing Powers” include this specific power, popularly known as the taxing and spending power, as well as the power to regulate interstate commerce, another constitutional authority available to Congress for the enactment of health care legislation.

The Power to Tax and Spend for the General Welfare

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

Recently, the Supreme Court, in *National Federation of Independent Business v. Sebelius (NFIB)*,⁴⁷ upheld a requirement in the Patient Protection and Affordable Care Act (Affordable Care Act/ACA)⁴⁸ beginning in 2014, that most individuals carry health insurance or pay a penalty for noncompliance as a valid exercise of Congress’ authority to levy taxes. Chief Justice Roberts, in his opinion, stated that “the mandate is not a legal command to buy insurance. Rather it makes going without insurance just another thing the Government taxes, like buying gasoline or earning income. And if the mandate is in effect just a tax hike on certain taxpayers who do not have health insurance, it may be within Congress’ constitutional power to tax.”

In reaching this conclusion, the Court looked beyond the “penalty” label given to the individual mandate by Congress, and instead relied heavily upon the consequences that the provision would have for affected individuals. Specifically, Chief Justice Roberts, writing for the majority, found that the operation of the individual mandate had many similarities to other taxes. For example, it is to be assessed as part of a taxpayer’s annual income tax return; it varies by income and number of dependents; and, it is to be administered by the IRS. The Chief Justice’s opinion also suggested that there are limits to the magnitude of financial incentives that Congress could create under the taxing power, but declined to “decide the precise point at which an exaction becomes so punitive that the taxing power does not authorize it.”⁴⁹

⁴⁴ It is noted that the Tenth Amendment provides that “powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.” See, for a general discussion of constitutional federalism principles, CRS Report RL30315, *Federalism, State Sovereignty, and the Constitution: Basis and Limits of Congressional Power*, by Kenneth R. Thomas.

⁴⁵ Other examples of powers in Section 8 for which Congress has the authority to enact “necessary and proper” laws include Congress’s power to provide for the common defense (clause 1), to pay the debts of the United States (clause 1), to borrow money (clause 2), to regulate interstate commerce (clause 3), to set citizenship requirements (clause 4), to coin money (clause 5), and to declare war (clause 11).

⁴⁶ 249 U.S. 86, 93 (1919). For a discussion of certain limitations that do apply to Congress’s power to tax, see, generally, CRS, *United States Constitution: Analysis and Interpretation*, coordinated by Kenneth R. Thomas.

⁴⁷ No. 11-393, 567 U.S. ____ (2012), available at <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>.

⁴⁸ P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152.

⁴⁹ *Id.*, Slip opinion, C. J. Roberts, at 43. In dissent, Justices Scalia, Kennedy, Thomas, and Alito argued that Congress’s repeated use of the “penalty” label, and the inclusion of a substantive command for individuals to maintain insurance, should foreclose any possible justification under the taxing power.

In like manner, the power to spend for the general welfare is one of the broadest grants of authority to Congress in the United States Constitution. The scope of the national spending power was brought before the United States Supreme Court in a landmark case in 1937 dealing with the newly enacted Social Security Act.⁵⁰ In *Steward Machine Co. v. Davis*,⁵¹ the Court sustained a tax imposed on employers to provide unemployment benefits to individual workers. It was argued that the tax and a state credit that went with the state's tax were "weapons of coercion, destroying or impairing the autonomy of the States."⁵² The Supreme Court, however, held that relief of unemployment was a legitimate object of federal spending under the "general welfare" clause, and that the Social Security Act, which also included old age benefits for individuals so they might not be destitute in their old age,⁵³ as well as provisions for child welfare and maternal child health projects, was a legitimate attempt to solve these problems in cooperation with the states.⁵⁴

Subsequent Supreme Court decisions have not questioned Congress's policy decisions as to what kinds of spending programs are in pursuit of the "general welfare," and so numerous programs have been funded in such diverse areas as education, housing, veterans' benefits, the environment, welfare, health care, scientific research, the arts, community development, and public financing of election campaigns. The Supreme Court accords great deference to a legislative decision by Congress that a particular spending program provides for the general welfare. Indeed, the High Court has suggested that the question whether a spending program provides for the general welfare is one that is entirely within the discretion of the legislative branch. Thus, in *Buckley v. Valeo*,⁵⁵ the Supreme Court held that federal funding of election campaigns was a proper exercise of Congress's power to spend for the general welfare:⁵⁶

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

⁵⁰ 42 U.S.C. §401 *et seq.*

⁵¹ 301 U.S. 548 (1937).

⁵² *Id.* at 591.

⁵³ See *Helvering v. Davis*, 301 U.S. 619 (1937), which upheld the old-age benefits provisions of Title II of the Social Security Act.

⁵⁴ *Steward Machine Co. v. Davis*, 301 U.S. 548, 591 (1937). The Supreme Court has suggested in decisions such as *South Dakota v. Dole*, 483 U.S. 203 (1987), that there are limits to Congress's power under the Spending Clause to require states to meet grant conditions. More recently, in *NFIB v. Sebelius*, discussed, *infra*, the Supreme Court has established limits under the Tenth Amendment on Congress' ability to impose certain conditions on federal grants to states. For more information, see CRS Report RL30315, *Federalism, State Sovereignty, and the Constitution: Basis and Limits of Congressional Power*, by Kenneth R. Thomas.

⁵⁵ 424 U.S. 1 (1975).

⁵⁶ *Id.* at 90-91.

In *National Federation of Independent Business v. Sebelius*,⁵⁷ the Supreme Court addressed Congress' power to spend for the general welfare, but in the context of Congress' ability to impose conditions on federal grant funds. At issue was the provision in the Affordable Care Act that would require the states to expand their Medicaid programs by 2014 to cover virtually all poor Americans under the age of 65, or risk losing all of the Medicaid funding that they receive from the federal government.⁵⁸ The Court accepted the argument that states were being "coerced" into expanding Medicaid benefits because failure to implement the expansion could result in the loss of all federal Medicaid funds. While Chief Justice Roberts, in his majority opinion, found that the termination of existing Medicaid funds was coercive, his opinion also went on to find that the statutory provision authorizing withholding of all Medicaid program funds could be severed in its application so as to allow withholding of just the new ACA funds associated with the expansion. In other words, states could decline to participate in the Medicaid expansion without financial penalty.

The newly articulated limitations on Congress' power under the Spending Clause under *NFIB* are significant, because, for the first time, the High Court has struck down conditions on federal grants to states that it determined cross the line from enticement to coercion. However, Chief Justice Roberts declined to fix the "outermost line where persuasion gives way to coercion," finding only that the ACA Medicaid expansion requirements were "surely beyond" that line.⁵⁹

The Power To Regulate Interstate Commerce

Congress has the power to regulate health care matters under its power to regulate interstate commerce,⁶⁰ and it did so when it enacted the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)⁶¹ which directly regulates the health care industry by imposing continuing insurance requirements for persons who lose employment-related health insurance benefits. Congress has also generally regulated employee benefits, including health insurance, under the Employee Retirement Income Security Act of 1974 (ERISA).⁶² In other legislation related to ERISA, Congress has also enacted various health insurance plan mandates for childbirth delivery hospital stays, breast reconstruction payments for mastectomies, and certain mental health coverage annual and lifetime limit requirements.⁶³

In *National Federation of Independent Business v. Sebelius*,⁶⁴ the Supreme Court upheld a requirement in the Affordable Care Act that most individuals acquire health insurance coverage beginning in 2014, as a valid exercise of Congress' power to levy taxes. However, before upholding the individual mandate on taxing power grounds, the High Court addressed what most thought was the constitutional basis for Congress imposing such a requirement on individuals, *i.e.*, Congress' power to regulate interstate commerce. Chief Justice Roberts, along with four other Justices, accepted the argument made by the challengers to the Affordable Care Act that,

⁵⁷ No. 11-393, 567 U.S. ____ (2012), available at <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>.

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

⁵⁹ *NFIB v. Sebelius*, Slip opinion, C.J. Roberts, at 55.

⁶⁰ U.S. Const. art. I, § 8, cl. 3.

⁶¹ 29 U.S.C. §§1161-1168.

⁶² 29 U.S.C. §1001 *et seq.*

⁶³ 29 U.S.C. §§1185, 1185a, 1185b.

⁶⁴ No. 11-393, 567 U.S. ____ (2012), available at <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>.

while the Commerce Clause allows Congress to regulate economic activity, it does not allow Congress to compel individuals to enter into that activity. The Court noted that this distinction is important because ignoring it would undermine the principle that the federal government is a government of limited and enumerated powers.⁶⁵ The Court also found that there was no limiting principle with respect to the individual mandate—that if Congress were allowed to require the purchase of health insurance, it could require individuals to make purchases as a solution to almost any problem.⁶⁶ The effect of this holding is limited by the fact that the Court upheld the individual mandate as a valid exercise of Congress’ power to levy taxes.

Federal Health Care Programs

The Medicare program, established as Title XVIII of the Social Security Act in 1965,⁶⁷ is the largest health care program enacted by Congress pursuant to its power to tax and spend for the general welfare. Medicaid (Title XIX),⁶⁸ also enacted in 1965, and the Children’s Health Insurance Program (CHIP) (Title XXI),⁶⁹ enacted in 1997, are examples of voluntary federal/state partnership programs providing health care benefits to certain low-income persons. The Supreme Court has not taken a case challenging these health care programs as an unconstitutional exercise of Congress’s taxing and spending power, possibly because the law on this point was settled by its earlier 1937 decision, discussed above, upholding Title II (Old Age Benefits) and Title III (Unemployment Compensation) of the same act. However, the Supreme Court recently rendered a decision in a case challenging two provisions of the Affordable Care Act, and while the Court upheld the majority of that health care reform law, the Court did limit Congress’ ability to condition certain grants under the Medicaid program.⁷⁰

Another example of a health care program is the Hospital Survey and Construction Act⁷¹ (Hill-Burton Act), enacted in 1946, which offers federal construction funds to hospitals, nursing homes, and other health facilities on the condition that the facilities provide a reasonable volume of services to indigent patients, and make their services available to all persons residing in the facility’s area.⁷² Congress has also created a statutory right to certain emergency services under the Emergency Medical Treatment and Active Labor Act (EMTALA).⁷³ EMTALA imposes a legal

⁶⁵ *NFIB v. Sebelius*, Slip opinion, C. J. Roberts, at 2.

⁶⁶ *Id.* at 22-26.

⁶⁷ Medicare is a federal health insurance program for persons aged 65 and older, certain other groups of persons such as persons with disabilities, and persons living with end-stage renal disease. 42 U.S.C. §1395 *et seq.* For more information on the Medicare program see CRS Report R40425, *Medicare Primer*, coordinated by Patricia A. Davis.

⁶⁸ Medicaid is a needs-based program that provides low-income persons with broad coverage for medical services. 42 U.S.C. §1396 *et seq.* The states may participate in this grant program by submitting a state plan meeting federal requirements to the Department of Health and Human Services. 42 U.S.C. §1396a(b). The federal government and the states jointly share the costs of providing benefits to persons meeting Medicaid eligibility requirements. See CRS Report RL32950, *Medicaid: The Federal Medical Assistance Percentage (FMAP)*, by Alison Mitchell and Evelyne P. Baumrucker.

⁶⁹ CHIP is a federal matching block grant program that provides health care services for certain uninsured children without access to Medicaid. 42 U.S.C. §1397 *et seq.* See, for more information, CRS Report R40444, *State Children’s Health Insurance Program (CHIP): A Brief Overview*, by Elicia J. Herz and Evelyne P. Baumrucker

⁷⁰ *NFIB v. Sebelius*, 567 U.S. ____ (2012), available at <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>.

⁷¹ 42 U.S.C. §§291 to 291o-1.

⁷² See HHS website on the Hill-Burton Act at <http://www.hrsa.gov/hillburton/default.htm>.

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

obligation on hospitals that participate in Medicare to provide screening, examination, and stabilization of emergency medical conditions and women in labor, prior to transferring them to another facility.⁷⁴

In addition, Congress has provided for health care services in many other contexts, including access to health care services for uninsured and underinsured persons through tax incentives to non-profit organizations such as hospitals for providing charitable care,⁷⁵ and by grant programs that fund certain “safety net providers,” such as community health centers, migrant health centers, and other health facilities that serve medically underserved populations.⁷⁶

The Affordable Care Act

On March 23, 2010, the President signed into law H.R. 3590, the Patient Protection and Affordable Care Act (Affordable Care Act/ACA), P.L. 111-148,⁷⁷ a comprehensive health care reform statute. The Affordable Care Act, which will be fully implemented by 2014, will restructure the private health insurance market, particularly for individuals purchasing coverage on their own (who may qualify for premium credits) and small businesses, partly by supporting states’ creation of “American Health Benefit Exchanges” through which eligible individuals and small businesses can access private insurers’ plans.⁷⁸ Considerable attention has been paid to Section 1501 of Title I of ACA, which will require most individuals to have health insurance that meets minimum essential coverage requirements beginning in 2014.⁷⁹ This provision imposes a tax⁸⁰ on people who do not purchase the required health insurance for themselves and their dependents. Some individuals will be provided subsidies to help pay for their premiums and cost-sharing. Others would be exempt from the individual mandate.⁸¹

Section 2001 of Title II of ACA, provides that, beginning in 2014, or sooner at state option, nonelderly, non-pregnant individuals with income below 133% of the federal poverty level will

⁷⁴ 42 U.S.C. §1395dd(a)-(c).

⁷⁵ See 26 U.S.C. §501(c)(3), which provides for an exemption from federal income tax for corporations organized and operated exclusively for religious, charitable, or educational purposes, provided no part of the organization’s net earnings inures to the benefit of any private shareholder or individual. Under Rev. Rul. 69-545, 1969-2 C.B. 117, the IRS recognized “promotion of health” as a charitable purpose when a “community benefit” standard is met. See CRS Report RL34605, *501(c)(3) Hospitals and the Community Benefit Standard*, by Erika K. Lunder and Edward C. Liu.

⁷⁶ See CRS Report RL32046, *Federal Health Centers Program*, by Barbara English.

⁷⁷ As amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152.

⁷⁸ For an overview of this law see CRS Report R41664, *ACA: A Brief Overview of the Law, Implementation, and Legal Challenges*, coordinated by C. Stephen Redhead.

⁷⁹ Section 1501 of P.L. 111-148, 42 U.S.C. §18091.

⁸⁰ The Supreme Court in *National Federation of Independent Business v. Sebelius*, 567 U.S. ____ (2012), available at <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>, upheld the individual mandate to purchase health insurance as a constitutional exercise of Congress’s authority to levy taxes.

⁸¹ Exempt individuals include those with qualifying religious exemptions, those in a health care sharing ministry, individuals not lawfully present in the United States, and incarcerated individuals. No penalty will be imposed on those without coverage for less than 90 days (with only one period of 90 days allowed in a year), members of Indian tribes, individuals whose household income does not exceed 100% of the federal poverty level, or any individual who the Secretary of HHS determines to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan. For more information about this, and related, provisions, see CRS Report R42069, *Private Health Insurance Market Reforms in the Patient Protection and Affordable Care Act (ACA)*, by Annie L. Mach and Bernadette Fernandez.

be made newly eligible for Medicaid.⁸² From 2014 to 2016, the federal government will cover 100% of the Medicaid costs of these newly eligible individuals, with the percentage dropping to 90% (with states covering the difference) by 2020. This change represents the most significant expansion of Medicaid eligibility in many years. In addition, the health reform law adds new mandatory benefits to Medicaid, including, for example, coverage of services in free-standing birthing centers and tobacco cessation services for pregnant women. The new law also expands state options for providing home- and community-based services as an alternative to institutional care, and provides financial incentives to states to do so. Among the Medicaid financing changes, the health reform law reduces Medicaid disproportionate share hospital allotments, increases certain pharmacy reimbursements, increases primary care physician payment rates for selected preventive services, and increases federal spending for the territories.⁸³

Supreme Court Decision in *National Federation of Independent Business v. Sebelius*

Several lawsuits were filed shortly after enactment of the Affordable Care Act in various federal courts challenging the constitutionality of two key provisions of the Act: the requirement compelling certain individuals to have health insurance (i.e., the individual mandate), and the expansion of the Medicaid program, which requires that states provide coverage to most adults under the age 65 with incomes up to 133% of the federal poverty level. On June 28, 2012, the United States Supreme Court, in *National Federation of Independent Business v. Sebelius (NFIB)*,⁸⁴ a case brought by 26 states and the National Federation of Independent Business, issued a highly anticipated decision largely affirming the constitutionality of ACA.

Before addressing whether the individual mandate was valid under Congress's taxing power, the Court tackled what had been a primary focus of the litigation: whether Congress's power to regulate interstate commerce gives it the authority to impose the individual mandate. Chief Justice Roberts, along with four other Justices, accepted the argument made by the challengers to ACA that while the Commerce Clause allows Congress to regulate economic activity, it does not allow Congress to compel individuals to enter into that activity. According to the Court, this distinction is important because ignoring it would undermine the principle that the Federal Government is a government of limited and enumerated powers.⁸⁵ The Court also found that there was no limiting principle with respect to the individual mandate—that if Congress were allowed to require the purchase of health insurance, it could require individuals to make purchases as a solution to almost any problem.⁸⁶

With respect to the individual mandate, Chief Justice Roberts, writing for the majority, upheld the individual mandate as a constitutional exercise of Congress's authority to levy taxes. In reaching

⁸² Following the Supreme Court's decision in *National Federation of Independent Business v. Sebelius*, 567 U.S. ____ (2012), the states may decline to participate in the Medicaid expansion without financial penalty, since the court held that the enforcement mechanism in ACA that tied non-compliance to the loss of all Medicaid funds was unconstitutional.

⁸³ For more information on the Medicaid provisions in ACA, see CRS Report R41210, *Medicaid and the State Children's Health Insurance Program (CHIP) Provisions in ACA: Summary and Timeline*, by Evelyne P. Baumrucker et al.

⁸⁴ 567 U.S. ____ (2012), available at <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>

⁸⁵ *Id.*, Slip opinion, C. J. Roberts, at 2.

⁸⁶ *Id.* at 22-26.

this conclusion,⁸⁷ the Chief Justice’s opinion looked beyond the “penalty” label that had been given to the provision by Congress, and instead relied heavily on the consequences that the provision would have for affected individuals. Specifically, he found that the operation of the individual mandate had many similarities to other taxes. For example, it is to be assessed as part of a taxpayer’s annual income tax return; it varies by income and number of dependents; and it is to be administered by the IRS. The Chief Justice’s opinion also suggested that there are limits to the magnitude of financial incentives that Congress could create under the taxing power, but declined to “decide the precise point at which an exaction becomes so punitive that the taxing power does not authorize it.”⁸⁸

With regard to the Medicaid expansion provision, the Court held that Congress cannot threaten the states with the loss of all federal Medicaid funding if the states decline to expand Medicaid coverage as mandated by the Affordable Care Act.⁸⁹ The Court found that compelling the states to participate in a “new grant program” or else face the possible loss of all federal funds under the current Medicaid program was coercive and unconstitutional under the Tenth Amendment. In other words, Congress acted constitutionally in offering states funds under ACA to expand Medicaid to the new coverage group. If a state decides to accept the new ACA Medicaid expansion funds, it must abide by the new expansion coverage rules. However, if a state chooses not to participate in the expansion it cannot lose all of its funds under the current Medicaid program. The states must have a “genuine choice” to accept or reject the new requirements.

State Attempts to “Nullify” or “Opt Out” of Affordable Care Act Requirements

In addition to lawsuits brought to challenge various provisions of ACA, states have considered, and some have passed, bills attempting to nullify, opt out of, or limit the provisions of ACA. Some states have also enacted, with voter approval, constitutional amendments opposing federal health reform measures. An alternative approach to opting out of federal health care requirements has involved consideration of state legislation to create an interstate compact which would give states primary responsibility to regulate health care goods and services. Such an interstate compact would require the consent of Congress under Article I, § 10, Cl. 3 of the United States Constitution.

State statutes and constitutional amendments

On March 10, 2010, Virginia became the first state in the nation to enact a statute which states that, as a matter of law in Virginia, no individual (with certain exceptions) “shall be required to obtain or maintain a policy of individual insurance coverage,” except as required by a court or

⁸⁷ The Chief Justice concluded that the financial penalty imposed by the individual mandate on citizens who failed to obtain health insurance “may reasonably be characterized as a tax. Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness.” *NFIB v. Sebelius*, Slip opinion, C. J. Roberts, at 44.

⁸⁸ *Id.* at 43.

⁸⁹ As Chief Justice Roberts stated: “Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in *that new program* by taking away their existing Medicaid funding.” (*emphasis added*). *NFIB v. Sebelius*, Slip opinion, C. J. Roberts, at 55.

state agency.⁹⁰ This state statute, entitled the Virginia Health Care Freedom Act, is arguably inconsistent with Section 1501 of ACA, which requires individuals to purchase health insurance coverage beginning in 2014.

While Virginia was the first state to pass a law relating to the federal requirement to purchase health insurance, legislators in at least 47 state legislatures from 2009 to 2012 have introduced bills to limit, change, or oppose various federal actions relating to health care reform, including the mandate to purchase health insurance or implementation of a single payer system.⁹¹ Most measures seek to make or keep health insurance optional for individuals, and to ensure that individuals can purchase any kind of coverage they want. A Utah bill, signed into law on March 22, 2010, prohibits an individual health insurance mandate, and, in addition, prohibits any state agency from implementing federal health reform measures without the Utah legislature “specifically authorizing the state’s compliance or participation in, federal health care reform.”⁹² As of June 2012, state statutes had been enacted in Arizona, Colorado, Florida, Georgia, Idaho, Indiana, Kansas, Louisiana, Missouri, Montana, New Hampshire, North Dakota, Oklahoma, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia and Wyoming that oppose elements of federal health care reform provisions in ACA.⁹³

Some proposed state measures to opt out of, or limit, federal health reform measures have been in the form of state constitutional amendments which must be approved by a ballot vote. For example, the resolution passed by the Arizona legislature, and approved by Arizona voters on November 2, 2010, amended the Arizona state constitution to provide that “a law or rule shall not compel any person, employer or health care provider to participate in any health care system.”⁹⁴ A similar state constitutional amendment providing in part that a “person or employer may pay directly for lawful health care services and shall not be required to pay penalties or fines for accepting direct payment from a person or employer for lawful health care services,” was approved by voters in Oklahoma on November 2, 2010.⁹⁵ However, Colorado voters disapproved a similar ballot measure on the same date.⁹⁶ The Wyoming state legislature has approved a similar proposed constitutional amendment to be placed on the voter ballot on November 6, 2012, as have Alabama and Florida.⁹⁷

⁹⁰ 2010 Session Law, Chapter 106, available at <http://leg1.state.va.us/cgi-bin/legp504.exe?101+ful+CHAP0106+pdf>, and codified at Virginia Code Section 38.2-3430.1:1.

⁹¹ For a comprehensive and continually updated survey of state activity in this area, see National Conference of State Legislatures, “State Legislation Challenging Certain Health Reforms, 2010,” at <http://www.ncsl.org/default.aspx?tabid=18906>.

⁹² H.B. 67, enrolled copy available at <http://le.utah.gov/~2010/bills/hbillenr/hb0067.pdf>.

⁹³ See footnote 91.

⁹⁴ See Arizona HCR 2014 of 2009, available at <http://www.azleg.gov/legtext/49leg/1r/bills/hcr2014h.pdf>. In most states that provide for an amendment to the state’s constitution by a ballot proposal, passage requires either a “supermajority” or two affirmative ballot votes in two separate years.

⁹⁵ Oklahoma Senate Joint Resolution 59 is available at <https://www.sos.ok.gov/documents/questions/756.pdf>.

⁹⁶ See National Conference of State Legislatures, “State Legislation Challenging Certain Health Reforms, 2011-2012,” at <http://www.ncsl.org/default.aspx?tabid=18906>.

⁹⁷ The Wyoming proposed constitutional amendment, SJR 2, states that residents have the right to make their own health care decisions, while “any person may pay, and a health care provider may accept, direct payment for health care without imposition of penalties or fines for doing so.” The proposed state constitutional amendment also provides that the state “shall act to preserve these rights from undue governmental infringement.”

A direct conflict between federal and state laws raises constitutional issues which are likely to be resolved in favor of federal law under the Supremacy Clause of the Constitution, which states: “This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; ... shall be the supreme Law of the Land; ... any Thing in the constitution or Laws of any State to the Contrary notwithstanding.”⁹⁸ When Congress legislates pursuant to its delegated powers, state laws, and even state constitutional provisions, must yield. For example, in *Cooper v. Aaron*, 358 U.S. 1 (1958), the U.S. Supreme Court upheld the federal law mandating desegregation of public schools in the face of Arkansas’s constitutional amendment which prohibited integration.⁹⁹ Now that the Supreme Court has upheld the individual coverage mandate in the Affordable Care Act in *NFIB v. Sebelius*,¹⁰⁰ this federal law fully applies to individuals, and any contradictory state laws will have no effect on this ACA provision, other than, in some cases, barring state agencies and employees from enforcing the individual mandate as of 2014.

Interstate compacts

Another approach some states have taken to oppose or opt out of provisions of the Affordable Care Act is to enter into an interstate compact with other states. Interstate compacts are agreements between two or more states that are used for cooperative interactions across state lines. The earliest interstate compacts were used to settle boundary disputes; however, beginning with the establishment of the Port of New York Authority in 1921,¹⁰¹ compacts began to be used to address more complex, regional issues requiring intergovernmental cooperation. Recent interstate agreements have addressed such wide-ranging concerns as law enforcement and crime control, education, driver licensing and enforcement, nuclear waste control, transportation, insurance regulation, and disaster assistance. There are approximately 200 interstate compacts in effect today.¹⁰²

As of June 2012, 25 states have considered interstate compact legislation which would give states primary responsibility for the regulation of health care goods and services, and, seven states, Georgia, Indiana, Oklahoma, Missouri, South Carolina, Texas, and Utah, have passed legislation assenting to an interstate health compact.¹⁰³ This health care compact, which would require approval by Congress before it would be effective,¹⁰⁴ provides that authority and responsibility for health care matters would reside with the compact member states. It also provides that states would have the authority to “suspend,” by state legislation, federal laws and regulations

⁹⁸ U.S. Const. art. VI, clause 2.

⁹⁹ See also *Gibbons v. Ogden*, 22 U.S. 9 Wheat. 11 (1824), *Douglas v. Seacoast Products, Inc.*, 431 U.S. 265 (1977), and Timothy S. Jost, *Can the States Nullify Health Care Reform?* 362 NEW ENG. J. MED. 869-871 (March 11, 2010), available at <http://content.nejm.org/cgi/content/full/362/10/869>. For a general discussion of the Supremacy Clause, see CRS, *United States Constitution: Analysis and Interpretation*, coordinated by Kenneth R. Thomas, at <http://www.crs.gov/conan/default.aspx?mode=topic&doc=Article06.xml&t=1|1&c=2>.

¹⁰⁰ No. 11-393, 567 U.S. ___ (2012), available at <http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf>.

¹⁰¹ 1921 N.Y. LAWS Ch. 154; N.J. LAWS Ch. 151; 42 Stat. 174 (1921).

¹⁰² The Council of State Governments, *Interstate Compacts, “Legislation and Laws,”* available at <http://ssl.csg.org/compactlaws/comlistlinks.html>.

¹⁰³ See National Conference of State Legislatures, “Some States Pursue Health Compacts” (updated, March, 2012) at <http://www.ncsl.org/issues-research/health/affordable-care-act-state-action-newsletter-11.aspx>.

¹⁰⁴ Article 1, § 10, clause 3 of the U.S. Constitution states: “No State shall, without the Consent of Congress, . . . enter into any Agreement or Compact with another State. . . .”

inconsistent with state health care laws, and Congress would assent to providing funding on an annual basis to the states to carry out their responsibilities.¹⁰⁵

State Constitutions and the Provision of Health Care Services

On the state level, governmental obligations to provide health care services either generally or for particular groups of persons may be found in a number of state constitutions. Thirteen state constitutions contain provisions which specifically refer to health.¹⁰⁶ The constitutions of the states of Alaska, Hawaii, Michigan, North Carolina, New York, and Wyoming have provisions which require the state to promote and protect the public health.¹⁰⁷ For example, Alaska's constitution provides that "[t]he legislature shall provide for the promotion and protection of public health."¹⁰⁸ And Wyoming's constitution states, "As the health and morality of the people are essential to their well-being, . . . it shall be the duty of the legislature to protect and promote these vital interests."¹⁰⁹ Other state constitutional provisions permit, and sometimes require, legislative action to fund health care services for specific activities or for certain groups, such as indigent persons. Mississippi has a constitutional provision that authorizes laws for the care of the indigent sick in state hospitals.¹¹⁰ Arkansas's constitution has a provision requiring the legislature to provide for the treatment of the insane.¹¹¹ By and large, however, state constitutional provisions authorize, but do not require, the provision of health care services.¹¹²

Some state courts have liberally construed state constitutional provisions mandating care of the poor to include the provision of health care services. For example, in *Graham v. Reserve Life Ins. Co.*,¹¹³ a provision in the North Carolina constitution mandating "beneficent provision for the poor" was held to require state provision of free medical treatment to indigent sick persons. And the constitutionality of Alabama's Health Care Responsibility Act,¹¹⁴ which imposed financial responsibility for the medical care of county indigents on counties, was upheld in part on the basis of Alabama's constitutional provision requiring counties "to make adequate provisions for

¹⁰⁵ For more information on the Health Care Compact, see <http://www.healthcarecompact.org/>.

¹⁰⁶ See discussion and survey of state constitutional provisions relating to health care in article by Elizabeth Weeks Leonard, *State Constitutionalism and the Right to Health Care* (updated August 13, 2009), available at http://works.bepress.com/elizabeth_weeks/3/. See also Cynthia Soohoo and Jordan Goldberg, *The Full Realization of Our Rights: The Right to Health in State Constitutions*, 60 CASE W. RES. L. REV. 997-1072 (2010).

¹⁰⁷ See Rory Weiner, *Universal Health Insurance Under State Equal Protection Law*, 23 W. NEW ENG. L. REV. 327, 334 (2002).

¹⁰⁸ ALASKA CONST. art. VII, §4 .

¹⁰⁹ WYO. CONST. art. 7, §20.

¹¹⁰ HAW. CONST. art. IX, §3 and MISS. CONST. art. IV, §86.

¹¹¹ ARK. CONST. art. 19, §19.

¹¹² See, e.g., the constitution of New York, which states that "[t]he protection and promotion of the health of the inhabitants of the state are matters of public concern and provision therefore shall be made by the state and by such of its subdivisions and in such manner, and by such means as the legislature shall from time to time determine." N. Y. CONST. art. 17, §3. According to one author, state judicial decisions construing provisions of state constitutions "demonstrate a general reluctance to recognize affirmative, enforceable health rights." See, generally, Leonard, Part II.B, at 22-40, supra, footnote 106.

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

¹¹⁴ ALA. CODE §§22-21-290–22-21-297.

the maintenance of the poor.”¹¹⁵ As a general matter, state constitutional rights may be more expansive than those found under the federal Bill of Rights, since federal rights set the minimum standards for the states. States are always free to provide for greater protections for their citizens than are provided on the national level.¹¹⁶

The provision of health care services under a state health care program may be subject to limitations under equal protection provisions in a state constitution. In 2009, Massachusetts denied state subsidies for the purchase of health insurance to a category of noncitizen immigrants lawfully residing in Massachusetts, specifically those who would be ineligible for certain federal benefits (those in the United States for less than five years, and certain others). Prior to that time, all lawful immigrants in Massachusetts were eligible for coverage under Massachusetts’ Commonwealth Care program, with subsidies provided for those individuals with incomes below 300% of the federal poverty level. The Supreme Judicial Court of Massachusetts, in *Finch v. Commonwealth Health Insurance Connector Authority*,¹¹⁷ used a strict scrutiny standard of review to determine that the state did not demonstrate a compelling interest that would justify excluding certain classes of lawful resident aliens from the state’s subsidized health insurance program. The court noted that the state was undergoing a financial crisis at the time the Commonwealth Care program was amended, and that the motivation for the provision appeared to be fiscal, which could not constitute a compelling justification for the exclusion of certain classes of legal aliens from the subsidized insurance program. “The discrimination against legal immigrants that [the statute’s] limiting language embodies violates their rights to equal protection under the Massachusetts Constitution.”¹¹⁸

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¹¹⁵ *Bd. of Comm’rs v. Bd. of Trs. of the Univ. of Ala.*, 483 So. 2d 1365, 1366 (Ala. Civ. App. 1985), and *Marengo County v. Univ. of S. Ala.*, 479 So. 2d 48, 51 (Ala. Civ. App. 1985). *See also* discussion, generally, at 333-337, Weiner, *supra*, footnote 107.

¹¹⁶ *See, e.g.*, *Cruzan v. Dir., Mo. Dep’t of Health*, 497 U.S. 261, 280-182 (1990), where the Court recognized that Missouri was entitled to accord stronger protection to preservation of life than federal law by requiring clear and convincing evidence to terminate life support.

¹¹⁷ 461 Mass. 237, 959 N.E.2d 970 (2012).

¹¹⁸ 461 Mass. at 250, 959 N.E.2d at 984.